RIGHTS-BASED SAFEGUARDS VS. SYSTEMIC IMPLEMENTATION: A SYSTEMATIC REVIEW OF STATUTORY COMPLIANCE, INTERSECTORAL GOVERNANCE, AND JUDICIAL ENFORCEMENT UNDER INDIA'S MENTAL HEALTHCARE ACT 2017

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ABSTRACT

Background: India's Mental Healthcare Act 2017 (MHCA) recognizes the right of persons with mental illness to treatment, community living and non-discrimination, and provides for certain safeguards. The Act does not create corresponding institutions, and did not immediately improve access to mental health care, though it established a legal right to mental health care. The aim is to review the observable compliance gap in law, intersectoral governance and the courts. Methods: We analyzed 2020-2025 published and unpublished studies, and institutional records, and court judgments, and used doctrinal analysis to interpret the MHCA. Results: In 2022, a South Indian government notification stated that most of the administratively formed Boards had ceased to function; and, in 2023, a Parliamentary Standing Committee report stated that Mental Health Review Boards were unformed in most of the states. In 2024, 92.5% of the 600 surveyed psychiatrists stated they were dissatisfied with the MHCA and 66.5% felt procedurally obstructed. In 2025, a survey of 235 health insurance policies showed that 88 of the policies included mental health benefits. An audit of 222 magistrate's court orders for psychiatric commitment at a tertiary care hospital in 2025 showed that 38 of the orders cited the MHCA. In 2025, the Supreme Court ordered reports from the statutory authorities and later on, gave directions to the National Human Rights Commission to continue monitoring. Conclusion: The evidence shows an implementation gap in staffing and functioning of the systems, intersectoral governance and supervision. National compliance cannot be generalized from the present heterogeneous studies. More indicators are needed to test the practical enforceability of rights. [1-16]

Keywords: Mental Healthcare Act 2017; mental health rights; statutory compliance; review boards; intersectoral governance; judicial enforcement; India; evidence synthesis.

1. Introduction

Indian mental health law recognizes the importance of a person's dignity, agency, and right to equality and access to care. One of the principal mental health laws, the Mental Healthcare Act, 2017 (MHCA), was enacted in 2017 and came into force in 2018. The MHCA defines legal capacity, provides for advance directives and nominated representatives, and explicitly mentions a person's right to treatment and residence in the community, right against degrading treatment, right to information and confidentiality, right to legal service, etc. One of the key questions that the Act raises is who will implement these rights, and what can a person do if the implementation agency does not take any action? The law may declare wide-ranging rights for a person, but the person may not find a working legal forum, or an affordable or accessible service, or an expeditious legal remedy. [1]

The law mentions various agencies at the center and in the states, mental health establishments, the review board, health professionals, the police, prisons, insurers, and public administrators, as the responsible agencies. These agencies work at various tiers of government and through various departments with different budgets and standards. This makes the implementation of the law variegated. No state has notified rules. Authorities may not have members. Boards may not meet or have a functioning secretariat. Establishments may not provide adequate care. Judicial orders may not lead to treatment. [1, 3, 5]

The little available implementation literature points to these differences.

Philip and others looked at publicly available information for southern states and described the varying statuses of authorities, laws, rules, websites and Mental Health Review Boards. Ghosh and others described issues related to the absence of Mental Health Review Boards and community mental health services, and the effect of these issues on day-to-day clinical practice. Gupta, Misra and Gill described some of the issues related to the design and resource allocation of quasi-judicial review, and these issues affect the functioning of mental health review boards. [2-4]

The 148th Report of the Parliamentary Standing Committee (2023) showed the existence of mental health laws in several states of the country, and identified review boards as being “unconstituted” in the majority of states. The Report further described the absence of an adequate number of staff, lack of financial resources and an effective mechanism to address

complaints. The National Human Rights Commission report (2023) observed similar problems with regard to the framing of mental health laws, the process of rule making, registration, and availability of trained personnel. [6,7]

There are a number of other studies that look at some of the issues raised above in different contexts. A national survey of Indian psychiatrists reported implementation issues and highlighted dissatisfaction of professionals. A review of insurance policies showed disparities in the types of mental health coverage provided. There was a hospital chart audit that reviewed legal citations for mental health admissions and found discrepancies. Although each of these studies reviewed different constructs, percentages reflecting the same parameter would be more useful to estimate the level of compliance as opposed to combining the percentages of the various parameters and reporting them as a single implementation figure. [8,10,11]

The review therefore seeks to identify the interaction of law, administration and judiciary with respect to mental health and distinguish implementation from mere compliance.

This contribution makes an integrated analysis of (i) the rights-to-duty translation, (ii) observable administrative and sectoral bottlenecks, and (iii) judicial tools for obtaining accountability. It uses a clear source ledger and descriptive interval display to keep observed denominators, and to avoid unsubstantiated national extrapolations. The underlying normative proposition is rather straightforward. The system built to monitor the implementation and execution of a suite of rights will not inspire confidence, or gain legitimacy, if the institutions established to investigate violations of the rights are unavailable, lacking independence and accessibility, and not actually used.

2. Constitutional and statutory framework

The MHCA's rights chapter is unusually specific for health legislation. It covers, among other things, the right to access mental health care and treatment (s.18); right to community living (s.19); protection against cruel, inhuman and degrading treatment (s.20) and discrimination (s.21); information (s.22); and the right to access one’s mental health records (s.25) as well as the right to contact and communication (s.26) and to legal aid (s.27). Formal complaint rights (s.28) also exist. However, for these rights to be meaningful, information and community support have to be made available. Rights to complain are meaningless without an accessible and available pathway to an adjudicatory or review function. A measuring mechanism must be

developed to correlate each statutory right with its duty bearer and indicate how the right will be enjoyed. [1]

Rights to advance directives (s.5) and nominated representatives (ss.14-17) are also provided. Supported decision making is addressed when individual rights and obligations conflict. The implementation of these rights has raised implementation issues due to the nature of documentation, interpretation of directives, and availability of records. The presence of difficulties in provider surveys should not be taken as evidence that the rights in question are deficient. A balanced legal evaluation of the MHCA should ask whether the training, infrastructure and legal processes could resolve the difficulties reported.

Rights pertaining to the Central and State Mental Health Authorities are provided in ss.33-56, respectively. Rights to mental health review boards are provided in ss.73-85.

