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India's Mental Healthcare Act, 2017: Content, context, controversy

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ABSTRACT

India's new mental health legislation, the Mental Healthcare Act, 2017, was commenced on 29 May 2018 and seeks explicitly to comply with the United Nations Convention on the Rights of Persons with Disabilities. It grants a legally binding right to mental healthcare to over 1.3 billion people, one sixth of the planet's population. Key measures include (a) new definitions of 'mental illness' and 'mental health establishment'; (b) revised consideration of 'capacity' in relation to mental healthcare (c) 'advance directives' to permit persons with mental illness to direct future care; (d) 'nominated representatives', who need not be family members; (e) the right to mental healthcare and broad social rights for the mentally ill; (f) establishment of governmental authorities to oversee services; (g) Mental Health Review Boards to review admissions and other matters; (h) revised procedures for 'independent admission' (voluntary admission), 'supported admission' (admission and treatment without patient consent), and 'admission of minor'; (i) revised rules governing treatment, restraint and research; and (j) de facto decriminalization of suicide. Key challenges relate to resourcing both mental health services and the new structures proposed in the legislation, the appropriateness of apparently increasingly legalized approaches to care (especially the implications of potentially lengthy judicial proceedings), and possible paradoxical effects resulting in barriers to care (e.g. revised licensing requirements for general hospital psychiatry units). There is ongoing controversy about specific measures (e.g. the ban on electro-convulsive therapy without muscle relaxants and anaesthesia), reflecting a need for continued engagement with stakeholders including patients, families, the Indian Psychiatric Society and non-governmental organisations. Despite these challenges, the new legislation offers substantial potential benefits not only to India but, by example, to other countries that seek to align their laws with the United Nations' Convention on the Rights of Persons with Disabilities and improve the position of the mentally ill.

1. Introduction

India is the second largest country in the world in terms of population and the seventh largest in terms of area. As a result, there are clear challenges delivering healthcare to India's 1.3 billion people spread across such a vast expanse (Lancet, 2017). India is ranked 154th among 195 countries for access to and quality of healthcare (GBD 2015 Healthcare Access and Quality Collaborators, 2017) and its health system continues to underperform compared to other countries, many of which are less developed (GBD 2016 SDG Collaborators, 2017). In addition, there are substantial variations between states within India (India State-Level Disease Burden Initiative Collaborators, 2017).

There are particular challenges in mental healthcare. In 2013, India had 100 million people with mental illness but just 43 psychiatric hospitals and approximately 4000 psychiatrists (Jiloha, 2015). While there have been significant advances in mental healthcare over past decades (Wig, 2015), human and financial resources remain inadequate, with less than 1% of India's health budget devoted to mental health (Patel et al., 2016) compared to 13% of the National Health Service budget in England (Campbell, 2016). The challenges in India are diverse and complex, ranging from inadequate resourcing (Patel et al., 2016), stigma and discrimination (Singh, 2017) to perceived coercion (Raveesh et al., 2016) and variable adherence to legal formalities governing care (Subramanian, Ramanathan, Kumar, Chellappan, & Ramasamy, 2016).

1.1. Mental health legislation in India

In 2017 the World Health Organisation (WHO) emphasised the 'vital role of law' in realising the 'right to health' (WHO, 2017). Reform of law can generate significant positive change (Gostin, DeBartolo, & Katz, 2017). Up until 2018, mental healthcare in India was governed by the Mental Health Act, 1987 which was implemented in 1993 and introduced de-stigmatising terminology and revised supervision and

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admission procedures, as well as articulating certain protections of rights. It outlined a procedure for 'admission under special circumstances' whereby 'any mentally ill person who does not, or is unable to, express his willingness for admission as a voluntary patient, may be admitted and kept as an inpatient in a psychiatric hospital or psychiatric nursing home on an application made in that behalf by a relative or a friend of the mentally ill person if the medical officer in charge is satisfied that in the interests of the mentally ill person it is necessary so to do' (Section 19(1)).

Although a significant advance at the time, the 1987 Act attracted criticism in relation to a range of areas including perceived failures to reduce stigma, address the issue of wandering mentally ill people, and reduce socially sanctioned detention customs (Jiloha, 2015). Other deficiencies related to perceived lack of sufficient opportunity for patients to challenge doctors' decisions (Sachan, 2013), legal procedures for admission and licensing of mental healthcare establishments, and inadequate support for care delivery and protection of rights (Firdosi & Ahmad, 2016). The latter came into sharp focus when the United Nations (UN), of which India is a member, adopted the Convention on Rights of Persons with Disabilities (CRPD) on 13 December 2006 and it came into force on 3 May 2008 (United Nations, 2006).

The purpose of the CRPD 'is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity' (Article 1). The Convention outlines a range of rights including 'that the existence of a disability shall in no case justify a deprivation of liberty' (Article 14). India signed the CRPD and ratified it on 1 October 2007 and, as a stated result of this, developed new mental health legislation, the Mental Healthcare Act, 2017, which received the assent of the president on 7 April 2017 and was commenced on 29 May 2018. The new legislation explicitly aims to comply with the CRPD and is thus a pioneering and exceptionally interesting development.

1.2. The Mental Healthcare Act, 2017

The evolution of India's Mental Healthcare Act, 2017 was accompanied by considerable discussion about the emerging legislation (Suresh, 2014). There was praise for the focus on human rights but concerns about the feasibility, cost and possible implications of post-admission reviews (Kala & Kala, 2015; Rao et al., 2016; Sachan, 2013); changes to the role of families (Kala & Kala, 2015; Rao et al., 2016); changes concerning electro-convulsive therapy (ECT) (Narayan & Shekhar, 2015; Rao et al., 2016); revised licensing requirements, especially for general hospital psychiatric units (Gupta & Basu, 2016; Narayan & Shekhar, 2015); and potential creation of administrative and legal barriers to care (Antony, 2016).

Internationally, it was the human rights protections that attracted most attention (Kelly, 2016a; Sachan, 2013). The Act's preamble is clear that these are the legislation's central focus, stating that it aims 'to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto'. The legislation seeks explicitly to comply with the CRPD, noting that 'it is necessary to align and harmonise the existing laws with' the convention.

