A COMPARATIVE ANALYSIS OF MENTAL HEALTH LEGISLATION OF INDIA AND THE UNITED KINGDOM

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ABSTRACT

Mental health law has undergone significant transformation in both India and the United Kingdom, reflecting shifting paradigms in the understanding of mental illness, patient rights, and state obligations. This study undertakes a comparative analysis of the Indian Mental Healthcare Act, 2017, and the United Kingdom's Mental Health Act, 1983, supplemented by the Mental Capacity Act, 2005. While the UK framework retains its emphasis on compulsion and public safety, the Indian legislation marks a paradigm shift from custodial care toward a rights-based model, embedding international human rights norms within domestic law. The analysis highlights key areas of convergence, including provisions for compulsory care and oversight mechanisms, while also underscoring divergences such as India's statutory recognition of advance directives and state responsibility to ensure access to mental healthcare. Challenges remain in both jurisdictions: India struggles with implementation gaps, infrastructural deficits, and resource constraints, while the UK faces criticism over rising detention rates, racial disparities, and an outdated legislative framework. The study concludes that while India has taken a progressive leap in aligning mental health law with human rights principles, the effectiveness of these rights depends on systemic reforms and resource allocation. For the UK, reform of the Mental Health Act remains urgent to reduce reliance on compulsion and to incorporate capacity-based, autonomy-focused standards. This comparative analysis thus contributes to the global discourse on mental health law by identifying strengths, shortcomings, and pathways for reform in two diverse legal systems.

Keywords: Mental health law, autonomy, human rights, comparative analysis

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Introduction to Mental Health Law

Health is significant for all human beings in their life. In today's fast-paced world, cutthroat competition in every aspect of growth, health, and particularly mental health, takes a toll and more often than not is neglected as well. Mental health is the state or condition where an individual can tackle stress, realise their potential, and utilise the same to learn and work well. The state of an individual's mental health is contingent upon multiple factors, including family, society, personal goals and ambitions, and insecurities, which may act as safeguards or as stressors depending on their nature and intensity. Every individual, at some point in their life, is faced with circumstances that are extremely difficult and hard to deal with. While most people are resilient, some tend to develop mental conditions when exposed to adverse circumstances like poverty, violence, disability, and inequality[2].

Mental health is an integral part of humans, and many mental health conditions can be effectively treated at relatively low cost, yet many healthcare systems remain undersourced, and gaps with respect to treatment exist globally. Many countries have regulated mental health, and there are systems in place to cater to the needs of the people; however, this care is often of poor, substandard quality when delivered. While people with mental health conditions not only face difficulties with treatment and its affordability, they also are subjected to discrimination, human rights violations, and often experience the social stigma associated with mental health issues.

When we talk about mental health, it is imperative to also address the stigma that people with mental health illnesses face. Living with any mental health condition is hard, but for many of these, the stigma, negative perceptions, and behaviors of others are worse to deal with and cope with[3]. While addressing the issue of stigma and discrimination in mental health, this paper draws reference from the *Report on the Lancet Commission on Ending Stigma and Discrimination in Mental Health,* prepared by Charlene Sunkel[4] and Sir Graham Thornicroft[5].

[2] World Health Organization, *Mental Health, WHO* (last visited on Aug. 29, 2025), https://www.who.int/health-topics/mental-health.
[3] World Health Organization, *The Overwhelming Case for Ending Stigma and Discrimination in Mental Health,* WHO Regional Office for Europe (June 26, 2024) https://www.who.int/europe/news/item/26-06-2024-the-overwhelming-case-for-ending-stigma-and-discrimination-in-mental-health
[4] Charlene Sunkel, Founder, Global Mental Health Peer Network, Paarl, South Africa.
[5] Prof Graham Thornicroft, Centre for Global Mental Health, Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK.

According to the Lancet Commission Report, Graham and Charlene have worked with 42 researchers and to understand and analyse the experience of people living with mental health conditions. They draw the inference that stigma about mental health is based on the lack of literacy about mental health conditions. The commission report also suggests that if the misinformation about mental health is corrected, we can reduce prejudice and consequently lessen the discrimination against people suffering from mental health conditions[6].

This paper undertakes to compare the standalone legislations of India and the United Kingdom, and study how both countries take different approaches to tackle the challenges with respect to mental health and well-being of people with mental illness. This paper aims to highlight how the provisions of the law focus on the protection of the rights of people with mental illnesses and how to protect their decision-making autonomy, which takes a balanced approach to ensure that the patients' rights are not violated and they make an informed decision about acceptance or refusal to the suggested course of treatment. The comparative analysis aims to highlight and address existing gaps in the field, as well as current practices in both countries, and provide suggestions to overcome them, ensuring meaningful contributions to the field of mental health and law.

Literature Review

1. **Dr Pinky Bangarh et al** delves into the understanding of the regulations laid down by the legislature to protect the rights of people suffering from mental illness. This article aims to study the rights of people with mental illness in India. The study follows a doctrinal method for its study, and they have conceptually analysed the laws with respect to mental health. The authors also try to highlight the provisions given in the Mental Health Care Act, 2017, like the provision of the definition of mental illness, the provision of advanced directives, representatives who can be nominated, and the power of the legislature to establish Mental Health Review Boards. The authors highlight the unique provision of decriminalising suicide by a person who is mentally ill. The article also brings to light the human rights guaranteed and enjoyed by mentally ill people. The author finally voices the concern that India's public healthcare is not up to the standards and cannot cater to the needs of the vast population in the country. The article also

[6] Graham Thornicroft et al., *The Lancet Commission on Ending Stigma and Discrimination in Mental Health,* 400 Lancet 10361 1438 (2022) 10.7759/cureus.39549.

reveals the statistics of the conditions of the people and how many doctors; psychiatrists are available for each mentally ill patient. The article critically evaluates and compares the Indian Lunacy Act, 1912, and the Mental Health Act, 1987. [7]