Bodies created for review, inspection, protection of rights and procedural oversight tend to be created and made operationally ready at the same time. For instance, a board may be created through legislation, but it may not have all members appointed, or may not sit regularly. Operational Readiness may require the presence of staff, budget, accessible documents, decisions and regular liaison with hospitals. The Act outlines regulatory requirements for mental health services, including registration and standards. [1, 3, 6]

The relationship between Sections 18 and 21 is particularly relevant to funding. Section 18 contains an entitlement to treatment for mental illness, and Section 21 requires insurers to provide medical insurance for treatment of mental illness on the same basis as physical illness. An equality guarantee is incomplete if insurance categories exclude mental health. There are concerns for all forms of mental health outpatient services including outpatient individual and group therapy. Therefore, coverage must be evaluated not only based on whether mental illness is included in the product, but also on terms, conditions and waiting periods, as well as claims experience. [1, 6, 10]

Section 115 presumes extreme stress for an individual attempting suicide, and changes the normal response of the criminal law. This section is relevant to crisis services, particularly the police, and the pathways of referral. The implementation of this section requires working in collaboration with emergency and crisis services. This section should not be interpreted to change the legal effect and other implications of self-harm.

The 2025 Sukdeb Saha judgment is pertinent in a related but separate regard: the Court reviewed mental health protections for students within the educational setting and issued directives in broad terms for institutional protections. It cannot be read in substitution of the specific review boards established under the MHCA. [1, 14]

In constitutional law, a second avenue of accountability can be seen in Articles 14 and 21 and Articles 32 and 226. The former give the right to equality and to life and liberty; and the latter provide for access to the court for enforcement of rights and for a writ of mandamus. Court supervised implementation of those rights can take the form of requesting and considering factual affidavits, and ensuring the coordination of administrative measures to effectuate such rights. But, such judicial supervision is expensive and only episodic for the majority of the population, and can place a burden on the administrative and fiscal resources of the courts. A more realistic approach would be to ensure access to effective first-instance review and then to judicial oversay where necessary. The relation to the Rights of Persons with Disabilities Act, 2016, and to international disability-rights standards, mainly points to the participation of the concerned persons as well as to non-discrimination and autonomy. [1, 12 -16]

Table 1. Selected statutory guarantees and implementation tests

Provision	Right or function	Observable implementation test
ss. 5–13	Advance directives	Accessible registration, retrieval, modification and review mechanisms
ss. 14–17	Nominated representatives	Appointment procedures and accessible support
s. 18	Access to mental healthcare	Service availability, affordability, geographic access and referral
s. 19	Community living	Supported housing, rehabilitation and reintegration arrangements
ss. 20–21	Dignity, equality and non-discrimination	Safeguard monitoring and insurance parity
ss. 22–28	Information, records, confidentiality, complaints	Patient-facing information and functioning grievance mechanisms
ss. 45–56	State authorities	Appointments, meetings,

Provision	Right or function	Observable implementation test
		staffing, published registers and budgets
ss. 73–85	Mental Health Review Boards	Constitution, staffing, hearings and adjudication records
s. 115	Attempted suicide and severe stress	Non-punitive crisis-care and interagency protocols

3. Review design and methods

This manuscript employs a structured, targeted evidence retrieval, and legal-doctrinal synthesis. It does not claim to represent a comprehensive search of Scopus, Web of Science, HeinOnline or other subscription databases for which complete query-level exports and screening records were unavailable. The PRISMA-style diagram includes only the candidate records inventoried in this exercise. This differentiation is to distinguish targeted evidence retrieval from a fully reproducible, systematic review of all databases. The evidence window for secondary scholarship and official implementation documents is 2020 to 2025; the MHCA itself is analyzed as a necessary earlier primary legal authority [1, 17].

Candidate sources were located through public searches on the MHCA and related laws, mental health authorities and review boards, constitutional enforcement, implementation surveys and parliamentary monitoring, insurance/admissions, and other related sources. Index listings and publication pages of the same article were treated as duplicates. Sources were eligible for inclusion if they examined the implementation, institutional governance, and/or enforcement of the MHCA, or the relevant rights-based service design. A court decision was assessed based on the exact parties, court, date, and preceding or subsequent decisions. The NHRC annual report was published after the literature cut-off, and therefore was excluded [2-16].

The 16 documents include the MHCA, scholarly articles and commentary, parliamentary and human rights reports and documents, a policy report, international practice and standards, and court decisions. Other documents include PRISMA and related methodological articles; these are not counted as independent studies.

Three articles retained empirical data amenable to descriptive interval analysis with respect to their choice of numerical units: psychiatric practitioners, types of insurance policies, and court

ordered admissions. Two articles derived from the same survey of psychiatrists, were considered as one participant sample for any numerical synthesis and thereby avoided duplicate weighting. [8-11, 17]

Data extraction centered on bibliographic verification, research design, jurisdiction, time period, statutory provisions, unit of analysis, concrete numerator and denominator, administrative status, and substance of the findings, and their limitations. Legal sources were classified and coded separately according to the legal hierarchy of the direction, remedial or prospective nature of the direction, and extent to which the direction was accompanied by an obligation to report and/or provide follow-up.

Critical appraisal of the above research was done domain-wise. Findings from cross-sectional surveys were reviewed regarding voluntary versus invited response, varying sample frame, self report, and the differences between item denominators, and the distinction between clinician attitudes and independently verified compliance. The extent to which products and policies were defined and identified was evaluated in a document audit. A retrospective case record review of admissions was vulnerable to local variation in coding and practice. Reports of Parliamentary Commissioner and other Commissions were considered as institutional evidence of high documentary relevance but low study design comparability. Judgments were assessed for their binding or advisory nature.

