MENTAL HEALTH AND HUMAN RIGHTS: CONNECTING GLOBAL LAWS WITH INDIAN LAWS

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ABSTRACT

This paper critically explores how mental health jurisprudence in India has evolved—moving from the colonial shadow of the Lunacy Acts to the more progressive and rights-based vision embodied in the Mental Healthcare Act, 2017. This legal journey is not isolated; it is deeply connected to India's international commitments, particularly under the UN Convention on the Rights of Persons with Disabilities, which places dignity, equality, and meaningful participation at the heart of its framework. The central question running through this analysis is whether the 2017 Act has successfully dismantled entrenched stigma, expanded access to care, and safeguarded individual autonomy in practice.

The discussion pays close attention to key legal developments, such as the decriminalisation of suicide under Section 115 of the Act. This landmark shift reframes despair not as crime but as a public health concern demanding care and compassion. Equally significant is its nuanced relationship with the Narcotic Drugs and Psychotropic Substances Act, 1985, where an emerging emphasis on treatment and rehabilitation over punishment reflects a slow but visible change in state priorities. The judiciary too has played an indispensable role in breathing life into these statutory rights—by ensuring humane treatment, pushing back against discrimination in areas like employment and health insurance, and reminding the state of its constitutional obligations towards persons with mental illness.

Yet, despite this progressive legal and judicial momentum, the Act's transformative promise remains partially unfulfilled. The gap lies not in the text of the law but in its uneven translation on the ground: insufficient infrastructure, limited financial commitment, and a glaring lack of sensitisation among law enforcement and medical personnel. Social prejudice, stubborn and deep-rooted, continues to act as a silent barrier—keeping many individuals from seeking help, and reinforcing cycles of exclusion. The judiciary has emerged as a powerful catalyst of change, but lasting reform cannot rest on courts alone. What is needed is a broader, collective push: sustained political will, stronger administrative measures, and perhaps most importantly, a societal shift in how we perceive mental

health—not as weakness or deviance, but as a shared human concern that demands empathy, dignity, and inclusion.

Introduction

India has the largest population in the world, and mental health has emerged as a significant concern both nationally and globally. In recognition of this, India enacted the Mental Health Care Act, 2017,[1] This conforms with the Convention on the Rights of Persons with Disabilities (CRPD),[2] Thereby reflecting the country's commitment to international human rights obligations. The primary objective of this Act is to guarantee access to mental health care and ensure the provision of essential services to persons affected by mental illness. However, legislation in itself cannot guarantee meaningful change; its effectiveness depends upon proper implementation, monitoring, and continuous evaluation to safeguard the rights and well-being of those suffering from mental health conditions.

The importance of mental health is not a recent discovery. References can be traced back to the Atharva Veda, which makes mention of various mental illnesses, including conditions resembling schizophrenia.[3]. The issue is inherently profound; the mind and body must function in consonance. As the mind governs the body, any dysfunction in mental processes inevitably impacts the individual's overall functioning.

This article seeks to examine the dual dimensions of the issue: first, the stigma and social prejudice that continue to be associated with mental illness, and second, the legal framework that seeks to address these concerns. The analysis will focus on the international legal framework, particularly obligations under instruments such as the CRPD and other human rights treaties, and the domestic legal framework, especially the Mental Health Care Act, 2017, along with related statutory and constitutional provisions. By situating mental health within the intersection of international and domestic law, the article aims to assess the extent to which these legal regimes have effectively addressed stigma, ensured access to care, and protected the dignity of persons with mental health conditions.

[1] The Mental Healthcare Act 2017 (No 10 of 2017)
[2] Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3
[3] M Weiss, 'History of Psychiatry in India' (1986) 11 *Samiksa* 31