2. **Leslie London** geographically focuses on Sub-Saharan African children and critically compares and analyzes them with those of the children from the developed countries of the Organization for Economic Co-operation and Development. The study uses the statistical data published by the United Nations Development Programme Report (2007-08). The author carries out a doctrinal study and critically analyzes the statistical data with the laws and procedures in practice in the country. The author critically analyses how the lawmakers delve into making policies on paper without understanding the gravity of the problems people face. The author highlights the rights-based approach by talking about the Grootboom case, which set the precedent in substantiating that the basic needs of all human persons are socio-economic entitlements in human rights law. The gist of having a rights-based approach to health is to ensure the government can be held responsible and promote health equity. The article also discusses in detail the human rights aspect when dealing with people and prisoners with mental illnesses. The article talks about the pros of having a human rights-based approach as it promotes proactive evolution of policies and programs. [8]

3. **Dr. Soumitra Kumar Chatterjee** discusses the right to health exclusively from the perspective of the Constitution of India. The author points out that although the '*right to health*' is not explicitly mentioned in the Constitution, the judiciary has played an active role in incorporating it within the purview of Part III of the Constitution, i.e., the Fundamental Rights. The article also discusses various cases where the courts have interpreted the right to health as one of the fundamental rights available to citizens. It delves into Articles 21, 23, and 24 of Part III of the Constitution. The article also discusses in detail the case laws that are established precedents with respect to the subject matter of the current study. It also talks about the Directive Principles of State Policy in Part IV of the Constitution. The author of the article highlights that the state has the obligation to ensure that every citizen has access to good health. The author

[7] Dr. Pinky Bangarh, Dr. Rakesh Pal, Dr. Ritu Deepti, *Human Rights for Those Who Suffer from Mental Illness: Regulations Provided in the Mental Health Care Act, 2017*, 4 IJLLR. 1-13 (2022-2023).
[8] Leslie London, *What is a Human-Rights Based Approach to Health and Does It Matter?*, 10 HHR. 65-80 (2008). https://www.jstor.org/stable/20460088**.**

discusses the provisions of articles in the DPSP, viz., Art. 38, 39, 41, 42, and 48A of the Constitution, which ensure proper and good health to the citizens. While doing so, it also lays down the procedure for remedies, in case these provisions are infringed. However, the article fails to talk about the Mental Health Care Act, 2017, and it does not discuss the rights and procedures given to the people by this legislation. This particular gap shall be addressed in the paper. [9]

4. **Mridula Sarmah** delves into the significance of health as a human right implicitly guaranteed under Article 21 of the Constitution of India, as interpreted by the courts in various cases, and therefore this article is relevant to the current study. The author has carried out this research using a doctrinal method, and the researcher has collected data from secondary sources. The author studies the legislation, legal institutions, analyzes the case laws and guidelines, and verdicts given by the courts. It delves into Articles 21, 23, and 24 of Part III of the Constitution. The uniqueness of the article is that it draws inferences from Art 51A, the Fundamental Duties, and the author points out how the duty towards the environment aids the good health of the people of the country. The author also discusses Art. 243W, which highlights the responsibility of the municipalities and connects the same with the matters included in item 6 of the Twelfth Schedule of the Constitution. The author also draws a similar reference to Art. 243G studying about the accountability of Panchayat and connects with Eleventh Schedule 23rd item. The rights-based approach is highlighted quite well in the paper and the same shall be considered in the current study. However, the author highlights the importance an individual possesses with respect to his/her health and how they can take necessary steps to maintain the same. The article primarily discusses about health in general and does not talk about mental health. This becomes a research gap which shall be dealt with, in the current study. [10]

5. **James F Drane** delves into the competency of a patient to give consent, either to get the treatment or to refuse the same. It is a conceptual study by the author as he studies and analyzes the significance of the competency of a patient to consent to treatment or refuse the same. He advocates for a modified sliding scale to check for competency

[9] Dr. Soumitra Kumar Chatterjee, *Right to Health, Constitutional Safeguards and Role of Judiciary*, OD. 85-89 (2016) https://magazines.odisha.gov.in/Orissareview/2016/April/engpdf/86-90.pdf

[10] Mridula Sarmah, *A Study of Right to Health under Constitution of India*, 5 IJHRSS. 85-90 (2019). https://www.ijhsss.com/files/10_ib71bw5y.-Mrs-Mridula-Sarmah-19-02-19.pdf

instead of opting for the standard test. The article talks in detail about the three different standards depending on the gravity and seriousness of the issue at hand. The '*Standard 1*' being the least stringent of all, offers the opportunity for the patient to weigh the options of available courses of treatment, in cases of *acute* illness. '*Standard 2*' is applied in case of *chronic* illness with considerably less benefit over risk, and '*Standard 3*' is the most stringent with highly dangerous decision making. He also talks about the three standards correlated with psychiatric abnormalities and how the article is going to provide guidelines for the usage of the same. The author highlights that the capacity of a patient to choose is their form of participation and a form of basic freedom, and this must be an informed one. The article also critiques the instances and practices where the decision-making is transferred to the treating physician. The article focuses predominantly on the issues with respect to the competency of patients, the methods to ascertain the same, and their implementation. The current paper shall refer to this article in highlighting the standards for competency tests and their implementation. [11]

6. **Paul S Applebaum** deals with the duty vested in doctors, both legally and ethically, to obtain consent from the patient, and since 'competence' is an integral part of the current study, this article holds significant relevance to the current study. The article is an analytical study that tries to find a solution to a clinical problem. However, it follows the doctrinal style of research. Consent must be obtained after ensuring that the patient understands the need for the treatment and comprehends the consequences of acceptance or refusal to proceed with the suggested course of treatment. The author makes a reference to why we have the development of advance directives in the healthcare system. The author tries to highlight the pivotal role of doctors in determining the capacity of a patient to consent. The article suggests criteria to determine competency or incompetence, as the case may be. The article addresses the dilemma faced by treating physicians when they are required to ascertain the capacity of the patient to consent to the treatment and to decide which criteria to be considered to determine the decision-making capacity of the patient. The article also discusses in detail the *MacArthur Competent Tool for Treatment* to ascertain the capacity of the patient. This study does not deal with the legal implications of the determination of the