Quantitative estimates were reported only when a usable numerator and denominator appeared in a verified publication. The 95% Wilson score confidence intervals, displayed for descriptive purposes, were recalculated from published counts. They do not adjust for selection bias, clustering, undercoverage or source measurement error. A pooled statistic, I^2, Q statistic, meta-regression, or test for publication-bias was not conducted. The outcomes do not share a common estimand and source independence or denominators are not sufficient for a coherent meta-analysis. A forest-style interval graph depicts the descriptive estimates in a pooled diamond format. [8, 10, 11]

Although the manuscript used PRISMA language to describe its source accounting, it did not describe independent duplicate screening, or full registration or PRISMA 2020 compliance. These would require a complete, pre-specified, search strategy, search record exports, second reviewer decisions, and a full-text exclusion record. The process used is appropriate as a bounded evidence synthesis and a foundation for a registered review; claiming more would be

to overstate the methods actually implemented. [17]

Table 2. Retrieval framework and evidence eligibility

Component	Operational rule	Documentation
Scope	India MHCA implementation and enforcement; 2020–2025 literature	Earlier Act retained as primary law
Search	Targeted public searches and official public sources	Appendix B enumerates candidate records
Population / units	State/UT authorities; clinicians; policies; admissions; legal matters	Do not treat different units as one pooled sample
Evidence	Empirical research, court orders, parliamentary reports, institutional material	Primary-versus-secondary source distinguished
Exclusions	Duplicates; out-of-window later publication; derivative coverage	Reasons shown in flow and ledger
Analysis	Structured thematic legal synthesis; source-specific proportions	Wilson 95% CIs, no pooled effect

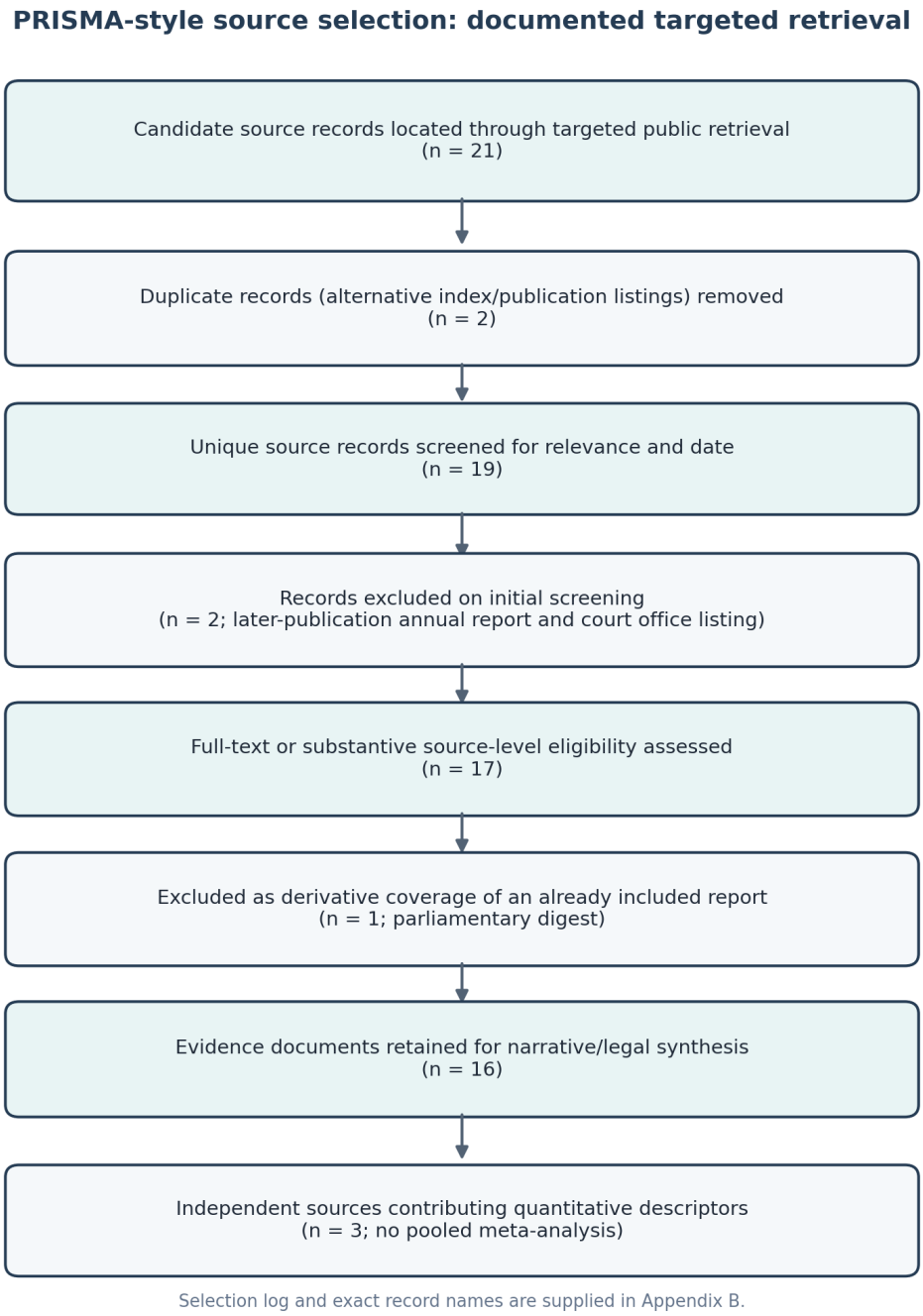


Figure 1. Source-selection accounting for the bounded targeted-retrieval evidence corpus. This is not a full multi-database PRISMA screening flow.

4. Results: evidence base and statutory compliance

The candidate set comprised 21 source records. Two duplicate index records were removed, and 19 records were screened for title and date. Two records were excluded. The remaining 17 records were assessed at the source. One record of a parliamentary digest was excluded since

the underlying parliamentary report was already included, yielding 16 records for the legal and narrative synthesis. Only 3 independent publications were used to estimate the quantitative outcomes. These publications reflect counts of the logged targeted retrievals, and do not reflect estimates of the entire universe of eligible MHCA publications. B Appendix identifies the records, and their respective dispositions.

There is a consistent divide between legal form and practical capacity. The south zone review noted differences among the states of Andhra Pradesh, Karnataka, Kerala, Tamil Nadu and Telangana, and indicated related Union Territories. The authors identified a number of states where the rules and review boards had been published, while the appointments, and/or the operational status, of the same remained incomplete and/or uncertain. In the absence of any information, it was imputed that such information was lacking. It must not be recoded to indicate that the institutions in question had never existed. This is an important caveat when interpreting the current state-wise dashboards: the existence of a webpage is a transparency indicator; it does not mean that the respective functions are, or have been, fulfilled. [2]

The August 2023 report of the Parliamentary committee provides a more general administrative assessment. It noted the appointments of officials in the State Mental Health Authorities and stated that the same was the case for executive officers and staff. It noted that mental health review boards had not been constituted in the majority of the states, and urged the development of an integrative tracker of the said authorities, boards, and staff and resources. This wording provided a concern of major implementation failure for the year 2023; it did not supply a ‘standard’ count of states or a functional capacity denominator at the board level. The same report mentioned the limited visibility of the Central Mental Health Authority and urged regular reporting and the setting up of a dedicated website. [6]

The NHRC review alluded to similar concerns when it reported weaknesses in the formation or functioning of statutory bodies, drafting of state rules, registration of professional bodies and qualified capacity.