Meaning of Mental Health Issues or Mental Illness

Mental illness refers collectively to all diagnosable mental disorders, which include changes in thinking, emotions, and distress, and problems functioning in social work or any Social activity.[4] Moreover, as per section 2(s) of the Mental Health Care Act[5] mental illness means a disorder in which the thinking capacity of the individual is impaired to the extent that he or she is unable to perform daily activities which also includes medical conditions wherein the individual has an addiction of alcohol and other drugs however the definition excludes individuals with intellectual disability (previously referred to as mental retardation). Further, As per Section 2 (h) of the Mental Health Care Act[6] mental health care means analysis and diagnosis of person suffering from mental health issues and treatment of the concerned persons and as per section 3[7] of the above mentioned act the determination of the Mental illness shall be determined by the National or international standards which is to be notified and revised by the Central govt for time to time. Moreover, as per ICD-11, the International Classification of Diseases, which came into effect on January 1 2025[8], Which includes and states that These include neurodevelopmental disorders such as autism spectrum disorder, attention deficit hyperactivity disorder, and intellectual disabilities; schizophrenia and other primary psychotic disorders; mood disorders including depression and bipolar disorders; and anxiety and fear-related disorders like generalised anxiety disorder, phobias, and panic disorder. Obsessive-compulsive and related disorders, body-focused repetitive behaviour disorders, and stress-related conditions such as post-traumatic stress disorder and prolonged grief disorder are also recognised. Further, feeding and eating disorders, substance use and addictive behaviours (including gaming disorder), impulse control disorders, dissociative disorders, personality disorders, and neurocognitive disorders such as dementia fall within the ambit of mental health conditions. The ICD-11 also acknowledges newly classified disorders such as body dysmorphic disorder, hoarding disorder, excoriation (skin-picking) disorder, and compulsive sexual behaviour disorder. This extensive classification reflects that mental health issues are not confined to a single illness category but extend across developmental, cognitive, behavioural, and affective domains, affecting the individual's mind and functioning in society[9].

[4] https://www.psychiatry.org/patients-families/what-is-mental-illness".
[5] The Mental Healthcare Act 2017 *(No 10 of 2017), s 2 (s).*
[6] The Mental Healthcare Act 2017 (No 10 of 2017), s 2(h).
[7] The Mental Healthcare Act 2017 (No 10 of 2017), s 3.
[8] World Health Organization, *International Classification of Diseases 11th Revision (ICD-11)* (WHO 2025).
[9] "Anirban Gozi, 'Highlights of ICD-11 Classification of Mental, Behavioural, and Neurodevelopmental Disorders' (2019) 13 *Indian Journal of Private Psychiatry* 11.

Although the definition is not exhaustive, other diseases can be considered mental health issues; the central government has the Authority to classify them further.

Past Indian Legislation on Mental Healthcare.

Before the enactment of specific legislation on mental health in India, references to mental ailments were already present in ancient traditions. The Vedic writings, particularly the *Atharva Veda*, described various mental afflictions, including schizophrenia, while traditional systems like Siddha acknowledged mental illnesses prevalent in southern India. Epics such as the *Ramayana* and *Mahabharata* also contain accounts of mental disturbances, reflecting Ayurveda's early recognition of the mind–body connection.[10]. Thinkers like Patanjali highlighted yoga as a means to attain harmony between body, mind, and spirit. Sushruta identified the four essential pillars of effective treatment—the patient, attendants, medicine, and physician. Spirituality played a vital role in diagnosing and treating mental illness, with evidence of organised care dating back to King Ashoka's period and later to the fifteenth century, when a mental hospital existed in Dhar under Muhammad Khilji. However, despite elaborate descriptions of symptoms and treatments, there were no well-documented asylums in early India.[11]

Furthermore, the legal journey of mental health in India has been shaped by colonial influence, early nationalist concern, and later, human rights discourse. The earliest laws, such as the Lunacy Acts of 1858[12] and the Military Lunatic Acts of 1877[13], were primarily custodial, focused on establishing asylums and regulating admission rather than treatment. With the growing awareness of poor conditions in these institutions, the Indian Lunacy Act of 1912[14] was enacted, introducing voluntary admissions, central regulation, and judicial provisions. However, its emphasis remained on protecting society from the "dangerous" mentally ill. Post-independence, the Mental Health Act of 1987[15] sought to modernise definitions, shift from custody to care, and safeguard rights through regulatory bodies, admission rules, and guardianship provisions. However, it was criticised for being overly procedural and inadequate in addressing human rights concerns. Subsequent legislations like the Persons with Disabilities

[10] SH Nizamie and N Goyal, 'History of Psychiatry in India' (2010) 52 (Suppl) *Indian Journal of Psychiatry* 7
[11] Gaurav Bharti and Manisha Matolia, 'Laws Concerning Mental Health in India: A National Perspective' (2025) 14(18s) *Journal of Neonatal Surgery* 408.
[12] Lunacy Acts 1858
[13] Military Lunatic Act 1877
[14] Indian Lunacy Act 1912
[15] *Mental Health Act 1987* (Act No 14 of 1987).

Act, 1995[16] and the National Trust Act, 1999,[17] expanded the focus to equality, accessibility, and community integration, recognising mental illness as a disability and providing welfare measures, while also moving towards compliance with the UN Convention on the Rights of Persons with Disabilities[18], thereby reflecting a gradual shift towards a rights-based and inclusive framework.[19]

International Framework and Indian Legislation.