[11] James F Drane, *Competency to Give an Informed Consent*, 252 JAMA. 925-927 (1984). https://bioetyka.uw.edu.pl/wp-content/uploads/2014/10/Drane.pdf

competence of the patient. The inferences of this literature shall be used in the comparative study to draw out the legal implications with respect to mental health. [12]

7. **Genevra Richardson Committee, Review of the Mental Health Act, 1983, 1998, Department of Health, (UK),** was created to review the Mental Health Act, 1983. This commission was constituted to address the mental health concerns of various groups of people. The report of the committee has followed the empirical method of research, where they have collected evidence, analysed and critiqued the laws, and suggested reforms. The report is structured well as it is divided into five phases. The scope of the expert committee report is to analyse and shape the mental health law of the United Kingdom to meet the new contemporary standards in changing times. The Department of Health is focusing on modernising healthcare for the ease of people. The report also mentions the non-discrimination based on the grounds of mental health. The report mainly focuses on the principles of patient autonomy and the notion of capacity that arises from it. The expert committee makes a point to express the importance of patient autonomy, which states that the Act should "*be treated and cared for in such a way as to promote to the greatest practicable degree their self-determination and personal responsibility, consistent with their own needs and wishes".* The report addresses lacunae in the Mental Health Act, 1983, and this shall be used in the comparative analysis in the current study. [13]

8. **Birgitt Vollm and Nagraj Konnappa,** conducted an empirical study on the Dangerous and Severe Personality Disorder (DSPD) programme established by the Department of Health in the year 1999. The background of the programme is a high-profile case of Michael Stone. This article aims to review the empirical research conducted on the DSPD. The authors analyse around 29 empirical research reports and 3 comprehensive reports. Although most studies highlight the description of the DSPD persons and how there are concerns regarding the same is stigmatised and has a restricted environment. The implications of this study are that it tries to address the question of what treatments are effective to treat the high-risk disordered offenders, which has remained unanswered. It talks about the provision of patients being declared 'untreatable' by psychiatrists. This provision included a "treatability test" for individuals with DSPD,

[12] Paul S. Applebaum, *Assessment of Patient's Competence to Consent to Treatment*, 357 N Engl J Med. 1834-1840 (2007). https://www.nejm.org/doi/full/10.1056/NEJMcp074045
[13] Genevra Richardson Committee, *Review of the Mental Health Act, 1983*, 1998, Department of Health, (UK).

as given under the Mental Health Act, 1983. The article deals with how patients with DSPD are to be treated and how such people can be handled without the need to detain them. The prison authorities in England and Wales even set up centres to accommodate prisoners with DPSD, who, over time, showed significant progress in their condition. The study considers and evaluates factors like economic issues, treatment, and views with special reference to patients' views. The data presented in the article shall be used in the current study. [14]

9. **Rohan Verma** about the effectiveness and efficiency of the Mental Health Act of 1987, which was replaced by the current legislation, The Mental Healthcare Act, 2017, and hence it is very relevant to the current study. The article highlights how the current legislation is better than the previous one, but still fails to meet the needs and issues faced by persons with disability in reality. The author of the article writes about how the Mental Health Act, 1987, was primarily enacted to implement the UNCRPD[15], which was ratified in 2007, but did not have enough policy to implement a robust policy. To address this gap, the present act was enacted. The study throws light on how the Mental Health Act, 2017, was amended to decriminalise the act of committing suicide under section 302 of the Indian Penal Code, 1860; however, it failed at this attempt as it created the provisions of the Mental Health Act, 2017, in a very vague and ambiguous manner. The author critiques the present legislation and states that it fails to implement the National Mental Health Policy across all states. The author, in his suggestions, states that the National Human Rights Commission should expand its ambit and deal with the atrocities committed against people with mental illness. The article also deals with the difficulty in implementing the policies, and the same shall be considered in the current study. [16]

10. **Sameeksha Shetty** attempts to address the mental health issues faced by convicts, under-trial prisoners, and people involved in civil lawsuits, and therefore, it is very relevant to the current study. The research has opted for a doctrinal methodology where the laws that delve into mental health care are studied and analysed. The fact that mental

[14] Birgitt Vollm and Nagraj Konnappa, *The Dangerous and Severe Personality Disorder Experiment - Review of Empirical Research*, 22 CRIM. BEHAV. & MENTAL HEALTH 165-180 (2012).
[15] United Nations Conventions on the Rights of Persons with Disability.
[16] Rohan Verma, *Dire Need of Structural Reforms in Law and Policy for Mental Health in India*, 2 JUS CORPUS L.J. 651-656 (2022).

health issues and mental illness are still looked at as taboo in India, and people are stigmatised for the same. The scope of this article is restricted to the territory of India. The article tries to address the question of the rights of prisoners who have mental illnesses and what recourse the law will take while dealing with them. The article talks about the history of the mental health laws in India, which shall be considered in this study. The article not only talks about the legislation passed by the parliament but also deals with the medico-legal aspect of the same. It addresses the wing of forensic psychiatry, which talks about a variety of civil aspects of mental health and the issues related to the treatment of illnesses. And finally, the author talks about the lack of access to mental health care due to the unavailability of resources, lack of infrastructure, manpower, and awareness, which are all pivotal in giving treatment to a person with mental health issues or disability. [17]

Statement of Problem

'Health is Wealth,' an age-old saying, is known by everyone but always overlooked. Humans are not simple beings anymore. With technological advancements and modernisation in every field, competition and change are the only constants of the world, and the result of all this, toll on health, particularly mental health. When discussing mental health, it is imperative not only to delve into it in a general sense but also to analyse and understand its legal implications for an individual and society as a whole. The Mental Health Act, 2017 of India is foundational as it embraces a paradigm change, taking India out of the custodial mode of mental health care to the rights-based approach by focusing on patient autonomy, informed consent, and treatment choice as per the UN Convention on the Rights of Persons with Disability, 2008. This Law removed the information 18-year-old archaic Mental Health Act, 1987 which put new progressive ideas of being competent and empowering patients. Yet, the success of this rights-based approach is rather doubtful when it comes to the real application and international benchmarks.