This is relevant because a weak board or regulator can be ineffectual in enforcing legal rights despite the presence of laws formally recognizing those rights. However, report-level statements must be read as inspection and institutional observations rather than as directly interchangeable estimates of statistical prevalence. Further evidence would require time-stamped records from all states and UTs, including appointment records and hearing

statistics.[7]

The 2024 survey on psychiatrists provides additional implementation insight. Six hundred psychiatrists completed an online questionnaire. The authors described respondent dissatisfaction, knowledge gaps regarding functioning authorities, inadequate registration procedures, and problems related to the use of advance directives and the Mental Health Review Boards. Sixty-six percent of respondents believed that procedural issues were a barrier to making medically appropriate decisions. Knowledge of the existence of a Mental Health Review Board in the area was reported by only 27.3% of respondents. Again, this survey provides respondent-awareness data; it does not provide information on the number of legally functioning boards in India. The same survey points out that procedural issues are a barrier to making medically appropriate decisions. The survey is provider-centered, and the concerns with the implementation process and training are appropriately noted; however, this must be balanced with the perspectives of people with mental illness, their families, and the disability-rights organizations and public institutions that are legally bound to provide care.

A rights-based law must be assessed for its potential impact on both administrative feasibility and the autonomy and dignity of the subject of the law. [8,9]

The findings related to access and equality are found in health insurance. Avula and others analyzed 235 insurance policies of 30 insurance providers and classified them according to their explicit coverage. They reported 88 policies covering mental illness, 28 policies covering people with disabilities and 119 policies covering neither category in the scheme described in their abstract. Product-level classification is not the same as the number of people covered, eligible admissions or paid claims. A policy covering mental illness may have a waiting period, exclusion, or coverage limited to outpatient treatment. These suggest the need for stronger regulatory disclosures and contract-level monitoring, in keeping with the MHCA equality principle. [10]

A retrospective study conducted in 2025 on a south Indian tertiary psychiatric hospital reviewed 354 patients, of which 222 were patients brought by a magistrate's order and 132 were mentally ill prisoners. Of the patients brought by a magistrate's order, the authors stated 115 were admitted based on the 1987 Act, 38 based on the MHCA, and 68 who were admitted without a reference to any Act. The category counts of 115 and 38, respectively, sum to 153. The 38/222 proportion is stated with its specified denominator but the legal basis of the

remaining records is not assumed. The results of the study describe challenges with documentation and transition at a single institution. [11]

Table 3. Retained studies and documentary evidence: selected characteristics

Source / year	Unit or scope	Design and principal use
Philip et al., 2022 [2]	Five southern states and related UTs	Notification and MHRB-status mapping
Gupta et al., 2022 [3]	Review-board structure	Comparative institutional/legal critique
Vashist et al., 2022 [4]	National policy framework	Implementation-oriented policy analysis
Ghosh et al., 2022 [5]	Clinical practice	Implementation commentary
Parliament, 2023 [6]	National ministries and institutions	Standing Committee administrative oversight
NHRC, 2023 [7]	Human-rights oversight	Institutional review and recommendations
Malhotra et al., 2024 [8–9]	600 psychiatrists	Online survey and associated qualitative reporting
Avula et al., 2025 [10]	235 insurance products	Insurance policy document audit
Veerendra et al., 2025 [11]	354 admissions	Single-centre retrospective review
Supreme Court, 2025 [12–14]	Judicial matters	Operative directions and broader mental-health safeguards

Table 4. Regional implementation signals from the 2022 southern-state review

Jurisdiction	Reported MHRB status	Reported operational information
Andhra Pradesh	Board reported as formed	No public operational information in the source
Karnataka	Five boards reported	Not operational in the source period
Kerala	Five boards reported	Vacancies; not operational in

Jurisdiction	**Reported MHRB status**	**Reported operational information**
		the source period
Tamil Nadu	Thirteen boards reported	Applications called; not operational in source period
Telangana	No publicly verified formation information	Absence of public information; do not infer legal non-existence
Puducherry and Lakshadweep	No public-domain board information in the review	Cannot classify functionality from this record alone

Table 4 shows the authors' 2021 information cut-off and should not be read as current state administration. Apparent differences between source years are due to changes over time, varying levels of verification and different thresholds for "constituted" versus "functional" status. [2,6,12-13]

5. Quantitative evidence and interval display

Specific published counts appear in three sources. In the clinician survey, 555 of 600 respondents is reported to correspond to 92.5% dissatisfaction; 399 of 600 is reported to correspond to 66.5% of respondents stating they were procedurally deterred and the published 73.3% in support of amendment is reported to correspond to approximately 440 of 600 at one decimal place. These figures are calculated directly from the articles denominator and percentage. The reported attitudes and experiences were measured on a voluntary basis; the intervals provided below illustrate the 95% confidence limits of binomial sampling distribution assuming no other constraints. [8]

The insurance audit showed that 88 of 235 products (37.4%) included mental illness coverage. The study abstract reported 37.5%. In this review, the source counts are preserved, and the source discrepancy, rather than calculating to one decimal place and making small approximations, is reported. The same abstract stated 28 products (11.5%) indicated mental health coverage. Using mathematics, 28/235 is equal to 11.9% and this review is focused on reproducibility. The admission study reported that 38 of 222 (17.1%) magistrate-ordered admissions were made under the MHCA. No generalization regarding the legal sufficiency of the other admissions is made without reviewing the case files. [10, 11]

Figure 2 is purposely a "scatterplot" presentation of descriptive proportions of non-comparable results.

The figure has no pooled diamond and doesn't claim an overall MHCA compliance prevalence. Estimates for clinicians are for people, the insurance estimate is for products, and the hospital estimate is for admissions. Because the units of comparison and operational definitions vary across studies, reporting an I^2 or Q would be an error in logic, rather than providing additional rigor.