The CRPD established the Committee on the Rights of Persons with Disabilities to monitor implementation of the Convention (Article 34). General Comment No. 1 addresses Article 12, concerning 'Equal recognition before the law' (Committee on the Rights of Persons with Disabilities, 2014). The most contentious section concerns how this right pertains to Articles 15 ('Freedom from torture or cruel, inhuman or degrading treatment or punishment'), 16 ('Freedom from exploitation, violence and abuse') and 17 ('Protecting the integrity of the person'). The Committee states that countries 'must abolish policies and legislative provisions that allow or perpetrate forced treatment' (Paragraph 42). This has caused significant controversy in relation to mental health law (Freeman et al., 2015; Scholten & Gather, 2018) and its implications must be considered when evaluating the India's concordance with the CRPD.

2. Material and methods

This paper presents a systematic description of the content of India's Mental Healthcare Act, 2017 based on a close reading of the legislation; discussion and analysis of key issues raised for India; and a distillation of central themes and innovations of relevance to other jurisdictions that seek to revise mental health legislation so as to increase compliance with the CRPD. To optimize coherence and integration within the paper, both the description of the legislation and analysis are presented together in the Results section under selected thematic headings, while key points are summarised and briefly discussed further in the Discussion and Conclusion.

3. Results

3.1. Definitions

India's Mental Healthcare Act, 2017 defines 'mental illness' as 'a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence' (Section 2(1)(s)).

This definition differs from that in England and Wales's Mental Health Act 1983 (as amended by the Mental Health Act 2007), which states that 'mental disorder' is 'any disorder or disability of the mind' although 'a person with learning disability shall not be considered by reason of that disability to be suffering from mental disorder [for specific purposes under the Act] unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part' (Section 1).

While the Indian definition of mental illness would appear to include personality disorder no explicit mention is made of it in the Act. The Inclusion of 'conditions associated with the abuse of alcohol and drugs' is very broad and could be applied to people engaging in harmful use (not just dependence). Unlike India, the definition in England and Wales excludes 'dependence on alcohol or drugs' but, like India, includes personality disorder. This contrasts with other countries such as Ireland which exclude both substance misuse problems and personality disorder for purposes of involuntary care. (Mental Health Act 2001, Section 8(2)). This may reflect the fact that the Indian Act has adopted a broader goal, of mental healthcare provision, rather than primarily providing a legal framework for involuntary treatment.

Unusually, the Indian legislation adds further provisions relating to the process of diagnosis, stating that 'mental illness shall be determined in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease of the World Health Organisation) as may be notified by the Central Government' (Section 3(1)). In addition:

- 'No person or authority shall classify a person as a person with mental illness, except for purposes directly relating to the treatment of the mental illness or in other matters as covered' in relevant legislation (Section 3(2));
- The 'mental illness of a person shall not be determined on the basis of (a) political, economic or social status or membership of a cultural, racial or religious group, or for any other reason not directly relevant to mental health status of the person; (b) non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person's community' (Section 3(3));

- 'Past treatment or hospitalisation in a mental health establishment though relevant, shall not by itself justify any present or future determination of the person's mental illness' (Section 3(4)); and
- 'The determination of a person's mental illness shall alone not imply or be taken to mean that the person is of unsound mind unless he has been declared as such by a competent court' (Section 3(5)).

These provisions appear focused on ensuring high quality diagnostic processes and go into considerably more detail than legislation elsewhere in pursuing this goal. Diagnosis is also incorporated into the new Indian definition of 'mental healthcare', which 'includes analysis and diagnosis of a person's mental condition and treatment as well as care and rehabilitation of such person' (Section 2(1)(o)). This reflects the reality that diagnosis is sometimes a protracted process and treatment can commence before the diagnostic process is complete; e.g. urgent treatment of acute psychosis before it is attributed to any specific mental illness.

A 'mental health establishment' is 'any health establishment, including Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy establishment, by whatever name called, either wholly or partly, meant for the care of persons with mental illness' where 'persons with mental illness are admitted and reside at, or kept in, for care, treatment, convalescence and rehabilitation', including 'any general hospital or general nursing home' but not family homes (Section 2(1)(p)). This broad definition reflects the diversity of approaches to mental health problems in India (Thirthalli et al., 2016). The definition of 'mental health professional' is similarly broad (Section 2(1)(r)).

3.2. Capacity

The Indian Mental Healthcare Act refers to the 'capacity to make mental healthcare and treatment decisions' (Section 4) rather than the broader concept of 'mental capacity'. The validity and appropriateness of this latter term has been questioned (Committee on the Rights of Persons with Disabilities, 2014).

The Act affirms that 'every person, including a person with mental illness shall be deemed to have capacity to make decisions regarding his mental healthcare or treatment if such person has ability to (a) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or (b) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or (c) communicate the decision under sub-clause (a) by means of speech, expression, gesture or any other means' (Section 4(1)). The word 'or', which appears after the first two components of this definition of mental capacity, is a typographical error and should read 'and'; this error is currently being corrected under the Act's 'power to remove difficulties' (Section 125(1)).

The Indian approach to defining capacity differs significantly from that in England and Wales where the Mental Capacity Act 2005 defines *lack of* capacity, stating that 'a person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain' (Section 2(1)). 'A person is unable to make a decision for himself if he is unable (a) to understand the information relevant to the decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate his decision (whether by talking, using sign language or any other means)' (Section 3(1)).

The Indian requirement to 'appreciate any reasonably foreseeable consequence' rather than being able to retain, use and weigh up information (as in England and Wales) arguably reflects a more consequentialist approach to defining capacity in India. This might also relate to the Indian legislators' decision to define 'capacity' rather than *lack of* capacity, a decision which might account for the failure to replace 'or' with 'and' in the definition. Other aspects of the Indian capacity definition, such as the requirement for information to be accessible (Section 4(2)) and tolerance of apparently 'inappropriate or wrong' decisions (Section 4(3)), are generally consistent with legislation elsewhere.