The Convention on the Rights of Persons with Disabilities[20] States its purpose as to promote protection and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons, including persons who are suffering from Mental illness. The Basic principle behind the Convention is to protect the inherent dignity, non-discrimination, inclusion in society, Mutual respect for differences, Equality of Opportunity, and Accessibility for persons with a mental illness. Moreover, the Convention starts by affirming in **Article 1** that persons with disabilities must enjoy all rights and freedoms with dignity and equality. **Article 2** explains that barriers shape disability and stresses concepts like communication, reasonable accommodation, and universal design. **Article 3** lays the guiding principles – autonomy, inclusion, non-discrimination, equality, accessibility, and respect for diversity. **Article 4** makes it the duty of States to remove discrimination and involve persons with disabilities in decisions. Moreover, article 5-14 states principles which are equality before law, particularly focus on women and children, and also states that the person should also be aware, also states for the assurance of accessibility to spaces and equal protection of law, lastly, most importantly, article 14 protects liberty and security, which states that disability can never justify detention. **Article 15** prohibits torture and forced experimentation, and **Article 16** shields against violence, abuse, and exploitation. **Article 17** protects physical and mental integrity, and **Article 18** secures liberty of movement, nationality, and identity. **Article 19** recognises the right to live

[16] *Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995* (Act No 1 of 1996).
[17] *National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act 1999* (Act No 44 of 1999)
[18] *Convention on the Rights of Persons with Disabilities* (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3.
[19] Choudhary Laxmi Narayan and Deep Shikha, 'Indian Legal System and Mental Health' (2013) 55 (Suppl 2) *Indian Journal of Psychiatry* S177 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3705679/ accessed 8 August 2025.
[20] Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3

independently and be included in the community, with choices like anyone else.

Finally, **Article 20** affirms the right to personal mobility, with affordable aids and support. **Article 21** guarantees freedom of expression and access to information in formats like Braille, sign language, and assistive technology. **Article 22** protects privacy, while **Article 23** secures family rights, including marriage, parenthood, and children's equal family life rights. **Article 24** affirms inclusive education at all levels with necessary support. **Article 25** recognises equal access to health services without discrimination, and **Article 26** ensures rehabilitation and rehabilitation for independence and participation. **Article 27** guarantees the right to work with equal opportunities and protection in employment. **Article 28** provides for an adequate standard of living and social security. **Article 29** secures political rights, including voting and participation in public life, and **Article 30** ensures equal access to cultural life, recreation, leisure, and sports. **Article 31** requires data collection to shape better policies. Article 32 is about nations teaming up to share resources and ideas, making sure disability rights aren't just a local issue but a worldwide priority. Then, Article 33 brings the work home, asking countries to set up their own special committees, with people with disabilities right at the table, ensuring the promise is actually kept on the ground. To keep everyone honest, Articles 34–39 create the UN Committee on the Rights of Persons with Disabilities—the global watchdog —that reviews reports, holds countries accountable, and reports back to the UN. The rest of the Convention (Articles 40–50) are the instructions, the nuts and bolts that make this whole system run, from how nations meet to how rules can be changed, all to ensure this isn't just a fleeting gesture but a lasting commitment to a more inclusive world.

Mental Healthcare Act, 2017[21]

The Mental Healthcare Act, 2017, has **16 chapters and 116 sections**, and has the objective of ensuring that every person with a mental illness is treated with dignity and equality. One of the most progressive aspects of the Act is that it recognises the right of every individual to plan their own care. Section 5 expressly allows a person to prepare an advance directive, setting out how they wish to be treated during a period of mental illness. Complementing this, the Act also permits appointing a nominated representative who can make crucial decisions on matters such as admission or treatment when the individual is not in a position to decide for themselves. Importantly, the Act does not stop at individual rights—it also places a duty on the State. Under

[21] The Mental Healthcare Act 2017 (No 10 of 2017)

Section 18, the government must ensure that mental healthcare services are available, affordable, and accessible to all, making mental health a matter of public responsibility. Further, it affirms that no person with a mental illness should be subjected to cruel, inhuman, or degrading treatment, and it guarantees equality in the enjoyment of rights and access to care. A significant reform under this law is in relation to suicide. Section **115** provides that any person who attempts suicide shall be presumed to be under severe stress and will not face prosecution under Section 309[22] of the Indian Penal Code. However, under the Bharatiya Nyaya Sanhita BNS), there is no such provision, as BNS has removed the punishment for attempting suicide, which means that individuals cannot be prosecuted under BNS, shifting the approach from punishment to care and rehabilitation.