Table 5. Numerical indicators supported by primary published counts

Indicator / source	Events/denominator	Observed proportion	Interpretation
Clinician dissatisfaction [8]	555/600	92.5%	Attitude among respondent psychiatrists
Procedural deterrence [8]	399/600	66.5%	Self-reported decision-making friction
Preference for amendment [8]	~440/600	73.3%	Rounded published proportion; count approximate
Insurance with mental-illness coverage [10]	88/235	37.4%	Policy-product classification
Magistrate cases citing MHCA [11]	38/222	17.1%	Single-hospital admission coding

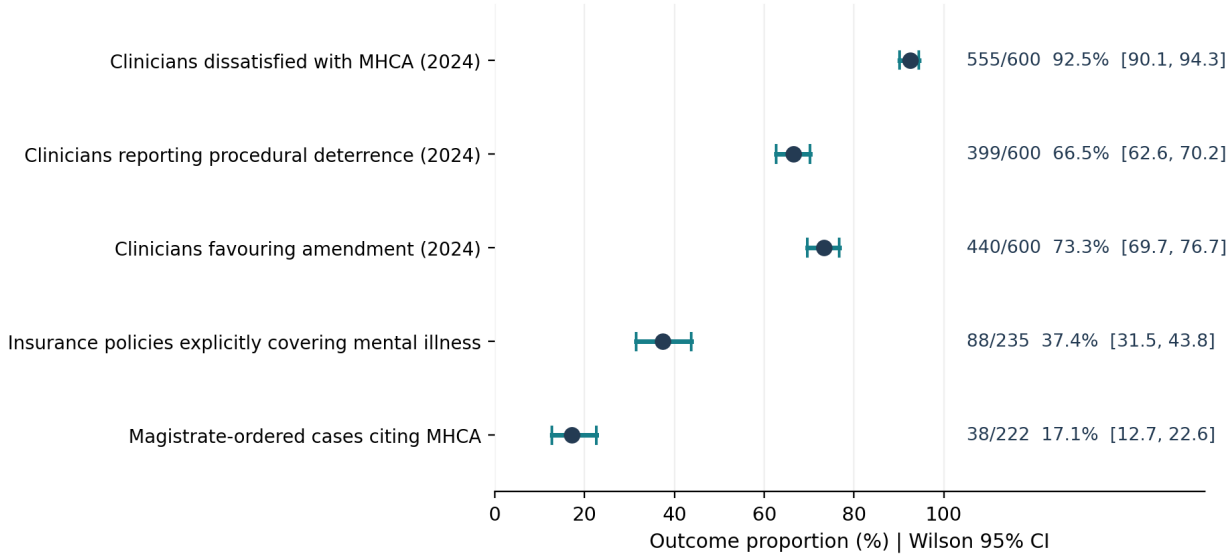


Figure 2. Forest-style display of non-pooled source-specific proportions and recalculated 95% Wilson confidence intervals. Heterogeneous endpoints are not interpreted as one compliance effect.

6. Intersectoral governance and administrative accountability

Implementation requires coordination of multiple sectors of government including health, social justice, welfare, finance, insurance, education, police, prison and court services. There is also a need for coordination of efforts across the civil society including the corporate world. If the law is to guarantee entitlement to community living, several social supports, community rehabilitation and integration would be necessary. It could also require the collaboration of different sectors including health, education and social welfare, justice and civil services. An emergency response to a person in mental distress could include collaboration of police, emergency medical services, legal and mental health services, social welfare and other supports. The statute creates practical risks for patients, at various agency interfaces, where no single agency has control of the entire patient journey. [1, 15, 16]

Weaknesses in governance could occur vertically, horizontally and at the facility level. A vertically fragmented situation may occur, for example, where the central government sets laws and the state governments implement the laws. Horizontal fragmentation may exist where various ministries handle different aspects of disability, health and social welfare. Where fragmentation occurs at the facility level, documentation may exist to recommend community discharge, yet board approval may be lacking, and linkages to home- or community-based

services may also be absent. Fragmentation at all these levels may mean that the community is not able to support the exercise of an individual's rights to community living. This includes legal availability of free care. The availability of legal care may be of little use if it is not accessible, especially if it is located far away.

Publication helps address superficial compliance with the OR (3,6,7)

One key example of intersectoral responsibility is mental healthcare in prison. The 2023 Standing Committee highlighted 9,180 inmates in 2021 with mental illness and stressed the need for the respective staff and training. This administrative data creates an imperative to develop a pathway from identification to assessment, treatment, and legal review, and to follow up in the community; this data does not assess the prevalence of mental illness that remains unaddressed. In this case, prison accountability ensures the effective and appropriate integration and cooperation of prisons, the public health and medical sectors as well as review institutions, and other partners, including protection against degrading treatment. [6]

The insurance aspect of the issue requires both legal and policy engagement. It should capture contract wording, exclusion wording and rationale, waiting periods, prior authorization, outpatient care, complaints and redress, and remedial orders. Product audits and other reports can be very informative, but are often silent on the legality of a given insurer’s actions. A modern reporting dashboard could help distinguish, for example, “claims approved” from “text mention.” Coverage should be disaggregated by region to truly assess access to healthcare (1,6,10).

International rights-based service guidance enables community-based crisis and rehabilitation systems connected to housing, education and social services. Such guidance does not reflect that Indian service networks meet these needs; it rather provides measures against which policy makers and public auditors may assess the adequacy of a services ecosystem. Therefore, a rights-based monitoring framework should rather be structured around the service beneficiary’s journey than institutional reporting. [16]

The 2022 global mental health assessment by the World Health Organization is calling for investment in community-based systems and the coordination of responses to social determinants of health.

The 2021 technical packages published by the organization discuss community mental health centres and mobile outreach, crisis care, and peer support. These components illustrate service functions such as the establishment and maintenance of local service continuity, and timely, non-coercive, and emergency responses. Along with planned and sustained participation of people with lived experience, they illustrate how voluntary and community initiatives can be established to ensure that the rights of people with psychosocial disabilities are fully respected and protected. They outline how India's section 18 access rights and section 19 community living rights safeguards can be integrated in a practical and accessible language without alluding to direct compliance in India. [18-22]

Table 6. Responsibilities and intersectoral coordination points

Actor	Core responsibility	Implementation indicator
Union and central authority	Standards, guidance and oversight	Annual public report and operational register
States and SMHA	Authority functions; establishment regulation	Full appointments, budget and complaints process
Mental Health Review Boards	Rights review and statutory oversight	Sittings, accessibility and disposal time
Hospitals and clinicians	Consent, clinical documentation and safe care	Rights notices, discharge planning and audits
Insurance sector / regulator	Parity in policy terms and practice	Product provisions and claims grievances
Police and prisons	Humane referral, assessment and coordination	Training, referrals and legal oversight
Welfare and housing services	Community living and rehabilitation	Supported placements and follow-up continuity
Courts, legal aid and NHRC	Remedy and implementation supervision	Reasoned orders and compliance tracking

