



# The Mental Healthcare Act 2017 of India: A challenge and an opportunity

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## ABSTRACT

The Mental Healthcare Act 2017 replaced the Mental Health Act 1987, subsequent to India's ratification of the United Nations Convention on the Rights of Persons with Disabilities in 2007. The Mental Healthcare Act (MHCA) 2017 upholds patient autonomy, dignity, rights and choices during mental healthcare and thus marks a bold step in India's mental health legislation. This new Law marks a major shift in the way mental healthcare is delivered, as it aims to protect and promote the rights of people during the delivery of mental healthcare. Within this Act, a capacitous individual cannot be coerced into receiving treatment for mental illness and inpatient admissions can be 'independent' or 'supported'. 'Supported admission' replaces involuntary admission from the previous legislation. State mental health authorities and mental health review boards will play a major role in the implementation of the new Act. The Mental Healthcare Act 2017 is aimed at bringing about radical transformation to mental healthcare in India.

## 1. Introduction

The Mental Healthcare Act 2017 is a bold step in a new direction for mental health legislation in India. India is the second most populous country in the world and is home to a sixth of the world's population. (The World Health Organisation, 2019). India became an independent country in 1947 and a Republic in 1950. India is a union of 29 States and seven Union Territories. Individual States are ruled by democratically - elected State governments. Although most healthcare is funded by the individual State governments, rather than the Central government of India, mental health legislation enacted by the Parliament of India is applicable to all States and Union Territories in India. A recent National Mental Health Survey (NMHS) estimated the one-time prevalence of any mental illness in India to be 10.6% (2016) (National Mental Health Survey of India et al., 2016; Gururaj et al., 2016). NMHS estimated the treatment gap for mental health disorders in India to be 83%. This is in keeping with the estimated treatment gap by the WHO consortium (2004). (Demyttenaere et al., 2004)

## 2. Mental health legislation in India

British India (prior to 1947) had several legislations governing mental health care (Lunacy Acts, Indian Lunacy Act, etc.). The Republic of India enacted The Mental Health Act 1987 (The Ministry of Health

and Family Welfare, Government of India, 1987), to replace its colonial predecessor, The Indian Lunacy Act, 1912. The Mental Health Act, 1987, did not contribute much towards protection of the rights of the mentally ill. The Mental Health Act, 1987 was repealed in 2018 and the new Act is The Mental Healthcare Act, 2017 (The Ministry of Law and Justice, 2017). The Mental Health Act 1987 provided legal provision for healthcare of persons with mental illness requiring inpatient treatment. The lack of provision for an independent judicial / quasi-judicial review of the decision for compulsory admission was a major drawback of The Mental Health Act 1987. There was no provision to ensure that compulsory treatment was least restrictive of the patient's rights. The previous Act was applicable only to specialist mental hospitals and thus excluded a large proportion of people receiving mental health care in general hospital settings from the purview of the Act.

India ratified the United Nations Convention on the Rights of Persons with Disabilities in 2007 (CRPD, 2006). This necessitated a review of the existing Mental Health Act to ensure compliance with the Convention. In compliance with the Convention, the new Act is firmly rooted in the rights of people with mental illnesses. It makes a presumption of equality in front of the law for people with mental illnesses, unless an individual has impaired decision-making capacity for mental healthcare decisions. The new Act focusses just on mental healthcare, rather than care of persons with mental illness (for example, welfare and management of property of a mentally ill person are not covered

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under this Act). The preamble of the new Act reads as below:

“The Mental Healthcare Act is to provide for mental healthcare for persons with mental illness and to protect, promote and fulfil the rights of people with mental illness during delivery of mental healthcare and services and for matters connected therewith or incidental thereto”. (The Ministry of Health and Family Welfare, Government of India, 1987)

### 3. Core principles of India’s new mental healthcare act

Mental Healthcare Act 2017, upholds patient autonomy, dignity, rights and choices during mental healthcare. For the first time in the country’s history, access to mental healthcare is described as a right of every citizen. In contrast, physical healthcare is still not stated as a right for every Indian citizen. This is commendable for a country like India with large unmet psychiatric need (Demmytenaere et al., 2004). Capacity to make decisions regarding mental healthcare for oneself has a pivotal position in this Act. The capacity for decisions on mental healthcare is articulated in the Act as ability to understand relevant information, (or) appreciation of consequences of decisions (or) ability to communicate the decisions (Section 4 of this Act). Mental healthcare for a capacitous individual can only be provided subject to informed consent. A capacitous individual is the sole decision maker for her/ his mental healthcare, irrespective of the mental illness or risks involved. Unlike in many other jurisdictions, a capacitous individual cannot now be forced inpatient treatment for mental health in India, even when the risks related to mental health are high. Even at times of incapacity, patient choice is to be listened to.