The Relationship Between the Mental Health care act and the NDPS act

Section 115 of the Mental Healthcare Act, 2017, recognises that a person attempting suicide is presumed to be under *severe stress* and therefore must receive **care, treatment, and rehabilitation instead of punishment**. This approach shifts the focus from criminalisation to a more compassionate, rights-based response. A similar perspective can be found under the **Narcotic Drugs and Psychotropic Substances Act, 1985 (NDPS Act)**[23], particularly in provisions that deal with people with an addiction. For example, **Section 64A** grants immunity from prosecution to people with a substance use disorder who voluntarily seek medical de-addiction treatment in a government-recognised centre. **Section 71** empowers the government to establish centres for identification, treatment, education, rehabilitation, and social reintegration of people with a substance use disorder. In contrast, **Section 39** allows courts to release people with a substance use disorder on probation so that they can undergo de-addiction treatment instead of serving imprisonment.

These provisions reflect an essential point of harmony between the Mental Healthcare Act (MHCA) and the NDPS Act. When a person attempts suicide as a result of drug dependence or withdrawal, Section 115 of the MHCA presumes that the act was carried out under severe stress.[24] This dovetails with Sections 64A, 71, and 39 of the NDPS Act, which encourage treatment and rehabilitation instead of punishment.[25] The cumulative effect is that individuals

[22] Indian Penal Code 1860, s 309.
[23] Narcotic Drugs and Psychotropic Substances Act 1985.
[24] Mental Healthcare Act 2017, s 115.
[25] Narcotic Drugs and Psychotropic Substances Act 1985, ss 39, 64A, 71.

facing challenges of mental health or substance use are no longer cast solely in the mould of offenders. Instead, they are increasingly recognised as persons needing medical attention, therapeutic support, and structured opportunities for reintegration into society. This change is not just semantic; it signals a broader transformation in Indian law, where the rigid punishment framework is gradually giving way to a more humane and treatment-oriented model. By acknowledging the complex interplay of health, dignity, and rehabilitation, the law reflects a growing constitutional ethos that seeks to protect rather than stigmatise. It shows an understanding that recovery and reintegration serve both the individual and the larger social fabric, aligning with India's evolving commitment to social justice and inclusive growth.

The NDPS Act, 1985, while largely prohibitionist and punitive in spirit, still acknowledges the medical and scientific value of narcotic and psychotropic substances.[26] Section 71 empowers the government to provide NDPS where there is a "medical necessity."[27] And the 2014 amendment introduced the category of Essential Narcotic Drugs (ENDs)—such as morphine, methadone, and fentanyl, vital for pain management and addiction treatment.[28][29] Psychotropic medicines like benzodiazepines and buprenorphine are similarly regulated under the Act, not banned outright, to allow clinical use while curbing misuse.[30] Yet, the overlap between the NDPS Act and the Drugs and Cosmetics Act, 1940, has often created uncertainty for psychiatrists, at times exposing them to harassment or even prosecution.[8] This brings to light a striking contradiction. On the one hand, the NDPS framework does recognise limited medical exceptions, but on the other, its dominant tone continues to lean heavily towards criminalisation. The result is a legal environment where individuals struggling with substance use disorders often find their path to essential treatment blocked by the very laws meant to regulate it. Instead of enabling care and recovery, the system risks deepening stigma and discouraging people from seeking help, revealing the gap between the law's stated intent and its lived impact.

In contrast, the Mental Healthcare Act, 2017, marks a decisive step towards a more humane and rights-based framework. By expressly including Substance Use Disorders within the definition of mental illness, the Act acknowledges the lived reality that addiction is not a matter

[26] NDPS Act 1985, Preamble and Statement of Objects
[27] NDPS Act 1985, s 71
[28] Narcotic Drugs and Psychotropic Substances (Amendment) Act 2014, s 2.
[29] Gazette Notification, Ministry of Finance (Department of Revenue), S.O. 1188(E), 5 May 2015
[30] Narcotic Drugs and Psychotropic Substances Act 1985, Sch I; Narcotic Drugs and Psychotropic Substances Rules 1985.

of moral failing but of health. True, the terminology it employs—referring to "abuse of alcohol and drugs"—may appear dated. Yet, its underlying spirit reflects a significant shift: recognising that those battling substance use require care, dignity, and legal protection rather than stigma or punishment. Central to the Act is the emphasis on dignity, consent, and protection against inhuman or degrading treatment. It requires all de-addiction and rehabilitation centres to be registered and overseen by Mental Health Review Boards.[31] Section 65 further empowers state governments to set minimum standards for treatment centres, ensuring accountability in a previously unregulated sector in legal grey areas. [32]A good example is the 2018 Delhi notification, which laid down detailed requirements on infrastructure, staffing, record-keeping, and consent, subject to oversight by the State Mental Health Authority.[33] This represents a decisive step in bringing addiction treatment within the fold of mainstream mental healthcare, guided by patient rights rather than punitive control.