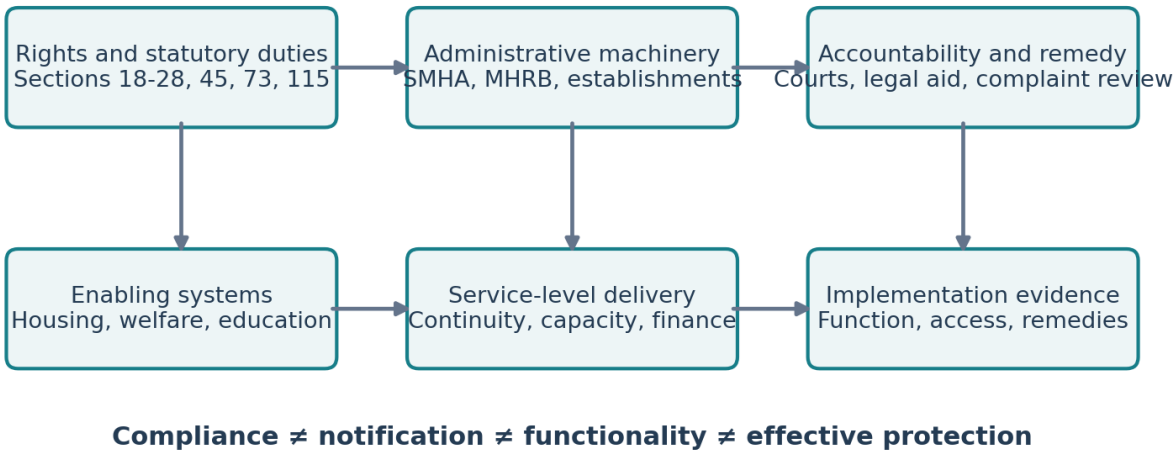


Figure 3. Analytical pathway connecting statutory rights, public administration, sectoral service delivery and remedies. Arrows represent institutional dependency, not measured causal effects.

7. Judicial enforcement and the limits of court-led implementation

JUDICIAL ENFORCEMENT has a special place in the MHCA ecosystem, as the statute creates a number of rights, the enjoyment of which can be thwarted by delay caused by the institution. Orders of the court can be sought to require the executive to explain how the enabling authorities were created, whether review boards have been established, whether required appointments have been made, etc. Orders of the court may be sought to direct, among other things, the recognition of a right, order disclosure of a document or direct an administration to take a particular action. Long-term supervision by the court is not uncommon. [1, 12, 13]

In Gaurav Kumar Bansal & Others v. Union of India, the petitioners' writ of mandamus was allowed by the Supreme Court on 7 February, 2025. As part of its operative order, the Supreme Court issued a mandamus to the Union of India to direct the central and state mental health authorities and review boards to be established and to make mandatory appointments. The order clearly illustrates how the court used its supervisory power to order production of information on the establishment of statutory bodies. The order signifies that the Court did not simply reiterate legal obligations but directed status reporting. The court order did not establish whether the bodies in question had been set up. [12]

The order of the court dated 28 October 2025 accepted the status of the Union of India in respect of the central mental health authorities, state mental health authorities and review boards. In the interim, the connected writ petitions were transferred to the National Human Rights Commission for appropriate disposal, the Supreme Court noting the status report in respect of Central and Union Territory authorities.

It should not be paraphrased as the final national conclusion that all states had met their obligations under MHCA. The record itself speaks about the ongoing operationalization and the need for monitoring. [13]

Sukdeb Saha v State of Andhra Pradesh (2025 INSC 893) dealt with the mental-health crisis among students and in educational institutions. The Court outlined preventive measures such as institutional safeguards, district level coordination and a monitoring architecture for coaching centres and educational institutions. For this review, the focus is on the importance of the Court's recognition of mental health as a salient constitutional issue cutting across various sectors. It should not be perceived as a judgment on the legality of every mental health establishment or as a national level conclusion on the National Mental Health Review Board. The correct comparative point is that student welfare, health services and administrative/regulatory measures ought to operate in conjunction for preventive rights protection. [14]

Judicial enforcement is best conceptualized as supplementary. A court can, and often does, order information and correct an evident refusal to perform a legal duty. It can also provide a mechanism for maintaining the necessary political pressure for intergovernmental cooperation. A court cannot, and often will not, supply psychiatrists or determine every urgent treatment. A tribunal or board may be more effective and efficient than litigation for providing timely, expert and specialist assessments. The combination of an internal clinical assurance framework, an operational statutory review body, legal aid, public oversight and the courts, may be the best means to respond effectively to structural issues that arise in urgent cases. [1,3,6,12-14]

A final caution concerns making causal claims. Telling a court case 'hastened' a notification or appointment may be reasonable in the temporal sense, but it may be necessary to provide evidence to show what would have happened in the absence of the court case.

A similar caution applies to transfer to a human rights body: being referred to a body for review does not mean that the review body has determined that the state in question has failed to provide adequate remedies for the person in question.

Table 7. Principal judicial documents and doctrinal significance

Court record	Nature of action	Review relevance
Gaurav Kumar Bansal v Union of India, 7 Feb 2025 [12]	Direction to submit affidavit on statutory bodies and appointments	Judicial information-forcing and compliance scrutiny
Gaurav Kumar Bansal v Union of India, 28 Oct 2025 [13]	Recorded central status and transferred monitoring to NHRC	Continuing oversight beyond formal litigation
Sukdeb Saha v State of Andhra Pradesh, 25 Jul 2025 [14]	Student mental health protections and institutional directions	Intersectoral preventive safeguarding

8. Quality appraisal, certainty and methodological constraints

The biggest limitation across the evidence set is heterogeneity rather than absence of concern. The administrative reports typically note the absence of some boards and staffing. The clinician survey measures attitudes and experiences. The insurance study classified documents and the admission study audited records. These data sources operate at different levels of the institution and were observed at different times. There is no "national statutory compliance" common denominator; constructing one from the published sources would create undue precision.

Surveys of 600 volunteers provided detailed information on respondents to a psychiatrist survey. Participants were recruited through professional channels and completion was voluntary. The likely impact of response and self-selection bias in the available outcome tables cannot be ascertained. It is not correct to state that respondents' views represent arbitrary perceptions. Respondents' perceptions may not be directly equivalent to factual state compliance; however, the state ministry position that the authorities are established does not, by itself, represent a verified measure of the functional efficiency of the authorities. [8]

The insurance review employs systematic document collection and explicit denominator approaches. Policy classes, as described in the abstract, are not necessarily equivalent to the level of enrollees or claims.