While the Indian Act defines 'capacity to make mental healthcare and treatment decisions' (Section 4), it makes only one direct reference to an individual ceasing to have such capacity; this is to describe the point at which an advance directive comes into force (Section 5(3)). This appears to contravene the General Comment No.1 on the CRPD (Committee on the Rights of Persons with Disabilities, 2014) which states that 'the point at which an advance directive enters into force (and ceases to have effect) should be decided by the person and included in the text of the directive; it should not be based on an assessment that the person lacks mental capacity' (Paragraph 17).

Indirect references to loss of capacity are made in the Indian Act in relation to supported treatments (Sections 86(3) and 89(1)(c)) and proxy consent (Sections 89(7) and 90(12)). However, it is unclear in the Act where the demarcation lies between a severe reduction in capacity being supported by a nominated representative on the one hand and a loss of capacity on the other. Failure to provide clear definitions in this area could lead to coercive treatments with limited review and appeal processes (Duffy & Kelly, 2017a).

The Committee on the Rights of Persons with Disabilities (2014) identifies the importance of separating the concepts of legal and mental capacity and is clear that 'Article 12 does not permit … denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity' (Paragraph 15). The Indian Mental Healthcare Act makes no mention of legal capacity, which is addressed in India's Rights of Persons with Disabilities Act, 2016 (Section 13). Further guidance on capacity to be produced by an Expert Committee might address some of these issues (Section 81(1)).

3.3. Advance directives and nominated representatives

Under the 2017 Act, every adult 'shall have a right to make an advance directive in writing', specifying 'the way the person wishes to be cared for and treated for a mental illness'; 'the way the person wishes not to be cared for and treated'; and 'the individual or individuals, in order of precedence' they want to appoint as their 'nominated representative' (Section 5(1)). Critically, this can be done 'irrespective of [the person's] past mental illness or treatment for the same' (Section 5(2)); this measure will hopefully help enhance respect for the autonomy of the mentally ill.

An advance directive is only invoked for the period during which a personal lacks capacity (Section 5(3)); 'may be revoked, amended or cancelled by the person who made it at any time' (Section 8(1)); is '*ab initio* void' if 'contrary to any law' (Section 5(5)); shall be kept in 'an online register' (Section 7); and does not apply to 'emergency treatment' (Section 9). Advance directives must be respected (Section 10) and those who do not wish to follow a patient's advance directive must apply to a Mental Health Review Board for a review (Sections 11(1) and (2)).

'The person writing the advance directive and his nominated representative' must ensure treating practitioners have 'access to the advance directive' (Section 11(3)) and 'a medical practitioner or a mental health professional shall not be held liable' for (a) 'any unforeseen consequences on following a valid advance directive' (Section 13(1)) or (b) 'not following a valid advance directive, if he has not been given a copy' (Section 13(2)). These are sensible caveats that increase the operability of advance directives in practice and pre-emptively address the likely concerns of mental health professionals.

Overall, the provisions relating to 'advance directives' are among the most potentially useful but also controversial in the legislation. There was concern during their development that India was not ready for advance directives and that the evidence base supporting their use is weak (Rao et al., 2016). Notwithstanding these points, the Indian court

system has already taken notice of this Section of the 2017 Act: in 2018, the Supreme Court of India delivered a judgment concerning advance directives and noted that 'Section 5 of the Mental Healthcare Act, 2017 recognises the validity of advance directives for the treatment of mental illness under the Mental Healthcare Act, 2017' (Paragraph 132).[1]

Advance directives will, also bring Indian legislation more in line with emerging developments elsewhere, such as in Ireland where the Assisted Decision-Making (Capacity) Act 2015 is introducing new, legally binding advance healthcare directives (Part 8) that are not unlike those in India. The role of advance directives in India, however, needs to be considered alongside the new and controversial roles for the patient's 'nominated representative' under the 2017 Act.

Every adult 'shall have a right to appoint a nominated representative' (Section 14(1)) who must be a competent, consenting adult (Section 14(3)), nominated in writing (Section 14(2)). 'Where no nominated representative is appointed', the following persons, 'in the order of precedence, shall be deemed to be the nominated representative of a person with mental illness, namely (a) the individual appointed as the nominated representative in the advance directive'; (b) 'a relative'; (c) 'a care-giver'; (d) 'a suitable person appointed as such by the concerned [Mental Health Review] Board; or (e) if no such person is available to be appointed as a nominated representative, the Board shall appoint the Director, Department of Social Welfare, or his designated representative' (Section 14(4)).

A person who has appointed a nominated representative 'may revoke or alter such appointment at any time' (Section 14(6)) and a Board may replace the representative 'if it is of the opinion that it is in the interest of the person with mental illness to do so' (Section 14(7)). 'While fulfilling [their] duties under this Act, the nominated representative shall (a) consider the current and past wishes, the life history, values, cultural background and the best interests of the person'; (b) 'give particular credence to the views of the person with mental illness to the extent that the person understands the nature of the decisions under consideration'; and (c) 'provide support to the person with mental illness in making treatment decisions', among other roles (Section 17).

The concept of the 'nominated representative' is an important one because the 'nominated representative' is likely to play many of the roles currently assumed by families (Singh, 2017). It is probable that many 'nominated representatives' will be family members but this is not necessarily the case (Duffy & Kelly, 2017a), leading to suggestions that the Act does not reflect the role of family in India and even undermines the fabric of Indian society as a result (Rao et al., 2016). Nonetheless, these measures give the individual receiving treatment a mechanism for preventing inappropriate coercion by their family.

3.4. Rights of persons with mental illness

In the international context, the Indian legislation's rights provisions are possibly its most significant measures, especially in light of the CRPD (Sachan, 2013). The Act states that 'every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government' (Section 18(1)); i.e. 'services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers' (Section 18(2)).

The government 'shall make sufficient provision as may be necessary' (Section 18(3)), including 'acute mental healthcare services' (outpatient and inpatient); 'half-way homes, sheltered accommodation, supported accommodation'; 'services to support family of person with mental illness or home based rehabilitation'; 'hospital and community based rehabilitation establishments and services'; 'child mental health services and old age mental health services' (Section 18(4)).