This is contrasted with the Mental Health Act 2007 (England and Wales) in the United Kingdom; it shows the biggest loopholes in India. The UK follows a more restrictive approach where patient autonomy is subordinated to clinical judgment, whereas the UK offers better

[17] Sameeksha Shetty, *Mental Health and Law: An Overview of its Affiliation with the Indian Justice System*, 3 IJIRL. 1-16 (2023) https://ijirl.com/wp-content/uploads/2023/09/MENTAL-HEALTH-AND-LAW-AN-OVERVIEW-OF-ITS-AFFILIATION-WITH-THE-INDIAN-JUSTICE-SYSTEM.pdf

forensic psychiatry services and standardization. The problem of legislation in India is that, although it is predominantly progressive in the aspect of supporting the rights of patients, it lacks proper forensic mental health infrastructure, especially in a prison setting, resulting in poor access to care among vulnerable groups. The resulting gap between the intentions of the legislator and the reality of the implementation process raises serious research issues: How can the legislation on rights-based mental health manage to keep in balance the autonomy of the patients and clinical necessity, and still provide sufficient services? The disagreement between theories of implementation and practice in the field weakens the financial potential of the legislation to solve mental health issues holistically. Moreover, the lack of strong comparative studies conducted across various models regarding legislative models contributes to the inability to create effective mental health policies. The recognition of this variability is significant in the alignment of the national systems with international requirements, especially the UN Sustainable Development Goal 3, which stresses the universal access and the well-being of healthcare.

Hypothesis

Hypothesis 1: If India adopts a mode-based approach to test capacity to consent, the laws would be more progressive.

Hypothesis 2: If the Mental Health Review Board is replaced with Mental Health Tribunals, the rights can be safeguarded more effectively.

Research Questions

1. In what ways does Article 21 in the Indian Constitution include the right to mental health, and what are the judicial understandings used to give support to the inclusion?

2. What can India learn from the UK in terms of adapting the system of Independent Mental Health Advocates (IMHAs) to improve the process of informed consent under Section 22 of the Mental Healthcare Act, 2017?

3. How would the replacement of the Mental Health Review Boards in India to independent Mental Health Tribunals, based on the UK system, and therefore better protect the rights of persons with mental illnesses, be more effective legally and in practical terms?

4. What are the legal and policy changes required to assist India in implementing a UK model of community-based mental health care system, and how will these changes facilitate deinstitutionalisation as required under Section 18 of the MHCA, 2017?

Research Objectives

- To analyse the interpretation of the right to mental health under Article 21 of the Indian Constitution in light of case law.

- To argue on the validity of importing the Independent Mental Health Advocate (IMHA) framework in the UK, in enhancing informed consent in the context of the Mental Healthcare Act 2017, India.

- To assess the possible advantages of the alternative to strong Mind Health Review Boards in India, namely, independent Mental Health Tribunals.

- To determine the legal and policy actions that India can borrow of the UK in order to establish effective mental health care in the community.

History and Development of Mental Health Law in India

'Mental Illness', the mention of the term causes immediate prejudice in the mind of any average person. Mental illnesses, like all other diseases, are beyond the control of the person and more often than not are capable of treatment. However, the stigma and prejudice associated with mental illness are unseen in the case of other diseases like 'cancer', 'AIDS', 'tuberculosis', etc[18]. "*Stigma is defined as a sign of disgrace or discredit, which sets a person apart from others. The stigma of mental illness, although more often related to context than to a person's appearance, remains a powerful negative attribute in all social relations."*[19]

In the last few years, the country has seen tremendous change and a shift in how mental illness is viewed. The credit for this shift rightfully goes to the United Nations, which has spread awareness about mental illnesses and treatments associated with them. It also undertook

[18] Neelima Tripathi, *A Brief History of Mind,* 61 J. Indian L. Inst. 229 (2019).
[19] Peter Byrne, *Stigma of Mental Illness and Ways of Diminishing It,* 6 Advances Psychiatric Treat. 65 (2000).

various programmes to tackle the stigma associated with mental illness[20].

The history and development of Mental Health Law in India shall be dealt with under the following headings:

A. Indian Lunatic Asylums Act, 1858.

B. Indian Lunacy Act, 1912.

C. Mental Health Act, 1987.

D. Mental Healthcare Act, 2017.

The Indian Lunatic Asylums Act, 1858: This act was brought by the Legislative Council of India in 1858. This is a pre-independence legislation that aimed at providing reception and detention of *lunatics in asylums* created for that purpose. The act laid down standard protocols and procedures to admit people with mental illness into these asylums established by the government. However, this legislation failed and was replaced by the Indian Lunacy Act, 1912, as it only focused on the detention aspect and turned a blind eye to the needs of these people. The Indian Lunatic Asylums Act, 1858, was met with stark criticisms as the ill were subjected to poor living conditions and were left with no hope of recovery[21].

The Indian Lunacy Act, 1912: This act replaced The Indian Lunatic Asylums Act, 1858. The idea of caring of people with mental illness were happening in mental asylums (now knowns as mental hospitals) was the brainchild of the British. Before this, mentally ill either faced neglect or ill treatment, however, they were managed by the Indian Ayurvedic treatment[22]. This act bought the lunatic asylums were bought under central supervision and it also recognised the specialists in psychiatry, who were appointed as full-time officers in the said asylums[23]. This act was primarily enacted to take a different approach in dealing with the mentally ill by providing care, custody and the management of these people. However, the act failed as it only claimed to care for the patients on paper, but in reality, it didn't consider the medical need of

[20] Supra *n.* 17.
[21] Aparna Goswami, *Indian Mental Health Laws: Emergence and Analysis,* J. for L. Students & Researchers (2020), https://www.jlsrjournal.in/indian-mental-health-laws-emergence-and-analysis-by-aparna-goswami.
[22] Behere Prakash B. et al., *A Journey from Indian Lunacy Act 1912 to Indian mental Health Act 1987 & Draft Amendment,* Indian J. Forensic Med. & Pathol., Vol. 3, No. 4, 229 (2010).
[23] S. Rajkumar, *Mental Health Services in India*, 18 J. SOC. & SOC. WELFARE 41 (1991).

the patients, rather focused on the legal aspect of this. An interesting aspect of this legislation is that, the decision of reception of any person with mental illness is decided by the magistrate (supported by the medical certificates given if by the medical officers)[24]. For all the said reasons, this act was repealed and replaced by the Mental Health Act, 1987.

