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From Statutory Right to Community Care: Reimagining the Role of Social Work in the Implementation of India's Mental Healthcare Act, 2017

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ABSTRACT

This paper argues that the Mental Healthcare Act, 2017 marks one of the most significant rights-based shifts in Indian health law, yet its transformative promise remains only partially realised because the legal architecture of rights has advanced faster than the community systems required to make those rights meaningful. The Act moved Indian mental health law away from the older custodial and institution-centred framework of the Mental Health Act, 1987 and towards a statutory model grounded in dignity, autonomy, community living, legal aid, discharge planning, and state accountability. However, a serious implementation gap persists. Community-based rehabilitation, supported accommodation, functional review mechanisms, district-level coordination, and access-to-justice pathways remain uneven across states. This paper contends that social work, especially psychiatric social work, is the missing implementation link between legal entitlement and lived care. Existing legal and psychiatric scholarship has adequately identified the progressive content of the Act, and public health scholarship has highlighted treatment gaps and service deficits, but there remains insufficient interdisciplinary work on how social work can operationalise statutory rights through case management, supported decision-making, family and community reintegration, entitlement access, legal aid linkage, and multidisciplinary coordination. The paper therefore advances a law-and-social-work framework for the next phase of implementation. It concludes that the future of the Mental Healthcare Act lies not merely in defending its rights language, but in building a community-care state around it through institutionalised social work practice.

Keywords: Mental Healthcare Act, 2017, social work, psychiatric social work, community care, mental health law, access to justice, rehabilitation, India.

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I. INTRODUCTION

The history of mental health law in India reflects a larger struggle between two competing imaginations of care. One imagines the person with mental illness as an object of control, management, and institutional supervision. The other recognises that person as a rights-bearing subject entitled to dignity, liberty, treatment, autonomy, and community life. The Mental Healthcare Act, 2017 (MHCA)¹ belongs decisively to the latter tradition. It replaced the Mental Health Act, 1987 and was enacted to provide mental healthcare and services while protecting, promoting, and fulfilling the rights of persons with mental illness. In doing so, it aligned Indian law more closely with the normative commitments of the UN Convention on the Rights of Persons with Disabilities ('UNCRPD'), especially on dignity, autonomy, legal capacity, and community inclusion.^{2,3}

This statutory shift was not merely symbolic. The MHCA recognises a right to access mental healthcare and treatment; a right to community living; a right to protection from cruel, inhuman, and degrading treatment; a right to legal aid; a right to make advance directives; a right to nominate a representative; and a right to discharge planning and review. It also places affirmative obligations upon governments to create services, train personnel, coordinate departments, reduce stigma, and provide community-based alternatives to institutional confinement. In doctrinal terms, this is a remarkable expansion of statutory mental health rights.⁴

Yet the enactment of a progressive law does not guarantee its social life. That is the central concern of this paper. Nearly a decade after the MHCA was enacted, and several years after its commencement, India continues to exhibit uneven implementation. Public materials show expansion of district mental health services and tele-mental-health infrastructure, but they also reveal continuing deficits in halfway homes, supported accommodation, review boards, workforce, registration systems, community rehabilitation, and rights-monitoring. The Supreme Court has itself noted the tardy implementation of the law and the failure to establish adequate halfway homes and rehabilitative infrastructure.⁵ The National Human Rights Commission

¹ The Mental Healthcare Act, No. 10 of 2017 (India).

² Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, U.N. Doc. A/RES/61/106 (Dec. 13, 2006).

³ R.M. Duffy & B.D. Kelly, *Concordance of the Indian Mental Healthcare Act 2017 with the World Health Organization's Checklist on Mental Health Legislation*, 11 INT'L J. MENTAL HEALTH SYS. 48 (2017); R.M. Duffy & B.D. Kelly, *India's Mental Healthcare Act, 2017: Content, Context, Consequences*, 62 INT'L J.L. & PSYCHIATRY 169 (2019).

⁴ The Mental Healthcare Act, No. 10 of 2017 (India).

⁵ *In re Inhuman Conditions in 1382 Prisons*, (2018) 18 SCC 777 (India).

('NHRC') has similarly expressed concern regarding institutional conditions, registration, community care, legal aid, and professional shortages.⁶

This paper starts from a simple but underexplored proposition: the implementation gap under the MHCA is not merely a problem of psychiatry, public administration, or finance. It is also a problem of professional translation. If the statute promises community living, legal aid, discharge planning, supported decision-making, and social reintegration, who is institutionally expected to transform those promises into practice? This paper argues that the answer lies in social work. More specifically, psychiatric social work should be understood not as an auxiliary therapeutic service but as the operational bridge between legal rights and lived community care.