Read together, these two laws present both friction and complementarity. The NDPS Act continues to criminalise most drug-related behaviour while recognising only narrow medical exceptions. The MHCA, on the other hand, reframes addiction as a mental health condition and mandates care and rehabilitation. Their intersection is clearest in situations of attempted suicide linked to substance use, where Section 115 MHCA presumes severe stress and directs the State to provide treatment instead of punishment. This aligns with NDPS provisions that allow voluntary treatment, empower courts to release offenders on probation for rehabilitation, and authorise the government to establish de-addiction centres. Taken together, the laws reveal an evolving legal landscape—one that balances control with compassion, seeking to regulate misuse while ensuring that people with addiction are not abandoned to the criminal justice system but recognised as patients in need of care.

Moreover, Section 115 of the Mental Healthcare Act, 2017, marks a significant shift in the legal response to attempted suicide by presuming that the person is under *severe stress* and requires **care, treatment, and rehabilitation instead of criminal punishment**. The Bombay High Court affirmed this principle. *Shital Dinkar Bhagat v. State of Maharashtra*[34] , where the

[31] ibid, s 65 read with ch XI
[32] MHCA 2017, s 65.
[33] Department of Health & Family Welfare, Government of NCT of Delhi, *Minimum Standards of Care for 'Centres Providing Substance Use Disorder Treatment and Rehabilitation – 2018* (Notification, 18 September 2018) http://health.delhigovt.nic.in/wps/wcm/connect/c0d640804708f11892e2db5fc3a1d29c/Notification_English.PDF accessed 8 August 2025
[34] Shital Dinkar Bhagat v State of Maharashtra (2024) SCC OnLine Bom 2765

Court quashed an FIR registered under **Section 309 IPC** against a police constable who had attempted suicide. The Court recognised that an act of this nature inevitably stems from immense mental distress. It held that such a person cannot be subjected to criminal punishment unless the prosecution establishes otherwise. Instead of penalisation, the Court placed responsibility on the State, directing it to act under Section 115(2) of the Mental Healthcare Act, 2017, which obliges the government to ensure care, treatment, and rehabilitation—so that the risk of recurrence is addressed with compassion rather than coercion.

In the words of the Court: *"Section 115 of the Mental Healthcare Act, 2017 creates a presumption of severe stress whenever a person attempts to commit suicide. Once such a presumption arises, prosecution under Section 309 IPC cannot be sustained unless rebutted. The legislative intent is not to punish, but to provide care and rehabilitation to reduce further risk."*[35] This observation reflects a decisive shift from criminalisation to compassion. By embracing the humanitarian spirit of the Act, the judiciary ensures that the law does not re-victimise those already in deep distress, but instead directs the State to extend care, treatment, and rehabilitation as a matter of right and dignity.

Social Stigma and Equal Opportunity in Mental Health Law

The debate on mental health in India has long been overshadowed by stigma, social exclusion, and a legal framework that once reinforced such marginalisation. The journey from the Indian Lunacy Act, 1912[36] to the Mental Healthcare Act, 2017[37] Marks a profound transformation—from a custodial and protectionist approach to one grounded in dignity, equality, and non-discrimination. Yet, even as the law has evolved towards progressive ideals, entrenched social stigma continues to obstruct equal opportunities for persons with mental illness. This persistent gap has made judicial interventions vital, bridging statutory rights, constitutional promises, and lived realities.

From Lunacy to Rights: The Legal Evolution

The *Indian Lunacy Act 1912* epitomised the colonial perception of mental illness, defining a "lunatic" as an "idiot or a person of unsound mind" and authorising the police to arrest

[35] Shital Dinkar Bhagat v State of Maharashtra (2024) SCC OnLine Bom 2765
[36] Indian Lunacy Act 1912
[37] Mental Healthcare Act 2017

individuals suspected of lunacy under section 13.[38] The Act treated persons with mental illness primarily as a threat to society, thereby legitimising stigma and institutionalisation rather than enabling care or inclusion. Its successor, the Mental Health Act, 1987[39]It was an attempt to move beyond the archaic custodial framework of 1912. Yet, it stopped short of recognising mentally ill individuals as rights-bearing persons with agency. The law remained largely institutional in spirit, prioritising the establishment of psychiatric hospitals and regulating property while failing to embrace a rights-based orientation that could safeguard dignity and autonomy.