The government shall 'integrate mental health services into general healthcare services'; 'provide treatment in a manner, which supports persons with mental illness to live in the community and with their families'; ensure that 'long term care' is 'used only in exceptional circumstances, for as short a duration as possible, and only as a last resort when appropriate community based treatment' has failed; ensure services are available locally insofar as possible; and pay for access elsewhere if needed (only for children and the elderly) (Section 18(5)).

'Persons with mental illness living below the poverty line [or] who are destitute or homeless shall be entitled to mental health treatment and services free of any charge' (Section 18(7)). All 'medicines on the Essential Drug List shall be made available free of cost to all persons with mental illness at all times at health establishments run or funded' by the government, as shall 'essential medicines from any similar list relating to the appropriate ayurvada, yoga, unani, siddha, homoeopathy or naturopathy systems' (Section 18(10)).

These rights provisions are greatly welcome and highly ambitious. They are clearly consistent with the CRPD and mark out the Indian legislation as both a pioneering reform in mental health law and an experiment to be watched with great care by other countries, especially those that have ratified the CRPD.

The concepts of rights to health and healthcare have histories that are long and complex (Rumbold et al., 2017; Tobin, 2012; Wolff, 2012), not least because while human rights protect important, fundamental needs, rights are not the same as needs (Osiatyński, 2009). Indeed, the vast majority of human needs are not claimed as rights but fulfilled through a range of other mechanisms such as political (rather than judicial) allocation of public resources, various commercial exchange mechanisms, family-sharing, community projects, charity, etc.

There is, however, a clear role for law when these mechanisms fail, such as when many people fail to receive the mental healthcare that they need. But even in this situation, it is not entirely clear if legally binding rights are the most effective, efficient and fair way of resolving matters, especially since the benefit of certain rights (e.g. a right to mental healthcare) depends on the degree to which other rights are fulfilled (e.g. the right to access an efficient court system). In addition, an increasingly legalized approach to these matters has been criticized as representing a fundamentally western approach that is potentially inappropriate to mental healthcare in India (Rao et al., 2016).

Notwithstanding these concerns, the new Indian legislation articulates not only rights to mental healthcare but also broader social rights for the mentally ill: 'every person with mental illness shall (a) have a right to live in, be part of and not be segregated from society; and (b) not continue to remain in a mental health establishment merely because he does not have a family or is not accepted by his family or is homeless or due to absence of community based facilities' (Section 19(1)). 'Where it is not possible for a mentally ill person to live with his family or relatives, or where a mentally ill person has been abandoned by his family or relatives, the appropriate Government shall provide support as appropriate including legal aid and to facilitate exercising his right to family home and living in the family home' (Section 19(2)) and access to 'half-way homes, group homes and the like' (Section 19(3)).

'Every person with mental illness shall have a right to live with dignity' (Section 20(1)); 'be protected from cruel, inhuman or degrading treatment in any mental health establishment' and shall have rights to (a) 'live in safe and hygienic environment'; (b) 'adequate sanitary conditions'; (c) 'reasonable facilities for leisure, recreation, education and religious practices'; (d) 'privacy'; (e) 'proper clothing'; (f) 'not be forced to undertake work in a mental health establishment and to receive appropriate remuneration for work'; (g) 'adequate provision for preparing for living in the community'; (h) 'adequate provision for wholesome food, sanitation, space and access to articles of personal

[1] *Common Cause (A Regd. Society) v. Union of India and Another* (2018) Supreme Court of India, Writ Petition (Civil) No. 215 of 2005.

hygiene, in particular, women's personal hygiene'; (i) 'not be subject to compulsory tonsuring (shaving of head hair)'; (j) 'wear own personal clothes' and 'not be forced to wear uniforms'; and (k) 'be protected from all forms of physical, verbal, emotional and sexual abuse' (Section 20(2)).

There are also specific rights according mental healthcare parity with physical healthcare (Section 21(1)); ensuring the welfare of children when their mother is mentally ill (Section 21(2)); promoting medical insurance for mental illness (Section 21(4)); ensuring access to information and reviews (Section 22(1)); confidentiality (Sections 23 and 24); access to medical records (Section 25); various matters relating to inpatient care (Section 26); to free 'legal aid' (Section 27); and to 'make complaints about deficiencies' in services (Section 28). These are very extensive rights provisions which would present substantial challenges to any country and will undoubtedly present challenges in India.

3.5. Roles of government, mental health authorities, and registration procedures

The 2017 Act accords extensive duties to government 'to plan, design and implement programmes for the promotion of mental health and prevention of mental illness' (Section 29(1)) and 'public health programmes to reduce suicides and attempted suicides' (Section 29(2)). The government has responsibilities in relation to human resources, education, training (Section 31) and co-ordination of services (Section 32), and 'shall make efforts to meet internationally accepted guidelines for number of mental health professionals on the basis of population, within ten years from the commencement of this Act' (Section 31(3)). This is a much-needed measure given current under-resourcing of mental health services in India (Jiloha, 2015; Patel et al., 2016; Singh, 2017).

The Central Government shall establish a 'Central Mental Health Authority' (Section 33) with membership to include various public officials and health professionals as well as 'two persons representing persons who have or have had mental illness', 'two persons representing care-givers of persons with mental illness', and 'two persons representing non-governmental organisations which provide services to persons with mental illness' (Section 34(1)). The Authority's functions relate to registration, standard-setting, supervision, training and advising government, among other roles (Section 43(1)).

In addition, each State Government shall establish a 'State Mental Health Authority' (Section 45) with membership including various public officials and health professionals (including 'one eminent psychiatrist') as well as 'two persons representing persons who have or have had mental illness', 'two persons representing care-givers of persons with mental illness' and 'two persons representing non-governmental organisations which provide services to persons with mental illness' (Section 46(1)). The functions of the State Mental Health Authority are similar to those of the Central Mental Health Authority, but at State level (Section 55(1)).

The Act requires that all mental health establishments are registered (Section 65). There is a detailed 'procedure for registration, inspection and inquiry' (Section 66) and the relevant 'Authority shall cause to be conducted an audit of all registered mental health establishments by such person or persons (including representatives of the local community) as may be prescribed, every three years' (Section 67(1)). The Authority can act upon complaints received (Sections 68 and 69). The key challenges with these authorities will undoubtedly lie in securing appropriate financial and human resources for them to operate effectively.