To ensure that patient choice is respected even in individuals with impaired capacity, this Law uses three tools: advance directives, nomination of representatives and supported decision-making.

#### 3.1. Advance directives (Sections 5-13 of the Act)

Any capacitous individual, irrespective of the presence of mental illness, can execute an advance directive to help design the care they will receive during an incapacitating mental illness. Valid advance directives are legally binding, unless revoked by the Mental Health Review Board or a court of law. A medical practitioner or a mental health professional shall not be held liable for any unforeseen consequences of following a valid advance directive. Advance directives are expected to be registered with the Mental Health Review Board (Section 82(1)(a) of the Act). Advance directives have no place in the care of a capacitous individual or at times of emergency treatment.

#### 3.2. Nomination of representatives (Section 14 of the Act)

Each patient can nominate a representative to support decision making at times of impaired capacity for decision-making regarding mental healthcare. Nominations are made by the patient and accepted by the nominee. The nominated representative is legally bound to give due respect to the patient choice, will and preferences, while making decisions for the patient. In the absence of a nominated representative, other relatives, carers and specific appointees (following the specific protocol in the Act) from the State can assume the role of a nominated representative. A nominated representative can make decisions for the patient only at times of incapacity.

**Supported decision-making** replaces substitute decision making in times of incapacity (of the previous legislation). In the previous legislation (The Mental Health Act, 1987), mental healthcare decisions were made for the patient by the treating team in their role as the substitute decision maker for the patient. The new Law instructs nominated representatives to make decisions, only after giving due credence to patient choice, best interests, will and preferences. Supported admission is a concept introduced in the new Act to replace involuntary admission of

the previous Act. Support lies on a continuum ranging from minimal to near complete. People requiring high levels of support for decision making are likely to require supported admission and treatment.

#### 3.3. Remit of the law

The law covers all ‘substantive’ mental illnesses including substance misuse disorders. Intellectual disability is, however, excluded. Mental illness as per Section 2(s) of this Act is *a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs (a) judgment, (b) behavior or (c) capacity to recognize reality or ability to meet the ordinary demands of life*. People with substance misuse disorders are explicitly brought under the purview of the Act.

All institutions where people with mental illness reside for treatment and care (excluding family homes) are considered as mental health establishments requiring registration with the authorities. This includes all rehabilitation homes, prisons, places for religious healings and institutions offering complementary therapies. General hospitals providing mental health care (in isolation or in combination with physical healthcare) also come under the remit of the Act. This is clearly a welcome step forward, as the previous legislation was restrictive in its remit.

Unlike the previous Mental Health Act of India (1987), the current law is restricted to mental health care (rather than care of the mentally ill). There is a separate legislation, enacted in 2016, to cover certain other aspects of life of people with disabling mental illness (Rights of People with Disabilities Act, 2016) (Ministry of Social Justice and Empowerment, 2017). This change is firmly grounded on the principle of equality before law (Article 12) of The United Nation’s Convention on Rights of Persons with Disabilities.

#### 3.4. Rights of persons with mental illness

In addition to the constitutional rights, every citizen of India now also has a right to access State-provided mental health care. Discrimination because of mental illness in any sphere of life is illegal (including for insurance purposes). This Statute also prohibits discrimination to access mental healthcare on grounds of sexual orientation (article 377 of the Indian Penal Code which criminalized consensual homosexuality was struck down by the Supreme Court of India in 2017 (Anon., 2018).

The Law presumes that everyone with mental illness is capacitous for mental healthcare (until proved otherwise) and enshrines the right to protection from cruel, inhuman and degrading medical treatment. The law demands equality of mental healthcare and physical healthcare.

The Law also views access to mental healthcare in the community as a governmental responsibility to people with mental illness. Free legal aid, access to medical information, access to community living, confidentiality of medical information, access to personal contacts and communication are all rights of patients receiving inpatient mental healthcare enshrined under this Statute.

#### 3.5. Admissions to mental health establishments

Admissions to mental health establishments under this Act can be either ‘independent’ or ‘supported’.