This lacuna was addressed by the *Mental Healthcare Act 2017*, enacted pursuant to India's obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD). Section 2(1)(s) of the 2017 Act defines "mental illness" broadly, while section 18 guarantees every person the right to access mental healthcare without discrimination on grounds of gender, caste, sex, or political belief.[40] Section 19 further affirms the right of persons with mental illness to live in, and not be segregated from, society.[41] Most significantly, section 20 recognises the right to live with dignity and protection from inhuman treatment, departing from earlier frameworks. [42]Section 30 obligates governments to implement programmes to reduce stigma, directly linking equality with de-stigmatisation.[43] The Act also decriminalises suicide under section 115, recognising those who attempt it as persons under severe stress who require care, not punishment.[44]

This rights-based framework represents a decisive break from earlier laws' medicalised, exclusionary approach. It incorporates the CRPD's social model of disability, recognising that barriers—social, economic, and attitudinal—are as disabling as medical conditions themselves. Article 12 of the CRPD, which guarantees equal recognition before the law, has been explicitly embedded within the Act through the recognition of the legal capacity of persons with mental illness to make their own treatment decisions.[45]

[38] Indian Lunacy Act 1912*, s 3(5).*
[39] Mental Health Act 1987, Preamble; s 2(l)
[40] *Mental Healthcare Act 2017*, s 18(2).
[41] Ibid s 19
[42] Ibid s 20
[43] Ibid s 30
[44] Ibid s 115
[45] United Nations Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May *2008) 2515 UNTS 3 (CRPD), art 12*

Judicial Recognition of Stigma and Equality

Indian courts have progressively recognised the corrosive impact of stigma on mental health and equal opportunity. In *Common Cause v Union of India*, the Constitution Bench considered the decriminalisation of suicide under section 115 of the MHCA. It held that individuals who attempt suicide must be seen as victims of circumstances, not offenders, and emphasised the necessity of viewing suicide as arising from barriers that demand care and rehabilitation.[46] This interpretation aligns legal reform with dignity and social justice.

Similarly, in *Navtej Singh Johar v Union of India*, Justice D.Y. explicitly connected stigma, discrimination, and mental health, citing psychiatric scholarship, the Court acknowledged that prejudice against LGBTQ+ persons generates profound psychological harm, requiring laws and social institutions to adopt a progressive, stigma-free approach.[47] In his concurring opinion, Justice Nariman highlighted that section 115 of the MHCA reflects constitutional values by mandating humane measures instead of punitive sanctions against vulnerable individuals. This judicial narrative reframes mental health not merely as a medical concern but as a civil rights issue, where stigma undermines equality and requires constitutional redress.

In *X v State of Maharashtra*, the Supreme Court accepted post-conviction mental illness as a mitigating factor in commuting a death sentence.[48]The Court observed that carrying out the death penalty against a person who cannot even comprehend the meaning or consequences of such punishment would erode the very "majesty of law." By acknowledging this, the judgment infuses compassion into the criminal justice system, ensuring that individuals with mental illness are not reduced to mere objects of punishment but are recognised as persons deserving of equal treatment and dignity under the law.

The Court has also directly addressed judicial insensitivity towards mental health. In *Mahendra K.C. v State of Karnataka*, it overturned remarks of a High Court judge who had trivialised suicide, describing the deceased as a "weakling" and dismissing his mental state as inconsequential. The Supreme Court condemned this reasoning as undermining the complexity of mental health, observing that behavioural variations are deeply individual and cannot be

[46] Common Cause v Union of India *(2018) 5 SCC 1, [366].*
[47] Navtej Singh Johar v Union of India *(2018) 10 SCC 1, [518]–[519]*
[48] X v State of Maharashtra *(2019) 7 SCC 1, [59].*

reduced to stereotypical notions.[49] This reflects a judicial awareness that stigma embedded in institutional discourse perpetuates discrimination.

Disability Rights and the Social Model

The *Rights of Persons with Disabilities Act 2016* (RPwD Act) further strengthens the discourse by defining disability as not a medical impairment but an outcome of interaction with barriers. Section 2(S) describes disability as arising when impairments interact with cultural, social, economic, or structural factors, thereby hindering full social participation.[50] Mental illness is expressly included within the schedule of specified disabilities, ensuring that persons with mental health conditions are entitled to reservations, protection from discrimination, and equal opportunities in education and employment.

The Supreme Court has drawn upon this social construction of disability in recent jurisprudence. In *V. Surendra Mohan v State of Tamil Nadu*, the Court underlined that mental illness cannot be a ground for exclusion but must trigger affirmative obligations on the State to dismantle stigma and ensure substantive equality.[51] The judgment reaffirmed that dignity, inclusion, and equal opportunity are not acts of benevolence, but binding constitutional mandates. It shifted the discourse from charity to justice, recognising these rights as inherent and non-negotiable guarantees owed to every individual.

Towards Equality: The Need to Eradicate Stigma

Yet, despite progressive legal measures, stigma continues to cast a long shadow over the lives of persons with mental illness. Deep-seated societal attitudes still equate mental illness with incapacity, danger, or even moral weakness, fuelling discrimination in workplaces, in access to healthcare, and in everyday social participation. The Mental Healthcare Act, 2017, acknowledges this lived reality by mandating awareness programmes and prohibiting inhuman treatment. However, implementation remains uneven, leaving a wide gap between the law's promise and people's experience.