The reported category "28 (11.5%)" doesn't match the cited total of 235. Respondents should verify their work against the study tables instead of assuming that the printed percentage is more trustworthy than the cited totals. There is a similar reconciliation issue with the magistrate order categories in the single-center hospital study, which add up to one fewer than the specified subcohort. Neither of these issues invalidates all the findings, but each shows that we should be careful with how precisely we state our findings. [10,11]

Judicial records provide evidence of what the court ordered. These do not necessarily prove that an executive branch assertion was subsequently implemented. Affidavits by the government show what the government has said and are subject to verification against staffing orders, the government's financial records, records of board sittings, and evidence of services provided to the public. Reports by human rights organizations provide institutional perspectives and may be based on inspections, but may not be representative of the entire population.

The most robust possible future design would be to provide independent and repeating definitions, and construct state by state and district by district compliance panels. [6,7,12,13]

Table 8. Evidence limitations and confidence judgments

Evidence family	Main concern	Conclusion supportable
Notification mapping [2]	Public availability and 2021 time restriction	Documentary status in sampled jurisdictions at source date
Clinician survey [8–9]	Voluntary professional response and self-report	Professional experience and stated opinions
Insurance product audit [10]	Policy wording ≠ actual claims experience	Frequency of classified wording in sampled products
Hospital admissions [11]	Single centre, retrospective	Legal citations documented

Evidence family	Main concern	Conclusion supportable
	case-record coding	in this institution
Parliament/NHRC [6–7]	Incomplete standardised denominator	Institutionally reported implementation gaps
Judicial orders [12–14]	Order text ≠ verified execution	Legal duties, directions and procedural status

9. Discussion

The synthesis proposes a three-fold gap in implementation. The first is a normative gap. This occurs when laws or policies do not exist to create mechanisms through which rights are formally protected. The second, organisational gap, occurs when a state or service provider creates a means to meet an obligation, for example, by allocating funding to employ staff, establish a procedure, and/or develop a reporting and service network. The third, experiential gap, occurs when a person who is entitled to a right, is able to exercise it at the point of care (treatment, discharge, rehabilitation, insurance and complaint).

The various design-related reasons for the poor functioning of review boards, as observed by inspection, help explain the reluctance to Statutorily require an institutional and appropriate response. The parliamentary committee also alluded to this when they called for the appointment and staffing of review boards to be improved. Improvement of track-ing was also called for. Taken together, these call for prioritisation of the improvement of boards, but do not establish this in a statistically rigorous way.

The burden of conducting evaluations of coercion cannot always fall on managers. Managers, too, may be morally and legally bound to respond to concerns about coercion. This requires systems to have sufficient resources to implement a range of burdensome but ultimately vital procedures, including reviews. The requirement is to have sufficient policy resources, procedures and systems to protect against coercion.

Simplifying forms and board capacity could improve access. [8,9,16]

In both access and financing, the insurance audit demonstrates how legal parity can be achieved with differentiated product terms. Whether specific exclusions break the law depends on the

policy, the regulations, the facts of the claim, and how the legislation is interpreted. There are a number of implementation vulnerabilities, including inadequate disclosure and parity monitoring, which are independent of the presence of a legal provision. The same is true of free treatment guarantees. It is critical to examine the availability and affordability of service in the context of geographic access and the resources of the target population. Multiple vulnerabilities may convert a nominally available right into a de facto right. [1,6,10,15]

The court records show that gains and limitations are possible with the use of the Constitution. The February 2025 order directed the Union to disclose its authority and status. The October 2025 order placed further oversight of the process with the NHRC. The prevention of student threats and the safeguarding of other students were ordered, requiring the public sector to undertake various reforms. Other orders fundamentally differ from these in purpose, remedy, and procedure. In assessing the implementation of human rights protection orders, one must look beyond the media coverage and the "success rates" published by the commissions. Much more useful information is available regarding the timing of protective orders, the reasons provided for refusing applications, the reasons for upholding orders, and the experience of rights holders. [12-14].

Three transferable design proposals are offered. First, for a function to be considered a service, there must be some minimum service outcome, with timely and verifiable notification.

Second, intersectoral responsibilities demand named lead agencies, joint operating procedures, and dedicated budgets, as opposed to cross-references in policies. Third, in the case of judicial and human rights supervision, compliance schedules should be published that identify the action to be taken, the office responsible and the deadline for completion. These steps should be monitored. This will enable later studies to move beyond descriptive identification of barriers to focus on the assessment of whether specific improvements to the exercise of rights improve the situation.

The review has to remain clear in the boundary it sets. The section covered will be structured, transparent, and target retrieval. This means it cannot and will not be an exhaustive, multiple database, systematic review. Thus, it will not and cannot estimate the level of publication selection bias. It does not result in a nationwide MHRB effectiveness rate. It does not (like some country level reviews) synthesize clinician opinions, hospital admissions and health insurance as if they were independent observations of the same outcome. Its main value is to

synthesize observations in a legal framework in a manner that distinguishes the concerns needed for responsible policy decisions.

10. Recommendations and implementation priorities

A common compliance register should be implemented through a joint Union-state reporting mechanism. Each state mental health authority and review board should have the following in the register: date of establishment, composition of the board (with unfilled posts), administrative contact, sitting schedule, budget, complaints received, average time to decide, and anonymized decision. Keeping the historical values archived makes it possible to assess the evolution of the situation. The call of the parliamentary committee for a tracker gives an identifiable institutional starting point. [6]

A formal intersectoral escalation protocol should exist for the movement of individuals between emergency contact and assessment, treatment, legal review, discharge and community support. Relevant agencies may include health facilities, police, prisons, social welfare, housing, legal services and disability support. These protocols should be time standard response and should define the points of contact. They should not require a person to have the capacity to litigate or to be referred by multiple persons.

Indicators should assess travel burden, language, supported participation, legal representation, availability of emergency listings, accessible decisions and their enforcement. Budgets and trainings are good starts but they should be complemented by user involvement and independent audits. Persons with lived experience should also be part of exclusion assessments.