The Mental Health Act, 1987 (hereinafter referred to as the MHA, 1987): The Parliament enacted the Mental Health Act, 1987, to ensure a shift in the paradigm from custodial care to community care. This legislation aimed to protect, promote, and improve the lives and mental well-being of citizens. From the 1912 legislation to the 1987 legislation, the perception of the mentally ill had changed due to various reasons, like advances in the treatment of the mentally ill, the human rights movement, and the awareness programmes of the WHO. The MHA, 1987, came into force in 1993, replacing the Act of 1912. MHA 1987 defines a mentally ill person as "*a person who is in need of treatment by reason of any mental disorder other than mental retardation."*[25] The act provides for the establishment and maintenance of psychiatric hospitals or psychiatric nursing homes for the treatment of patients with mental illnesses. An interesting provision of Sec. 5 is that it even considers the treatment of addicts who experience behavioural change[26]. The act also addresses the care of outpatients in these psychiatric care facilities[27]. The act allows admission of a mentally ill patient on a voluntary basis,[28] and in case of a patient under special circumstances, the relative or a friend of the mentally ill person can get the person admitted into the psychiatric facility, where the person is admitted as an inpatient receiving treatment for not more than 90 days, except for special circumstances[29]. The MHA, 1987, is silent on the aspect of consent for treatment and the method/course of treatment. It does not address the circumstances when a patient refuses to consent to a proposed course of treatment. It is also worth noting that the MHA, 1987, does not establish a systematic protocol in such situations. The MHA (1987) does not address patient autonomy and forced treatment when the patient refuses treatment[30].

[24] *Indian Lunacy Act,* No. 4 of 1912, § 8 (India) (laying down the procedure for reception orders for mentally ill persons).
[25] *The Mental Health Act*, No. 14 of 1987, § 2(l) (India).
[26] *Id* at § 5.
[27] *Id* at § 14.
[28] *Id* at § 15.
[29] *Id* at § 19.
[30] S. B Math, P. Murthy & C.R. Chandrashekar, *Mental Health Act (1987): Need for A Paradigm shift from Custodial to Community Care,* 133 Ind. J. Med. Res. 246 (2011). https://ijmr.org.in/view-pdf/?article=b813b96a5446553464d9f06d0156b991rG5wOkJEfmY=

Mental Healthcare Act, 2017 (hereinafter referred to as MHCA, 2017): The Parliament of India enacted the Mental Healthcare Act, 2017, to ensure the provision of mental healthcare and related services for persons with mental illnesses and to protect their rights. India signed the **United Nations Convention on the Rights of Persons with Disabilities** on 30th March 2007 and ratified the same on 1st October 2007[31]. MHA, 1987, does not provide a robust policy with regard to the mentally ill and the protection of their rights, and hence, the MHCA, 2017, was brought by the Parliament. This was a progressive step taken by the lawmakers, which attempted to bring provisions that aimed at the protection of both the mentally ill and their rights. The National Mental Health Policy, formulated in 2014, is the fundamental foundation of the MHCA, 2017, which replaced the MHA, 1987. However, the act still ignores the implementation of the National Mental Health Policy across the country, and this was widely criticised[32]. The provisions of the act are as follows:

i. **Definition of mental healthcare**: mental healthcare includes analysis and diagnosis of a person's mental condition and treatment, as well as care and rehabilitation of such person for his mental illness or suspected mental illness[33]. This definition avoids words like 'idiocy, lunacy,' making it more non-stigmatizing and dignified for people with mental illness.

ii. **Determination of Mental Illness**: This section describes the grounds and standards on which a medical practitioner can determine the mental illness of a person. These standards are nationally or internationally accepted standards. The section also highlights that the determination of the mentally ill should be done only for the purpose of treatment, and mere determination of illness does not imply that the person is of unsound mind unless a competent court declares it so[34]. The condition of determination, only for the purpose of treatment, achieves the objectivity of inclusion of these, unlike the previous legal frameworks, which aimed at the separation of the mentally ill from society as a whole.

iii. **The capacity to make decisions**: The current legislation expressly provides that every person, even a mentally ill individual, has the capacity to make decisions

[31] Convention on the Rights of Persons with disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.
[32] Rohan Verma, *Dire Need of Structural Reforms in Law and Policy for Mental Health in India*, 2 JUS CORPUS L.J. 652 (2022).
[33] *The Mental Healthcare Act,* No. 10 of 2017, § 2(1)(o) (India).
[34] *Id* at § 3.

regarding his mental healthcare and treatment as long as he understands the information, processes it to know the consequences, and communicates his decision[35]. This ensures informed decision-making and maintains transparency between the individual with mental illness and the treating physician. The section also highlights that a patient's mere refusal to consent to a particular treatment or an allegedly wrong or inappropriate decision shall not be perceived as an incapacity to make decisions[36].

iv. **The Advance Directive**: The Mental Healthcare Act, 2017 ("MHCA 2017") introduced the concept of advance directives (ADs) in India, granting individuals with mental illness the legal right to specify their treatment preferences in advance of any crisis situation[37]. An AD allows a person to state how they wish to be treated, or not treated, during periods when they may lose the capacity to make informed decisions[38].This provision reflects India's commitment to the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), ensuring patient autonomy, dignity, and participation in healthcare decisions[39]. The Act mandates that every advance directive must be made in writing, signed by the person, witnessed, and registered with the Mental Health Review Board (MHRB)[40]. Importantly, the directive can cover choices regarding treatment, preferred healthcare professionals, and even the nomination of a representative to make decisions on behalf of the person[41]. Mental health professionals are legally bound to follow a valid AD, except in cases where it may lead to serious harm to the patient or others[42]. One of the most progressive features of the MHCA 2017 is that it shifts the focus from a paternalistic medical model to a rights-based approach by recognising the individual's voice even in moments of incapacity. However, challenges remain, including a lack of awareness, administrative difficulties in registration, and possible conflicts between families and professionals[43]. Despite

[35] *Id* at § 4.
[36] *Id.*
[37] *Id*.
[38] *Id* at § 5.
[39] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.
[40] *The Mental Healthcare Act,* No. 10 of 2017, § 6 (India).
[41] *Id* at § 5(2).
[42] *Id* at § 11.
[43] Soumitra Pathare & Shekhar Saxena, Mental Health Legislation in India: Past, Present, and Future, 40 *Indian J. Psychiatry* 207, 210 (2017).

these hurdles, advance directives mark a transformative step towards empowering patients and aligning Indian law with global human rights standards[44].