**Independent admissions** (Section 85–86) are voluntarily requested by capacitous patients, with freedom (and responsibility) to make decisions and care plans. There is no limit to the time period for independent admissions. Independent admissions do not necessarily require a psychiatrist to be part of the process (even for discharge) and they are not required to be reported to the Mental Health Review Boards under the Law. Discharge requests made by independent patients are to be honoured, unless criteria of capacity and risks allow a retention for 24 h for an assessment for supported admission.

One of the core principles of the Act is parity for mental healthcare and physical healthcare. Independent admissions require to pass a threshold of severity. Besides an informed choice to access inpatient mental healthcare, this Act limits independent admissions only to those who pass a severity criterion. This can become a barrier to those who seek inpatient treatment below the threshold. This is opined as against the principle of parity with physical healthcare (Kumar, 2018).

*Supported admissions (Section 89)* replace involuntary admissions of the previous legislation. The aim is to use support to minimize involuntary admissions. Impaired decision making is essential, though not sufficient, for supported admissions. Supported admissions are to be used only when there is no less restrictive option. The patient is expected to benefit (as judged by the admitting clinician) from the hospitalization. Risks to self, others or of self-neglect should be recent (what can be 'recent' is open to individual interpretation). Support is meant to be from a nominated representative (patient-nominated or appointed by the State). Supported admissions can take place with minimal or no agreement from the patient. The law mandates that even patients with impaired capacity for decision making for mental healthcare need to be supported and involved in decision making, as far as possible. The Law views support as being on a spectrum, ranging from minimal requirement of support to near total support.

Supported admissions (Section 89) require two independent professional examinations and recommendations (a psychiatrist and a medical practitioner/ mental health professional). All supported admissions are to be intimated to the Mental Health Review Boards within a week. The Mental Health Review Boards are quasi-judicial, led by a judge. They have powers to discharge a patient from supported admission.

The State is bound to provide free legal aid to patients appealing against supported admission. Decisions by the Review Boards are to be within seven days of appeal and the maximum duration for an initial supported admission is thirty days.

### 3.6. Extension of supported admission (Section 90)

Supported admission can be extended upon renewal. Extensions can vary from 30 days to a maximum of 180 days. Each renewal must be approved by the Mental Health Review Board. The Law mandates that the treating team must make every effort to move the patient to a setting outside the hospital as soon as possible. An extension of supported admission can be made on the recommendation of two independent psychiatrists. There are also processes for appeal and hearing by the Mental Health Review Boards (described below). Extensions can only be used at times of persistent risks and prior to such an extension, every effort must be made to ensure lesser restrictive options in the community are explored.

## 4. Discharges

All discharges from hospitals need to be coupled with discharge care planning involving patients, clinicians and nominated representatives. Compulsory community-based treatment is not possible under this Act. However, the legislation binds the State to provide easily accessible community mental health care and rehabilitation services. Individual States and Union Territories are expected to create specific rules under the Act regarding service provision. If the minimum services provided by the government for mental healthcare is not available in the district, the Law demands a reimbursement of expenses incurred by the patient to access mental healthcare elsewhere. In India, with its high mental health service availability gap, eligibility for reimbursement may not be sufficient to ensure the gap gets bridged.

## 5. Mental Health Review Boards

These Boards consist of a District Judge Equivalent, independent

psychiatrists, other independent clinicians and lay people. Though there is a provision for an independent psychiatrist to be a member of the Board, the Board can potentially be constituted even without a psychiatrist. In addition to mandatory independent reviews and appeals by patients and nominated representatives, the Boards are also entrusted with responsibilities of review of advance directives, review of nominated representatives, approvals of extensions of supported admission, and ECTs for minors and psychosurgeries. Any appeals against decisions by the Mental Health Review Boards are to be at the High Court of the State. The Central and State Mental Health Authorities oversee the implementation of Mental Healthcare Act.

The Mental Health Review Boards and Mental Health Authorities are still in stages of infancy. Although it has been thirteen months since the Act came into force, these boards are not functional entities yet. The Act is ambitious and is aimed to bring out drastic change in the delivery of mental healthcare.

## 6. Miscellaneous provisions

There is a distinct provision for emergency mental healthcare by any registered medical practitioner for a maximum period of 72 h or until a mental health assessment is completed (whichever is earlier). It is clarified that advance directives do not apply to emergency situations.

Unmodified electro convulsive therapy, chaining and sterilization as treatment for mental illnesses are explicitly prohibited. Certain procedures like psychosurgery, ECT for minors and restraints are not prohibited, but should be subject to prior approval from the Mental Health Review Board.