Regulators must provide standardized product-level parity indicators and claims-based outcomes to insurance transparency. Consistent fields should document covered diagnoses, outpatient psychotherapy and counseling benefits, inpatient restrictions, waiting periods and exclusions. Complaints and appeals data should be made auditable. Parallel hospital audits should assess legal basis for admission, capacity records, nominated representatives, and request for review and discharge planning, with emphasis on staff training for correcting reoccurring coding errors. [10,11]

Compliance with court orders and supervision of the NHRC should employ follow-up matrices, rather than one-time assurances. Every direction should have a legal basis, implementing

authority, measurable end-point, and evidence with verification date. Claiming completion should be distinguished from verifying completion. Public reporting should differentiate claimed completion from verified completion, and partially completed and not ascertainable status. This would serve to integrate and complement the constitutional remedies available to the people and routine governance, while phasing-out complete reliance on individual public-interest litigation. [12-14]

Table 9. Priority actions, responsibilities and monitoring measures

Priority	**Lead duty-holder**	**Indicator**
Authority and board dashboard	MoHFW / state authorities	Dated vacancies, funding, hearings and decisions
Accessible statutory review	State authorities / MHRBs	Time to hearing and resolution of complaints
Community-care pathway	State health and welfare departments	Follow-up, supported placements and service continuity
Parity in mental health insurance	IRDAI / insurers	Coverage terms, exclusions and claims outcomes
Admissions documentation	Healthcare establishments	Concordant legal basis and independent audit
Prison referral safeguards	Prisons / health / legal services	Training coverage, referrals and review
Order-compliance tracker	Union, states, NHRC	Verified completion status for each direction

11. Conclusion

The Mental Healthcare Act of 2017 introduced a framework based on rights. This requires proper administration and service-level mechanism to make it effective and viable. The evidence available in the verified set of 2020-2025 raises implementation issues with regard to the functioning of mental health review boards, state regulation, clinical documentation and

processes, insurance parity, support and coordination of different government and judicial agencies. The reports of the 2023 Parliamentary Standing Committee and the 2025 orders of the Supreme Court indicate that post enactment of the laws, statutory institutions remained under public scrutiny. The three quantitative sources identify clinician and policy-document and hospital-admission patterns, respectively, but none of them supply a valid denominator for nationwide compliance or support a pooled effect. The most viable option is to replace the binary notion of statutory formation with time-stamped and auditable notions of operating capacity and remedies. It is important to conduct a comprehensive registered search, independent screening and standardized state-level data extraction and participation of people with mental illness. Court orders can direct access to and provide remedies for statutory documentation, but normal, functioning state and service level institutions determine whether protection is durable.

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Appendix A. Retrieval and search logic

Targeted public retrieval combined legislation names with “implementation”, “State Mental Health Authority”, “Mental Health Review Board”, “insurance”, “admissions”, “judicial enforcement”, “Parliamentary Standing Committee”, “NHRC”, and identified case titles. Sources were cross-referenced between PubMed/PMC, original journal publishers, India Code, the Rajya Sabha repository, and court records. Search activity was conducted during manuscript preparation on 21 October 2026, restricted substantively to 2020–2025 secondary documents; older law was retained for doctrinal analysis. Subscription-database record exports were not available; therefore this is not represented as a comprehensive multi-database systematic search.

Appendix B. Auditable candidate-source selection ledger

01. MHCA 2017 / India Code — Included: primary statute

02. Philip et al. / SAGE 2022 — Included: implementation mapping

03. Philip et al. / PubMed 2022 — Duplicate of journal listing

04. Gupta et al. / Elsevier 2022 — Included: board critique

05. Vashist et al. / SAGE 2022 — Included: implementation policy

06. Ghosh et al. / SAGE 2022 — Included: clinical practice

07. Parliament Report 148 / 2023 — Included: parliamentary evidence

08. PRS parliamentary digest / 2023 — Excluded at full text: derivative of Report 148

09. NHRC mental healthcare report / 2023 — Included: institutional perspective

10. Malhotra Paper 1 / PMC 2024 — Included: quantitative survey

11. Malhotra Paper 1 / PubMed 2024 — Duplicate of full text

12. Malhotra Part 2 / PMC 2024 — Included: companion interpretation

13. Avula et al. / PubMed 2025 — Included: quantitative policy audit

14. Veerendra et al. / SAGE 2025 — Included: quantitative admissions audit

15. Gaurav Kumar Bansal / Feb 2025 — Included: judicial order

16. Gaurav Kumar Bansal / Oct 2025 — Included: follow-up judicial order

17. Sukdeb Saha / Jul 2025 — Included: judgment

18. Young people policy review / 2022 — Included: implementation setting

19. WHO community MH guidance / 2021 — Included: normative implementation comparator

20. NHRC annual report 2023–24, released 2026 — Excluded at title/date: publication after cut-off

21. Supreme Court administrative office filing / Apr 2025 — Excluded at title/type: office listing, not an enforcement decision

Appendix C. PRISMA 2020 reporting applicability

A documented source-selection diagram, eligibility rationale, named included sources,

methodological limits and evidence synthesis are presented. The following elements remain unfulfilled for a full PRISMA 2020 systematic review: complete database-by-database search exports, independently duplicated screening decisions, preregistered protocol, comprehensive excluded-full-text records, and formal evidence-certainty ratings for every study. These deficiencies are explicitly reported rather than replaced with unverifiable claims. See Page et al. [17].

Appendix D. Statistical calculation and reproducibility

Wilson score interval for a binomial proportion: for events x from denominator n, $p = x/n$, $z = 1.9599639845$; denominator $d = 1 + z^2/n$; centre $c = (p + z^2/(2n))/d$; half-width $h = z \times \mathrm{sqrt}[p(1-p)/n + z^2/(4n^2)]/d$; reported interval = $(c-h, c+h)$. This calculation describes count precision without correcting self-selection or documentation biases. The main plot uses the five numerical series shown below; separate outcome meanings preclude quantitative pooling.

Clinicians dissatisfied with MHCA (2024): source=Malhotra et al. 2024; x=555, n=600, x/n=0.92500; Wilson 95% CI=(0.90111, 0.94348).

Clinicians reporting procedural deterrence (2024): source=Malhotra et al. 2024; x=399, n=600, x/n=0.66500; Wilson 95% CI=(0.62629, 0.70161).

Clinicians favouring amendment (2024): source=Malhotra et al. 2024; x=440, n=600, x/n=0.73333; Wilson 95% CI=(0.69655, 0.76715).

Insurance policies explicitly covering mental illness: source=Avula et al. 2025; x=88, n=235, x/n=0.37447; Wilson 95% CI=(0.31507, 0.43790).

Magistrate-ordered cases citing MHCA: source=Veerendra et al. 2025; x=38, n=222, x/n=0.17117; Wilson 95% CI=(0.12732, 0.22621).