3.6. Mental health review boards

The system of post-admission reviews outlined in the 2017 Act is one of its key features (Duffy & Kelly, 2017a; Sachan, 2013). The Act states that 'the State Authority shall, by notification, constitute Boards to be called the Mental Health Review Boards' (Section 73(1)) with each Board comprising (a) 'a District Judge, or an officer of the State judicial services who is qualified to be appointed as District Judge or a retired District Judge' (who shall chair the Board); (b) a 'representative of the District Collector or District Magistrate or Deputy Commissioner'; (c) 'two members of whom one shall be a psychiatrist and the other shall be a medical practitioner'; and (d) 'two members who shall be persons with mental illness or care-givers or persons representing organisations of persons with mental illness or care-givers or non-governmental organisations working in the field' (Section 74(1)). A quorum is three members (Section 76(2)) and decisions will be made by consensus, majority vote, or 'casting vote' (Section 76(1)).

'Any person with mental illness or his nominated representative or a representative of a registered non-governmental organisation, with the consent of such a person, being aggrieved by the decision of any of the mental health establishment or whose rights under this Act have been violated, may make an application to the Board seeking redressal or appropriate relief' (Section 77(1)).

'The Board, on receipt of an application' relating to 'admission of person with mental illness as independent patient in mental health establishment' (Section 85(1)), shall 'endeavour to hear and dispose of the same within a period of 90 days' (Section 80(1)). Applications 'for appointment of nominated representative' (Section 14(4)(d)), 'challenging admission of a minor' (Section 87), and 'challenging supported admission' (Sections 89(10) and (11)) shall be dealt with within seven days (Section 80(2)). 'The Board shall dispose of an application challenging supported admission under Section 90 ['supported admission beyond 30 days'] within a period of 21 days' (Section 80(3)) and all other applications within 90 days (Section 80(4)).

'The proceeding of the Board shall be held *in camera*' (Section 80(5)) and, 'in respect of any application concerning a person with mental illness, [at] the mental health establishment' (Section 80(8)). 'The powers and functions of the Board shall, include all or any of the following':

(a) 'To register, review, alter, modify or cancel an advance directive';
(b) 'To appoint a nominated representative';
(c) 'To receive and decide application from a person with mental illness or his nominated representative or any other interested person against the decision of medical officer or mental health professional in charge of mental health establishment' under Sections 87 ('admission of minor'), 89 ('supported admission') or 90 ('supported admission beyond 30 days');
(d) 'To receive and decide applications in respect non-disclosure of information';
(e) 'To adjudicate complaints regarding deficiencies in care and services'; and
(f) 'To visit and inspect prison or jails and seek clarifications from the medical officer in-charge of health services in such prison or jail' (Section 82(1)).

This model of post-admission review, although clearly very important, fulfils some but not all of the human rights standards outlined by the WHO (2005) for independent reviews; e.g. it does not include long-term 'voluntary' patients (Duffy & Kelly, 2017a). It has been criticized as creating barriers to care delivery and potential delays owing to resource challenges (Rao et al., 2016), as well as placing mental healthcare decisions in the hands of non-experts (Narayan & Shekhar, 2015). Rao et al. (2016) suggest consumer-friendly independent hospital review boards as a more workable, less legalistic alternative, or the creation of a board of visitors at each hospital.

3.7. Admission, treatment and discharge

The 2017 Act outlines four admission statuses: 'independent admission' (voluntary admission), 'admission of minor', 'supported

admission' (admission and treatment without patient consent) and 'supported admission beyond 30 days'.

3.7.1. 'Independent admission' (voluntary admission)

'Independent admission' refers 'to the admission of [a] person with mental illness, to a mental health establishment, who has the capacity to make mental healthcare and treatment decisions or requires minimal support in making decisions' (Section 85(1)). 'All admissions in the mental health establishment shall, as far as possible, be independent admissions except when such conditions exist as make supported admission unavoidable' (Section 85(2)).

'Independent admission' occurs at the person's request (Section 86(1)) once 'the medical officer or mental health professional in charge of the establishment […] is satisfied that (a) the person has a mental illness of a severity requiring admission'; (b) 'is likely to benefit from admission and treatment'; and (c) 'has understood the nature and purpose of admission'; 'has made the request for admission of his own free will, without any duress or undue influence'; and possesses mental capacity (Section 86(2)).

An 'independent patient' 'shall be bound to abide by order and instructions or bye-laws of the mental health establishment' (Section 86(4)) but 'shall not be given treatment without his informed consent' (Section 86(5)). Discharge must occur 'immediately on request made by such person or if the person disagrees with his admission' (Section 88(1)) unless 'the mental health professional is of the opinion that':

(a) 'Such person is unable to understand the nature and purpose of his decisions and requires substantial or very high support from his nominated representative'; or
(b) 'Has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself'; or
(c) 'Has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him'; or
(d) 'Has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself' (Section 88(3)).

Under these circumstances, 'a mental health professional may prevent discharge of [an independent patient] for a period of 24 hours so as to allow his assessment necessary' for 'supported admission' (Section 88(3)). The person shall then 'be either admitted as a supported patient' or discharged within 24 h (Section 88(4)). These measures are similar to those pertaining in many other jurisdictions for voluntary admission and treatment.

3.7.2. 'Admission of a minor'

For the admission of a minor (not yet 18 years of age) (Section 2(1)(t)), 'the nominated representative of the minor shall apply to the medical officer in charge of a mental health establishment for admission' (Section 87(2)). Admission may occur 'if two psychiatrists, or one psychiatrist and one mental health professional or one psychiatrist and one medical practitioner, have independently examined the minor on the day of admission or in the preceding seven days' and both conclude that the minor requires admission, admission is in the minor's best interest ('taking into account the wishes of the minor if ascertainable'), and there is no alternative, community treatment to meet the minor's needs (Section 87(3)).