Mental Health Law in the United Kingdom

Historical Development: The history and evolution of mental health legislation in the United Kingdom date back to the 1700s. The country has witnessed development from early custodial statutes towards a more patient-centred approach, which focuses on autonomy, dignity for patients with illnesses, and proportionality. Some of the key legislations from the 1700s to the present times are as follows:

A. Madhouses Act, 1774.

B. County Asylums Act, 1808.

C. Lunacy Act, 1890.

D. Mental Health Act, 1959.

E. Mental Health Act, 1983.

F. Mental Capacity Act, 2005.

G. Mental Health Act, 2007.

While understanding the history of mental illnesses, it is pivotal to understand how society viewed mental illness and how this perception has evolved alongside the law. Before the mental health laws were enacted, illnesses affecting a person's cognitive ability were viewed very poorly and lacked sympathy and compassion towards the ill. In England, people with such illnesses were believed to be possessed by spirits or cursed, and treatment for such illnesses was out of the question. The asylums were first established in the 16th century. Bethlehem Hospital was the first hospital to treat individuals with mental illnesses. The conditions were, however, still brutal and inhuman as the establishment of the hospital was with the goal to confine and not treat the mentally ill.

[44] World Health Organization, *Mental Health, Human Rights and Standards of Care* (2021), https://www.who.int/publications/i/item/9789240036703 (last visited Sept. 21, 2025).

The Madhouses Act, 1774: For the first time, the parliament came up with the Madhouses Act in the year 1774. This marked a significant milestone in the history of mental health care and legislation related to the same. In the 1700s, understanding mental illness was severely limited and was often based on superstition and stigma[45]. This act enabled the establishment of asylums, then commonly referred to as madhouses. The act prescribed conditions, such as the privately run madhouses required to be registered with magistrates. The aim was to confine people with mental illnesses and protect them from abuse and malpractice. The act also provided for inspection of the madhouses, ensured protection of the patients from brutal and inhuman treatments and also made an attempt to curb malpractice by the medical professionals[46].

The County Asylums Act, 1808: The Criminal Lunatics Act of 1800 was brought by the British Parliament. This act made it possible for the authorities to detain the criminal lunatics in County goals. The pressure built by this legislation laid down the foundation for the lawmakers to pass the County Asylums Act, 1808, which is also popularly known as the Wynn's Act[47]. The County Act of 1808 allowed and promoted local authorities to build and maintain public asylums, marking a shift from madhouses to asylums. This legislation aimed to provide care and treatment to patients, rather than merely confining them. The money to build the asylum was raised publicly through taxes, and the people with illnesses were moved from prisons to better facilities, which aimed at improving their living conditions[48].

The Lunacy Act, 1845: The Lunacy Act, 1845, established a framework for the treatment and care of the mentally ill. This legislation was the first in the history of mental health law of the UK to promote the treatment of individuals with mental illness as 'patients' rather than outcasts or cursed and possessed. It legally mandated the counties to build asylums to accommodate and treat people with mental illness. The act laid down the foundation for the new system of providing standard treatment and care to the mentally and this was credited to Anthony Ashley

[45] Cleaver, Rex, *250 Years Since the 1774 Madhouses Act Gained Royal Assent*, Brit. Online Archives (May 20, 2024), https://britishonlinearchives.com/posts/category/notable-days/773/250-years-since-the-1774-madhouses-act-gained-royal-assent.
[46] Concise Admin, *History of Mental Health Law in the UK: Key Reforms & Challenges*, Concise Medico (Sept. 27, 2024), https://concisemedico.co.uk/blogs/history-mental-health-law-uk.
[47] Staffordshire's Asylums, *The Asylum Story in Britain*, Staffordshire's Asylums (July 6, 2019), https://staffordshireasylumrecords.wordpress.com/the-asylum-story-in-britain/
[48] Concise Admin, *History of Mental Health Law in the UK: Key Reforms & Challenges*, Concise Medico (Sept. 27, 2024), https://concisemedico.co.uk/blogs/history-mental-health-law-uk.

Cooper, the 7th earl of Shaftesbury[49].

In the 1880s and 1930s, numerous legislations were passed by the British Parliament, marking a significant change and redefining the terms associated with lunacy. The legislation, the Idiots Act of 1886, made a distinction between 'idiots', 'imbeciles', and 'lunatics'[50]. The Mental Deficiency Act of 1913 provided a distinct structure and defined 'mental defectives' into four categories, viz:

- *'Idiots'– "persons so deeply defective in mind from birth or from an early age as to be unable to guard themselves against common physical dangers."*
- *'Imbeciles'– "persons in whose case there exists from birth or from an early age mental defectiveness not amounting to idiocy, yet so pronounced that they are incapable of managing themselves or their affairs, or in the case of children, of being taught to do so."*
- *'Feeble-minded persons'– "persons in whose case there exists from birth or from an early age mental defectiveness not amounting to imbecility, yet so pronounced that they require care, supervision, and control for their own protection or for the protection of others, or, in the case of children, that they by reason of such defectiveness appear to be permanently incapable of receiving proper benefit from the instruction in ordinary schools."*
- *'Moral imbeciles'– "persons who from an early age display some permanent mental defect coupled with strong vicious or criminal propensities on which punishment has had little or no deterrent effect."*[51]

The act reflected the bias and prejudices of its time, but it also viewed cognitive health as a social issue that required government attention.