Judicial pronouncements have attempted to bridge this gap by situating mental health within the constitutional promise of equality and dignity. As Justice Chandrachud noted in *Navtej*

[49] Mahendra K.C. v State of Karnataka *(2022) 2 SCC 150, [32*
[50] Rights of Persons with Disabilities Act 2016*, s 2(c), s 2(s).*
[51] V. Surendra Mohan v State of Tamil Nadu *(2023) 2 SCC 209*

Singh Johar, prejudice and stigma are not just private biases but systemic barriers that directly impair psychological well-being.[52] The jurisprudence thus underscores the indivisibility of mental health, stigma eradication, and equal opportunity.

The recognition of legal capacity under the MHCA, the decriminalisation of suicide, and the inclusion of mental illness in the RPwD Act collectively affirm that persons with mental illness are rights-bearing individuals entitled to full participation in society. However, as the Court observed in *Mahendra K.C.*, institutional insensitivity and societal stereotyping continue to undermine these gains.[53]The law must not only prohibit discrimination but actively dismantle stigma through education, sensitisation, and affirmative measures.

Critical Analysis of the Implications of the Mental Healthcare Act, 2017

The trajectory of Indian jurisprudence on mental health reflects a slow yet determined journey from neglect and discrimination to an affirmation of mental illness as a question of constitutional dignity and statutory right. Across High Courts in Jharkhand, Punjab & Haryana, Patna, Bombay, Manipur, and Chandigarh, the Mental Healthcare Act, 2017[54]**,** has been invoked not as a dormant text but as a living rights framework. In these rulings, the judiciary has steadily dismantled practices that perpetuate exclusion—whether through denial of medical coverage, arbitrary financial barriers to admission, or the criminalisation of suicide survivors—ensuring that law becomes an instrument of inclusion rather than exclusion.

Yet, these rulings simultaneously expose the gaps in implementation. The Jharkhand High Court in *Santosh Kumar Verma* rightly struck down the exclusion of psychiatric treatment from reimbursement. Still, the persistence of such clauses in many insurance policies reflects weak regulatory oversight.[55] The Punjab & Haryana High Court's interventions in *Pushpanjali Trust* and *Satish Kumar* show that compliance with statutory duties under Sections 18–21 often arises only through judicial monitoring, not administrative initiative.[56] Similarly, the Patna High Court in *Akanksha Maviya* and the Manipur High Court in *Maibam Jatiswor Singh* highlighted the staggering infrastructure deficit—States with populations in crores had only one or no

[52] Navtej Singh Johar v Union of India (2018) 10 SCC 1
[53] Mahendra K.C. v State of Karnataka (2022) 2 SCC 150
[54] Mental Healthcare Act 2017
[55] Santosh Kumar Verma v Bharat Coking Coal Ltd, 2025 SCC OnLine Jhar 375
[56] Pushpanjali Trust v State of Punjab and Ors, CWP-PIL-110-2024 (Punjab & Haryana HC, 25 February 2025); Satish Kumar v U.T. Chandigarh & Ors, CWP No. 10284 of 2025; CWP-PIL No. 211 of 2024 (Punjab & Haryana HC, 16 May 2025).

functioning mental health establishments, despite clear statutory mandates.[57]Even in decriminalisation, *Shital Dinkar Bhagat* reaffirmed that Section 115 of the Act overrides Section 309 IPC, but in practice, FIRs continue to be filed, reflecting inadequate sensitisation of law enforcement.[58] Moreover, practices like demanding exorbitant deposits for admission, as struck down in *Satish Kumar*, show how social stigma is translated into financial exclusion.[59]

In the present scenario, these rulings underscore that the judiciary has emerged as India's primary driver of mental health rights, often filling the vacuum left by executive inaction. The implication is twofold: while the Act's promise of non-discrimination, access, and dignity has been judicially entrenched, the reliance on courts alone reveals systemic fragility. Without substantial budgets, functioning Mental Health Authorities, trained police and medical staff, and active de-stigmatisation, the Act risks remaining more aspirational than real. Thus, the jurisprudence represents both progress and paradox: rights are firmly recognised in principle, yet denied in practice.