'A minor so admitted shall be accommodated separately from adults, in an environment that takes into account his age and developmental needs' (Section 87(4)). 'The nominated representative or an attendant appointed by the nominated representative shall under all circumstances stay with the minor in the mental health establishment for the entire duration of the admission' (Section 87(5)). 'A minor shall be given treatment with the informed consent of his nominated representative' (Section 87(7)) and 'if the nominated representative no longer supports admission' or requests discharge, 'the minor shall be discharged' (Section 87(8)). Admissions of minors are to be notified to the Mental Health Review Board within 72 h (Section 87(9)) and, if continued beyond 30 days, reviewed by the Board (Section 87(12)). The key issues here are likely limitations on the availability of suitable admission units, mental healthcare staff, and resources for post-admission reviews.

3.7.3. 'Supported admission' (admission and treatment without patient consent)

A person 'shall' be admitted as a 'supported admission' 'upon application by the nominated representative of the person' if:

(a) 'The person has been independently examined on the day of admission or in the preceding seven days, by one psychiatrist and the other being a mental health professional or a medical practitioner, and both independently conclude based on the examination and, if appropriate, on information provided by others, that the person has a mental illness of such severity that the person (i) has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself; or (ii) has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or (iii) has recently shown or is showing an inability to care for himself to a degree that places the individual at risk of harm to himself';
(b) 'The psychiatrist or the mental health professionals or the medical practitioner, as the case may be, certify, after taking into account an advance directive, if any, that admission to the mental health establishment is the least restrictive care option possible in the circumstances'; and
(c) 'The person is ineligible to receive care and treatment as an independent patient because the person is unable to make mental healthcare and treatment decisions independently and needs very high support from his nominated representative in making decisions' (Section 89(1)).

The initial 'supported admission' must end when the person no longer meets these criteria (Sections 89(3) and 89(13)) or after 30 days (Section 89(2)). At this point, the person is discharged; the person can remain as an 'independent patient' (Section 89(5)); or the 'supported admission' can continue (Section 89(4)) under certain circumstances (Section 90).

The 'supported' patient 'shall be provided treatment after taking into account (a) an advance directive if any; or (b) informed consent of the patient with the support of his nominated representative' (Section 89(6)). If the person 'requires nearly 100% support from his nominated representative in making a decision in respect of his treatment, the nominated representative may temporarily consent to the treatment plan of such person on his behalf' (Section 89(7)). The medical officer must 'review the capacity of the patient to give consent every seven days' (Section 89(8)).

'Supported admissions' must be notified to the Mental Health Review Board within three days (for 'a woman or a minor') or seven days (others) (Section 89(9)). 'A person admitted under this section or his nominated representative or a representative of a registered non-governmental organisation with the consent of the person, may apply to the concerned Board for review of the decision' to admit the person (Section 89(10)). The Board will perform binding review within seven days (Section 89(11)).

This 'supported admission' status corresponds to 'involuntary admission' in other jurisdictions given that admission and treatment can occur without the consent of the patient. This status differs from involuntary admission in many other jurisdictions by apparently requiring the consent of the nominated representative in the absence of patient consent, rather than leaving final treatment decisions in the hands of medical professionals when patients lack mental capacity. It is

noteworthy that the 'supported admission' criteria in the Indian legislation do not include likelihood of deterioration without admission or a requirement for therapeutic benefit with admission, as suggested by the WHO (Duffy & Kelly, 2017a).

3.7.4. 'Supported admission beyond 30 days'

If a 'supported' patient 'requires continuous admission and treatment beyond 30 days' (or readmission within seven days of discharge) (Section 90(1)), 'the medical officer or mental health professional in charge of a mental health establishment, upon application by the nominated representative of a person with mental illness, shall continue admission of such person' if relevant criteria are still 'consistently' fulfilled, following independent examinations by two psychiatrists (Section 90(2)). The medical officer must 'review on the expiry of every fortnight, the capacity of such person to give consent' (Section 90(13)).

Such admissions must be reported to the Mental Health Review Board within seven days (Section 90(3)) and 'the Board shall, within a period of 21 days from the date of last admission or readmission […] permit such admission or readmission or order discharge of such person' (Section 90(4)), bearing in mind '(a) the need for institutional care to such person' and '(b) whether such care cannot be provided in less restrictive settings based in the community' (Section 90(5)).

'The Board may require the medical officer or psychiatrist in charge of treatment of such person with mental illness to submit a plan for community based treatment and the progress made, or likely to be made, towards realising this plan' (Section 90(6)). The 'non-existence of community based services' locally cannot justify such an admission (Section 90(7)), which is, in the first instance, limited to 90 days (Section 90(8)) but can be extended for 120 days and periods of 180 days thereafter, if criteria are met (Section 90(9)). These provisions for extending a 'supported admission' place welcome emphasis on active consideration of community-based alternatives.

The patient 'or his nominated representative or a representative of a registered non-governmental organisation with the consent of the person, may apply to the concerned Board for review of the decision of the medical officer or mental health professional in charge of medical health establishment to admit such person in such establishment and the decision of the Board thereon shall be binding on all parties' (Section 90(14)).

This 'supported admission' approach appears to be more concordant with General Comment No. 1 (Committee on the Rights of Persons with Disabilities, 2014) which states that the 'human rights-based model of disability implies a shift from the substitute decision-making paradigm to one that is based on supported decision making' (Paragraph 3). However, the Indian Act deviates from the CRPD in permitting proxy consent in circumstances where the individual receiving treatment 'requires nearly hundred per cent support from his nominated representative in making a decision in respect of his treatment' (Sections 89(7) and 90(12)). This proxy consent is, however, a temporary arrangement subject to review, weekly in the case of individuals in the first 30 days of a supported admission (Section 89(8)) and fortnightly thereafter (Section 90(13)).

3.7.5. Treatment

'Emergency treatment' 'may be provided by any registered medical practitioner to a person with mental illness either at a health establishment or in the community, subject to the informed consent of the nominated representative, where the nominated representative is available, and where it is immediately necessary to prevent (a) death or irreversible harm to the health of the person; or (b) the person inflicting serious harm to himself or to others; or (c) the person causing serious damage to property belonging to himself or to others where such behaviour is believed to flow directly from the person's mental illness' (Section 94(1)). This 'includes transportation of the person with mental illness to a nearest mental health establishment for assessment' (Section 94(1)) but not ECT (Section 94(3)). There is a 72-hour time-limit, increasing to seven days 'during a disaster or emergency' (Section 94(4)).