The Mental Health Act, 1959: The British Parliament enacted the Mental Health Act, 1959 which replaced the Lunacy and Mental Treatments Act, 1890 to 1930 and the Mental

[49] Britannica Editors, *Anthony Ashley Cooper, 7th Earl of Shaftesbury*, *Encyclopædia Britannica*, https://www.britannica.com/biography/Anthony-Ashley-Cooper-7th-earl-of-Shaftesbury
[50] UK Parliament Archives, *Mental Health in Legislation*, UK Parliament (Mar. 14, 2024), https://archives.blog.parliament.uk/2024/03/14/mental-health-in-legislation/
[51] *Id.*

Deficiency Act, 1913 to 1938 and the provisions of this act will be followed with respect to the reception, care and treatment of the people with mental illnesses and matters related to the management of their property as well[52]. This act, for the first time, made an attempt to define what mental illness is and distinguish it from psychopathic disorder and subnormality[53]. The act also provides for the establishment of Mental Health Review Tribunals, prescribing their composition, powers, and functions. This was a very progressive step taken in the direction of providing care, treatment and aid to the mentally ill. The act also spoke about the management of the property of patients suffering from mental illness.

The Mental Health Act, 1983: The 1983 Act is one of the most important pieces of legislation, covering not only the treatment and rights of individuals with mental illnesses but also clearly outlining the assessment of such individuals. The MHA 1983 regulates both civil and criminal pathways to detention, referred to as "sections."[54] Civil detention is primarily governed by Sections 2 (assessment) and 3 (treatment), which require medical recommendations and an application by an Approved Mental Health Professional[55]. Patients may be detained if suffering from a mental disorder warranting hospital treatment, and if detention is necessary for their health or safety, or the protection of others[56]. The Act grants rights of appeal to Mental Health Tribunals, ensures involvement of the "nearest relative," and provides oversight by the Care Quality Commission[57]. Treatment under compulsion may be given without consent, although safeguards exist for certain interventions such as psychosurgery and long-term medication[58]. Critics have long argued that the MHA 1983 prioritises public protection over individual autonomy[59].

Criticism of the Current Regime: Over the past three decades, the use of compulsory detention has risen significantly, with a disproportionate impact on ethnic minorities[60]. Empirical research shows that detentions under the MHA have nearly doubled between the mid-1980s and 2015[61]. Scholars argue this trend reflects systemic risk aversion, lack of

[52] Mental Health Act 1959, 7 & 8 Eliz. 2 c. 72, § 1 (UK).
[53] Supra *n.* 51 § 4.
[54] Julie Carr, Reform of the Mental Health Act 1983: Implications of Safety, Capacity and Compulsion, 64 *Br. J. Occupational Therapy* 567, 569 (2001).
[55] *Id.*
[56] Patrick Keown et al., Changes in the Use of the Mental Health Act 1983 in England 1984/85 to 2015/16, 213 *B.J. Psychiatry* 595, 597 (2018).
[57] *Id.*
[58] Mills & Phull, supra *n.* 44, at 668.
[59] *Id.*
[60] Keown et al., supra *n.* 50, at 598.
[61] *Id* at 599.

community alternatives, and structural inequalities[62]. Moreover, the Act's criteria for detention do not adequately consider decision-making capacity, meaning that capable objecting patients may still be detained[63].

Reform Proposals: In 2018, the UK government commissioned the Independent Review of the Mental Health Act, which proposed reforms emphasising autonomy, choice, and least restriction[64]. Recommendations included requiring stronger justification for detention, improving patient advocacy, and ensuring that detention delivers therapeutic benefit. White papers and draft bills have followed, although reforms remain under consideration by parliament[65]. Recent academic commentary has highlighted the potential unintended consequences of reform[66]. For example, proposals to exclude autism and intellectual disability as grounds for detention aim to reduce inappropriate hospitalisation but may inadvertently leave individuals without sufficient safeguards[67]. Others note that new safeguards, such as increased tribunal oversight, will require significant resources to be effective[68].

International Influences: The reform agenda is strongly shaped by the UN Convention on the Rights of Persons with Disabilities (CRPD), which emphasises autonomy, legal capacity, and freedom from discrimination[69]. Commentators argue that UK law must reconcile CRPD principles with domestic concerns about public safety and risk management[70]. The ongoing debate reflects a broader international movement away from paternalistic mental health law toward rights-based models[71]. Mental health law in the UK is at a crossroads. The MHA 1983, despite amendments, reflects an era of paternalistic compulsion, while the MCA 2005 pushes toward autonomy and proportionality[72]. Rising detention rates, ethnic disparities, and systemic inequalities underscore the urgency of reform[73]. The Independent Review and subsequent proposals indicate a shift toward patient empowerment and alignment with international human

[62] Carr, supra *n.* 48, at 570.
[63] Gunn, supra *n.* 46, at 62.
[64] Independent Review of the Mental Health Act, Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion (2018).
[65] *Id.*
[66] Editorial, The Potential Unintended Consequences of Mental Health Act Reforms in England and Wales on People with Intellectual Disability and/or Autism, 222 *B.J. Psychiatry* 205, 206 (2023).
[67] *Id* at 207.
[68] *Id* at 208.
[69] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.
[70] Editorial, supra *n.* 60, at 208.
[71] *Id* at 209.
[72] Gunn, supra *n.* 46, at 66.
[73] Keown et al., supra *n.* 50, at 600.

rights norms, yet implementation will require balancing autonomy with safety, and rhetoric with resources[74].

Analysis of Mental Health Laws of India and the UK: The legal frameworks governing mental health in India and the United Kingdom reflect divergent historical trajectories yet share a contemporary shift toward rights-based approaches[75]. India's Mental Health Act 1987 (MHA 1987) was primarily custodial in character, focused on regulating asylums and admissions rather than safeguarding patient rights[76]. By contrast, the UK's Mental Health Act 1983 (MHA 1983) provided a more elaborate statutory scheme for compulsory detention and treatment, albeit one criticized for prioritizing public safety over autonomy[77]. India's paradigm shifted with the enactment of the Mental Healthcare Act 2017 (MHCA 2017), which repealed the MHA 1987 and embraced a rights-based framework influenced by the UN Convention on the Rights of Persons with Disabilities (CRPD)[78]. The MHCA 2017 guarantees every person the right to access mental healthcare, prohibits inhuman treatment, and mandates government provision of mental health services[79]. Notably, it introduces advance directives and the role of nominated representatives, allowing individuals to participate in decisions about their treatment—concepts absent in the MHA 1987[80].