The duties of Police to assist patients and families to ensure protection, safety and access to mental healthcare for people with mental illness are explicit. Unlike in the earlier Act, the role of the judicial magistrate in decisions of admission and discharge of people with mental illness from inpatient settings is minimized.

Section 115 of this Act makes a presumption of severe stress for suicide attempts and recommends that trial under the Indian Penal Code is to be avoided for suicide attempts due to stress. The duty of the government to provide care, treatment and rehabilitation for persons attempting suicide is marking a change in the perspective towards suicide in India.

Supported admissions require the ongoing involvement of a nominated representative during the inpatient mental healthcare. Applications for supported admission, decisions for mental healthcare for patients with impaired capacity during a supported admission and request for discharge are explicit duties of the nominated representatives, even during a State-provided inpatient mental healthcare. These can be viewed both as empowering and burdensome<sup>09</sup>.

In India, with its huge judicial backlog in court systems (Anon., 2019), the additional responsibility in relation to the Mental Health Review Boards requires explicit commitment of resources from the State. Legislative reform is a necessary first step for changes in this direction. There is a criticism that Indian mental health legislation is far more progressive of the actual state of mental health service at the time of enactment (Kumar, 2018; Duffy et al., 2018).

One of the options to ensure least restrictiveness of treatment is the availability of compulsive (or 'supported' in the spirit of this Act) treatment in the community. This avenue is largely unaddressed in this Act. Compulsive treatment in the community is associated with a marked diminution in the more restrictive hospital stay for persons with mental illness requiring long-term admissions (Taylor et al., 2016). The shift of focus from mental illnesses to mental well-being and from hospital-based mental healthcare to community-based care is an increasingly recognized need of the hour for India's mental healthcare system (Murthy, 2018). This legislation falls short of empowering community based mental healthcare (Table 1).

The new legislation has received mixed response from mental health

**Table 1**  
Comparison of the previous and the current mental health legislations of India.

Mental Health Act 1987 (The Ministry of Health and Family Welfare, Government of India, 1987) (Repealed in 2018)	Mental Healthcare Act 2017 (The Ministry of Law and Justice, 2017), in effect from 2018
Applicable only to specialty mental hospitals (excluded general hospitals providing inpatient mental healthcare run by the State).	Applicable to all settings where people with mental illness reside for care of mental illness (including those providing traditional care).
Admissions – Voluntary, Involuntary and Reception Order from the Magistrate. No provision for independent judicial review / appeal. Compulsory inpatient treatment for mental illness posing risks (irrespective of the capacity of the individual).	Admissions— ‘Independent’ and ‘Supported’. Provision for quasi-judicial review and appeal (Mental Health Review Board). Supported inpatient admission and treatment are only for incapacitous individuals meeting a threshold (including risks).
Substitute decision making for people undergoing involuntary treatment.	Protects and promotes the rights of individuals during mental healthcare. Promotes choices of the individual through supported decision making, advance directives and nomination of representatives.
No special safeguards for minors requiring psychiatric admission. A large role for judicial magistrate in admissions and discharge decisions. Remit of the Law included not just mental healthcare, but care of people with mental illnesses including guardianship.	Separate provision for minor admissions under section 87, with additional safeguards. Minimal, if any, role for judicial magistrate in admission and discharge decisions. The remit of the law is just mental healthcare.

professionals across the country. In summary, the new Act demands a drastic change in the day – to – day practice of the average mental health professional (Duffy and Kelly, 2017).

## 7. The future

Both mental health professionals and the judiciary are in unchartered territory here. Advance directives, supported decision - making and nomination of representatives are all relatively new issues for mental health professionals in India. The duty of care for a mentally ill person lacking capacity, has shifted from the mental healthcare professional to the nominated carers and the State. States, which were not actively involved in bringing about this key legislation change, and their already stretched judiciaries should find additional resources to deliver the comprehensive care being promised in the new Act. India has taken the initial steps of judicial reform to uphold the rights of the persons with mental illness. The legislation is widely regarded as progressive, with a high level of concordance (in comparison with the legislations of other jurisdictions) with the United Nations Convention on Rights of People with Disabilities (Duffy and Kelly, 2017). There are provisions in the Law to ensure that the government is duty-bound to train all its mental health professionals in the use of this Act in their day – to – day clinical practice. The law is ambitious and aspirational in its spirit and offers opportunities for India to revamp the care of its citizens with mental health difficulties, upholding their rights.

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## Conflict of interest

None.

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