'The following treatments shall not be performed': '(a) ECT without the use of muscle relaxants and anaesthesia; (b) ECT for minors; (c) sterilisation of men or women, when such sterilisation is intended as a treatment for mental illness; (d) chained in any manner or form whatsoever' (Section 95(1)). However, 'if, in the opinion of psychiatrist in charge of a minor's treatment, ECT is required, then, such treatment shall be done with the informed consent of the guardian and prior permission of the concerned Board' (Section 95(2)).

The ban on unmodified ECT (i.e. without muscle relaxants and anaesthesia) has been criticized on the grounds that many Indian psychiatric hospitals do not have access to anaesthetists and that it is inappropriate to ban any treatment in mental health legislation (Narayan & Shekhar, 2015). Retention of unmodified ECT is supported by the Indian Psychiatric Society, the Indian Association of Biological Psychiatry, and the Indian Association of Private Psychiatry, who support the position that, under exceptional circumstances, if there is a strong indication for ECT and seizure modification with succinylcholine is not feasible, unmodified ECT, especially benzodiazepine-modified ECT, may be a viable option (Andrade et al., 2012). The ban, however, is supported by a broad range of user groups, care-giver groups and non-governmental advocacy organisations and by international authorities such as the WHO.

Under the new legislation, psychosurgery shall require informed consent from the patient and approval from the Mental Health Review Board (Section 96(1)). A patient 'shall not be subjected to seclusion or solitary confinement, and, where necessary, physical restraint may only be used when (a) it is the only means available to prevent imminent and immediate harm to person concerned or to others; (b) it is authorised by the psychiatrist' (Section 97(1)). 'Physical restraint shall not be used for a period longer than it is absolutely necessary to prevent the immediate risk of significant harm' (Section 97(2)); must be recorded and justified (Section 97(3)); 'shall not be used as a form of punishment or deterrent' or 'on the ground of shortage of staff' (Section 97(4)); and must be notified to the Board (Sections 97(7) and 97(9)) and the patient's nominated representative (Section 97(5)).

Researchers 'shall obtain free and informed consent from all persons with mental illness for participation in any research involving interviewing the person or psychological, physical, chemical or medicinal interventions' (Section 99(1)). If the person 'is unable to give free and informed consent but does not resist participation', permission 'shall be obtained from concerned State Authority' (Section 99(2)). The State Authority may allow research 'based on informed consent being obtained from the nominated representative' only if specific conditions are met (Section 99(3)). Consent to research may be withdrawn at any time (Section 99(5)) and the Act does 'not restrict research based study of the case notes of a person who is unable to give informed consent, so long as the anonymity of the persons is secured' (Section 99(4)). Rao et al. (2016) suggest that too many regulations governing research might undermine further work.

3.8. Other provisions

The 2017 Act outlines provisions relating to police officers (Section 100), magistrates (Sections 101–102), prisoners (Section 103) and custodial institutions (Section 104).

One of the final key features of the legislation is the de facto decriminalization of suicide. The Indian Penal Code states that 'whoever attempts to commit suicide and does any act towards the commission of such offence, shall be punished with simple imprisonment for a term which may extend to one year or with fine, or with both' (Section 309). The 2017 Act states that 'notwithstanding anything contained in Section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code'

(Section 115(1)). 'The appropriate Government shall have a duty to provide care, treatment and rehabilitation to a person, having severe stress and who attempted to commit suicide, to reduce the risk of recurrence of attempt to commit suicide' (Section 115(2)).

Finally, the Act defines 'offences and penalties' for specific infringements (Chapter XV) and the Mental Health Act, 1987 is repealed, subject to transitional arrangements (Section 126).

4. Discussion

The outstanding feature of India's Mental Healthcare Act, 2017 is that it seeks explicitly to comply with the CRPD and grants a legally binding right to mental healthcare to over 1.3 billion people. The legislation accords with many but not all of the specific human rights standards previously outlined by the WHO (2005); key areas of low concordance include the rights of families and carers, competence and guardianship, non-protesting patients and involuntary community treatment, which are not addressed adequately in the legislation (Duffy & Kelly, 2017a).

The Indian Act is one of the first in the world to make a concerted and explicit effort to adhere to the CRPD and it generally succeeds in this endeavour. However, General Comment No.1 (Committee on the Rights of Persons with Disabilities, 2014) appears to set a higher standard than the CRPD itself and in this respect the Indian Mental Healthcare Act might fall short. Clearly, legislators need to negotiate carefully the areas of capacity and demarcation between supported and proxy decisions if they are to accord with the General Comment. Careful consideration of unintended consequences will be paramount as there is a high risk that an overly rigid interpretation of the General Comment No.1 would undermine important human rights (Duffy & Kelly, 2017c; Freeman et al., 2015; Scholten & Gather, 2018).

On the other hand, the 2017 Act has the important strength of articulating not only extensive rights to mental healthcare but also social rights for the mentally ill as well as rights in many other areas that are often neglected, such as confidentiality (Duffy & Kelly, 2017b; Kelly, 2017). While there has been much discussion in the literature about the application of rights-based approaches in psychiatry (Javed & Amering, 2016), with particular concern about possible excessive legalism (Rao et al., 2016), the Act's clear articulation of rights can be a very positive step once it is implemented in a progressive, realistic and sustainable fashion, taking account of local resources, traditions and structures. The focus on rights is further emphasised by the Rights of Persons with Disabilities Act, 2016, another piece of legislation written to bring Indian legislation in line with the CRPD. This Act legislates for multiple social and economic rights for individuals with disabilities, including those with mental illness.