In contrast, the UK's MHA 1983 continues to regulate compulsory detention under broad criteria, authorising hospitalisation when a person suffers from a "mental disorder" and detention is necessary for their health, safety, or protection of others[81]. Safeguards include review by Mental Health Tribunals and oversight by the Care Quality Commission. However, the Act does not hinge detention on a person's decision-making capacity, which has raised criticism in light of modern autonomy standards[82]. The Mental Capacity Act 2005 (MCA 2005) complements the MHA 1983 by providing a capacity-based framework for individuals unable

[74] Independent Review of the Mental Health Act, supra *n.* 58.
[75] Jonathan Mills & Jaspreet Phull, *The Mental Health Act 1983*, 10 InnovAiT 666, 666–67 (2017).
[76] P. Murthy, *Mental Health Act 1987: Need for a Paradigm Shift from Custodial to Community Care*, 45 Indian J. Med. Rsch. 16, 17 (2011).
[77] Michael Gunn, *Reform of the Mental Health Act 1983: The Relevance of Capacity to Make Decisions*, 3 Int'l J. Mental Health & Capacity L. 56, 57 (2000).
[78] Soumitra Pathare & Laura Shields, *Mental Health Legislation in India: Analysis of the Mental Healthcare Act 2017*, 55 Indian J. Psychiatry 1, 2 (2017).
[79] *Id* at 3.
[80] *Id* at 4.
[81] Julie Carr, *Reform of the Mental Health Act 1983: Implications of Safety, Capacity and Compulsion*, 64 Br. J. Occupational Therapy 567, 569 (2001).
[82] Gunn, supra *n.* 71 at 62.

to make decisions, but the coexistence of the two statutes creates doctrinal complexity[83].

While both India and the UK recognize the need for patient rights, their approaches diverge in implementation. India's MHCA 2017 expressly codifies rights to community living, confidentiality, and protection from discrimination[84]. It also places statutory duties on governments to ensure access to mental health services, thereby expanding state responsibility[85]. In the UK, reform efforts, including the Independent Review of the Mental Health Act (2018), have proposed greater alignment with autonomy and capacity principles, but legislative change has been gradual[86]. Another point of divergence lies in oversight mechanisms. India establishes Mental Health Review Boards to review advance directives and treatment disputes, empowering patients and representatives in decision-making[87]. The UK, though providing tribunals, has been critiqued for limited accessibility and resource constraints[88]. In conclusion, Indian law has moved swiftly toward a rights-based model with the MHCA 2017, whereas the UK still relies heavily on the MHA 1983's paternalistic framework, albeit tempered by the MCA 2005 and ongoing reform proposals. Both systems illustrate the tension between autonomy and public protection, yet India's legislation reflects stronger incorporation of international human rights norms, while the UK remains in a transitional phase[89].

Conclusion and Suggestions

The evolution of mental health law in both India and the United Kingdom reflects the ongoing global struggle to balance individual autonomy with the state's responsibility to ensure care and maintain public safety. While the United Kingdom's Mental Health Act of 1983 remains rooted in a paternalistic model of compulsion, India's Mental Healthcare Act of 2017 represents a bold departure from custodial traditions by enshrining mental health as a justiciable right. Both jurisdictions, however, face practical and structural challenges in translating legal guarantees into meaningful protections for individuals living with mental illness. A central conclusion from this comparative study is that India's legislative framework has taken a more

[83] *Id* at 64.
[84] Pathare & Shields, supra *n.* at 5.
[85] *Id* at 6.
[86] Independent Review of the Mental Health Act, Modernising the Mental Health Act: Increasing Choice, Reducing Compulsion (2018).
[87] Pathare & Shields, supra *n.* 5, at 7.
[88] Patrick Keown et al., *Changes in the Use of the Mental Health Act 1983 in England 1984/85 to 2015/16*, 213 B.J. Psychiatry 595, 599 (2018).
[89] *Id* at 600.

progressive turn by explicitly aligning itself with international human rights instruments, particularly the Convention on the Rights of Persons with Disabilities. The statutory right to access mental health services, the provision for advance directives, and the creation of Mental Health Review Boards place India among the few jurisdictions that prioritize patient autonomy and state accountability. Nevertheless, the Act's effectiveness depends heavily on the availability of resources, infrastructure, and trained professionals, which remain uneven across states. Without significant investment, the rights guaranteed under the legislation risk becoming aspirational rather than enforceable.

The United Kingdom, by contrast, continues to operate under a framework that allows broad powers of detention and treatment without consent, justified primarily on grounds of safety. Although the Mental Capacity Act 2005 and subsequent human rights jurisprudence have introduced elements of proportionality and best interests, the dual system of the MHA and MCA creates complexity and uncertainty. Rising rates of detention, coupled with well-documented disparities affecting ethnic minorities, demonstrate that legislative reform is urgently needed. While the Independent Review of the Mental Health Act has charted a clear reform agenda, political will and resource allocation remain crucial to its realization.

Drawing from this comparative analysis, several suggestions emerge. First, both jurisdictions must strengthen community-based mental health services as an alternative to institutional care. Compulsory hospitalization should be a measure of last resort, not a default response to mental illness. Second, robust mechanisms for patient participation in decision-making, such as advance directives and nominated representatives, should be supported with awareness campaigns and legal literacy initiatives so that individuals are empowered to exercise these rights. Third, independent oversight mechanisms, whether tribunals in the UK or Review Boards in India, should be strengthened with adequate funding, trained personnel, and simplified access procedures to ensure that they function as genuine checks on state power. Finally, both India and the UK must commit to reducing stigma and discrimination in mental health. Legislation can set normative standards, but societal attitudes often determine whether rights are respected in practice. Comprehensive mental health education, anti-stigma campaigns, and integration of mental health into primary healthcare can complement the legal frameworks. A balanced approach that protects autonomy, ensures safety, and delivers care within a rights-based framework should be the guiding principle for the future of mental health law in both jurisdictions.