Further, at a structural level, it is equally important to underline that the responsibility for implementing the Mental Healthcare Act, 2017, does not rest in abstraction but flows directly from the constitutional division of powers. Entry 6 of List II (State List) in the Seventh Schedule, "Public health and sanitation; hospitals and dispensaries,"[60] squarely places the domain of public health within the legislative and administrative competence of States. This implies that the persistent deficits in mental health infrastructure, regulatory oversight, and enforcement of statutory rights are administrative lapses and constitutional failures of duty by State governments. While courts across Jharkhand, Punjab & Haryana, Patna, Bombay, Manipur, and Chandigarh have intervened to secure compliance, the more profound message is that the Act's transformative potential can only be realised if States discharge their primary responsibility under Entry 6. Judicial monitoring, while necessary, cannot substitute for systemic governance—adequate budgetary allocations, functioning State Mental Health Authorities, and establishing hospitals and dispensaries are constitutional as much as statutory obligations. Without such state-led implementation, the Mental Healthcare Act[61] risks being

[57] *Akanksha Maviya v Union of India & Ors*, CWJC No. 19702 of 2021 (Patna HC, 1 April 2022); *Maibam Jatiswor Singh v State of Manipur*, PIL No. 12 of 2018 (Manipur HC, 1 September 2020).
[58] *Shital Dinkar Bhagat v State of Maharashtra*, APL No. 783/2023 (Bombay HC, 5 August 2024).
[59] *Satish Kumar v U.T. Chandigarh & Ors*, CWP No. 10284 of 2025; CWP-PIL No. 211 of 2024 (Punjab & Haryana HC, 16 May 2025).
[60] Constitution of India 1950, Seventh Schedule, List II, Entry 6.
[61] Constitution of India 1950, Seventh Schedule, List II, Entry 6; Mental Healthcare Act 2017.

reduced to a judicially policed mandate rather than a robust, lived reality of healthcare governance.

Conclusion

The evolution of mental health law in India reflects a significant departure from custodial colonial regimes towards a rights-based framework rooted in dignity, equality, and non-discrimination. From the Lunacy Acts of the nineteenth century to the Mental Healthcare Act, 2017, the shift has been from treating persons with mental illness as objects of protection or suspicion to recognising them as rights-bearing individuals entitled to care, inclusion, and autonomy.[62] This transformation has been guided by domestic constitutional principles and international obligations under the CRPD, which demand that persons with disabilities enjoy all rights and freedoms equally.[63]

Yet, the jurisprudence surveyed demonstrates that rights on paper are not always rights in practice. Courts across jurisdictions—from *Santosh Kumar Verma* to *Shital Dinkar Bhagat*—have sought to enforce statutory guarantees, dismantling stigma, and affirming dignity. [64]However, the gaps are undeniable: weak regulatory oversight in health insurance, dependence on judicial monitoring instead of administrative compliance, staggering infrastructure deficits, poor sensitisation of police and medical authorities, and the persistence of stigma that translates into financial or social exclusion. [65]These shortcomings highlight that implementing the Mental Healthcare Act, 2017, remains fragmented, often requiring judicial intervention to activate obligations that should function independently.

The present scenario, therefore, underscores a paradox: while the legal framework has embraced a progressive, humane, and internationally compliant orientation, its lived reality remains constrained by systemic inertia and societal prejudice. Unlike other areas of law, mental health is inseparable from social attitudes. Without dismantling stigma through education, awareness, and institutional accountability, the statutory guarantees of equality and

[62] The Indian Lunacy Act 1912*;* The Mental Health Act 1987*;* The Mental Healthcare Act 2017.
[63] UN Convention on the Rights of Persons with Disabilities, adopted 13 December 2006, UNGA Res A/RES/61/106 (CRPD).
[64] Santosh Kumar Verma v Bharat Coking Coal Ltd, 2025 SCC OnLine Jhar 375 (Jharkhand HC); Shital Dinkar Bhagat v State of Maharashtra, APL No. 783/2023 (Bombay HC, 5 August 2024).
[65] Pushpanjali Trust v State of Punjab and Ors*,* CWP-PIL-110-2024 (Punjab & Haryana HC, 25 February 2025); *Satish Kumar v U.T. Chandigarh & Ors*, CWP No. 10284 of 2025; CWP-PIL No. 211 of 2024 (Punjab & Haryana HC, 16 May 2025); Akanksha Maviya v Union of India *& Ors*, CWJC No. 19702 of 2021 (Patna HC, 1 April 2022); *Maibam Jatiswor Singh v State of Manipur*, PIL No. 12 of 2018 (Manipur HC, 1 September 2020).

dignity will remain aspirational. The judiciary has played a critical role, but the responsibility cannot rest solely with the courts. Sustained political will, adequate budgetary allocation, effective monitoring bodies, and community-level sensitisation are indispensable to bridging the law and life gap.

Thus, the future of India's mental health jurisprudence lies in affirming rights and ensuring that these rights are meaningfully realised. Only when access, dignity, and equality are operationalised beyond the courtroom will the promise of the Mental Healthcare Act, 2017, truly be fulfilled.

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