Other key measures in the 2017 legislation include:

- New definitions of 'mental illness' (which includes both personality disorder and addiction problems but places particular emphasis on the diagnostic process), 'mental health establishment' (to include a broad range of facilities, reflecting the diversity of approaches to mental illness in India) (Thirthalli et al., 2016), and 'capacity';
- 'Advance directives' to permit persons with mental illness to direct future care as is increasingly the case in other jurisdictions, although concerns have been expressed that India might not yet be ready for this measure and that the evidence-base for advance directives is weak (Rao et al., 2016);
- Creating 'nominated representatives', who need not be family members but most likely will be; it is unusual in the international context that the 'nominated representative' will have the power to consent to treatment if the patient lacks capacity, although this might help address concerns that the legislation disempowers families (Narayan & Shekhar, 2015; Rao et al., 2016);
- Post-admission reviews by Mental Health Review Boards, although the effectiveness of these are reliant on adequate financial and human resources so that they function in an effective, timely manner; there is concern that these may place healthcare decisions in the hands of non-experts (Narayan & Shekhar, 2015) and that independent hospital review boards would be more workable (Rao et al., 2016);
- Revised procedures for 'independent admission' (voluntary admission), 'supported admission' (admission and treatment without patient consent), and 'admission of a minor'; these procedures meet some but not all of the relevant WHO standards; e.g. criteria for 'supported admission' do not include likelihood of deterioration without admission or requirement for therapeutic benefit with admission (Duffy & Kelly, 2017a);
- Revised rules governing treatment, restraint and research; in particular, it is to be hoped that the research provisions facilitate research rather than delay or complicate it (Rao et al., 2016);
- De facto decriminalization of suicide, which brings India into line with international trends.

The greatest challenge presented by the new Indian legislation relates to resourcing of both mental health services and the new structures proposed in the Act. With India's mental health system generally under-resourced (Patel et al., 2016; Singh, 2017), doubts have been raised about the appropriateness of an increasingly legalized approach to care (especially the implications of potentially lengthy judicial proceedings) (Rao et al., 2016) and possible paradoxical effects resulting in barriers to care (e.g. revised licensing requirements for general hospital psychiatry units, which had previously been exempt from the same licensing standards) (Narayan & Shekhar, 2015).

There is particular ongoing controversy about specific measures including the legislation's ban on unmodified ECT (Section 3.7.5). As noted, this ban has been criticized on the basis that anaesthetists are not always available and that legislation should not be used to ban specific treatments (Narayan & Shekhar, 2013). The retention of unmodified ECT is supported by the Indian Psychiatric Society, the Indian Association of Biological Psychiatry, and the Indian Association of Private Psychiatry, who have agreed on recommendations governing its use; i.e. that, under exceptional circumstances, if there is a strong indication for ECT and seizure modification with succinylcholine is not feasible, unmodified ECT, especially benzodiazepine-modified ECT, may be a viable option (Andrade et al., 2012).

It must be borne in mind, however, that our analysis of the 2017 Act reflects predominantly the voice and views of the psychiatric profession, through our use of academic papers and similar sources. It is necessary to acknowledge that various non-professional stakeholders (e.g. mental health services users, advocacy non-governmental organisations, care-givers, etc.) often hold quite different views. For example, as already mentioned, the ban on unmodified ECT is supported by a range of user groups, care-giver groups and non-governmental advocacy organisations and the WHO. Some groups want all ECT banned and criticize the 2017 Act for legalizing modified ECT.

This is an important issue because almost half of administrations of ECT in India are unmodified (Firdosi & Ahmad, 2016). The need to resolve differences of opinion on this matter (e.g. through time-lined implementation and upgrading of services, with defined resource targets) reflects the need for continued and meaningful engagement by multiple stakeholders including patient groups, families and carers, Central and State governments, the Indian Psychiatric Society, other professional groups, and non-governmental organisations as implementation progresses.

In particular, it remains to be seen how the nominated representative's role will facilitate the treatment of individuals who need very high levels of support in making decisions. It is conceivable under that new Act potential coercion by mental health professionals will be reduced but potential coercion by nominated representatives could replace it. This might result in individuals with limited experience and potentially competing interests exercising high levels of influence over

vulnerable individuals, in the place of trained professionals regulated by accrediting bodies and held to professional standards (Duffy & Kelly, 2017a).

5. Conclusions

Despite various conceptual and (especially) practical challenges, India's new mental health legislation offers substantial potential benefits not only to India but also, by example, to other countries that seek to align their laws with the CRPD and improve the position of the mentally ill in their societies.

During implementation, the opportunities offered by rights-based approaches (Funk & Drew, 2017) need to be set against some of the limitations of rights-based mental health laws, including problems deciding which rights matter most in situations when rights conflict, as well as broader issues relating to the fundamental notion of rights-based legalism in mental health in the first place (Kelly, 2015, 2016b; McSherry & Weller, 2010). It would be deeply regrettable, for example, if the new Indian legislation, despite its focus on rights, and especially the right to mental healthcare, was to present obstacles to accessing appropriate services (Antony, 2016; Duffy, Narayan, Goyal, & Kelly, 2018), delays in care delivery, or barriers to research aimed at improving future services (Rao et al., 2016).

Much depends on the content and operation of the final draft of rules made under the legislation, the willingness of government to enhance resources to meet the standards outlined, and the extent to which the effects of the legislation, both positive and negative, are studied over the coming years. This issue of empirical evidence is an important one and outcome evaluations will hopefully emphasise a realization-focused understanding of justice, based on the real-life outcomes of measures intended to protect rights, rather than just an arrangement-focused view of justice, based on verifying that current legislation and other arrangements appear *likely* to promote human rights (Sen, 2009). Sometimes, the effects of legislation can be paradoxical and even negative, despite everyone's best intentions.

Most of all, it is important that India's experiment in granting a legally binding right to mental healthcare is progressed in a timely, collaborative and sustainable fashion so as to ensure it truly delivers benefit to those who need it; i.e. the mentally ill and their families and carers. It would be a matter of great regret if the 2017 Act ended up stranded in an indeterminate no-man's land between excellent intentions on the one hand and terminal difficulty with implementation on the other (Sharma, 2017). That could be an outcome worse than doing nothing at all.

The mentally ill deserve the highest levels of mental health and social care that are possible. The Mental Healthcare Act 2017 presents a unique opportunity to pursue both better care and greater social justice for the mentally ill in India, once implementation is informed by realism, rooted in genuine collaboration, and subject to ongoing evaluation and research over the coming years.

Declaration of interest

None.

Animal and human rights

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