The paper therefore makes three claims. First, the MHCA has indeed produced a serious normative shift from custody to rights. Secondly, its implementation remains partial because the legal framework has not been matched by adequate community infrastructures and interdisciplinary systems. Thirdly, social work is the missing implementation link in India's mental health law, and unless it is formally recognised and institutionally embedded, the rights framework of the MHCA will remain unevenly realised.

II. RESEARCH PROBLEM, RESEARCH GAP, QUESTIONS AND HYPOTHESIS

The principal research problem addressed in this paper is the gap between statutory recognition and practical realisation under the MHCA. The Act speaks the language of rights, autonomy, and community. Yet much of the Indian mental health system continues to be shaped by institutional dependence, uneven district services, fragmented welfare support, and weak interdisciplinary coordination. The problem is therefore not simply that the law is absent. The deeper problem is that the law's rights architecture is not adequately translated into operational practice.

The literature is rich in at least three areas. First, there is substantial legal and medico-legal scholarship explaining the progressive content of the MHCA and its alignment with international rights standards.⁷ Secondly, there is important work assessing the financial and administrative burden of implementation, including concerns about Mental Health Review Boards ('MHRBs'), workforce deficits, and uneven state preparedness.⁸ Thirdly, there is a

⁶ MINISTRY OF HEALTH & FAMILY WELFARE, National Mental Health Programme (NMHP), National Health Mission; NATIONAL HUMAN RIGHTS COMMISSION, Human Rights Advisory on Mental Health (Oct. 10, 2023).

⁷ S.B. Math et al., *Mental Healthcare Act 2017: Aspiration to Action*, 61 INDIAN J. PSYCHIATRY S660 (2019); R.K. Chadda, *Influence of the New Mental Health Legislation in India*, 17 BJPSYCH INT'L 20 (2020).

⁸ S.B. Math et al., *Cost Estimation for the Implementation of the Mental Healthcare Act 2017*, 61 INDIAN J. PSYCHIATRY S650 (2019); A. Jagadish, F. Ali & M.R. Gowda, *Mental Healthcare Act 2017: The Way Ahead: Opportunities and Challenges*, 41 INDIAN J. PSYCHOL. MED. 113 (2019).

growing body of work on community care, homelessness, and rehabilitation models, especially in relation to non-governmental organisations and community-based interventions.⁹

However, a serious interdisciplinary gap persists. Much of the legal literature stops at doctrinal analysis. Much of the psychiatric literature centres institutional burden, clinical autonomy, or administrative feasibility. Much of the public health literature discusses the treatment gap and system deficits. What remains underdeveloped is a sustained account of how legal rights under the MHCA are supposed to travel through actual social relations and service institutions: families, shelters, hospitals, district programmes, welfare offices, legal services authorities, community clinics, and civil society organisations. In short, there is inadequate scholarship on social work as the profession that mediates between legal entitlement and lived rehabilitation.

This paper asks the following research questions:

- To what extent has the Mental Healthcare Act, 2017 shifted Indian mental healthcare from a custodial model to a rights-based and community-oriented framework?
- What legal, administrative, and service-delivery barriers continue to hinder the implementation of the Act's community-care provisions?
- What role should social work play in translating statutory rights under the Act into actual community care, rehabilitation, and access to justice?

The hypothesis of this paper is that, although the MHCA marks a transformative normative shift in Indian mental health law, its practical success remains limited because India has not adequately institutionalised social work within the statutory architecture of implementation. Where social work roles are properly integrated into community services, discharge planning, family support, homelessness intervention, and legal aid linkage, the rights guaranteed by the Act become significantly more real.

III. METHODOLOGY

This paper adopts an interdisciplinary doctrinal methodology. It combines four streams of material. First, it undertakes doctrinal analysis of the MHCA, allied rules, and related legal materials. Secondly, it reviews official and quasi-official sources, including programme documents, government updates, NHRC materials, and legal services schemes. Thirdly, it synthesises peer-reviewed scholarship on mental health law, community care, and psychiatric social work. Fourthly, it draws on selected public case examples and community models to show how rights are, or are not, translated into everyday care.

⁹ L. Narasimhan et al., *Responsive Mental Health Systems to Address the Poverty, Homelessness and Mental Illness Nexus: The Banyan Experience from India*, 13 INT'L J. MENTAL HEALTH SYS. 54 (2019).

This is not an empirical field study. No interviews, surveys, or original datasets were generated for this paper. The contribution of the paper is analytical and normative. It identifies a structural omission in current mental health law scholarship and proposes a framework through which social work can be repositioned as a central implementation profession under the MHCA.

IV. THE INTERFACE BETWEEN SOCIAL WORK AND LAW

The relation between social work and law has often been described in functional terms: law creates rights, while social work responds to social need. That description is no longer sufficient, especially in mental health. In modern welfare and rights-based systems, law and social work are not parallel domains; they are mutually constitutive. Law names entitlements, defines duties, creates procedures, and allocates responsibility. Social work translates those entitlements into lived relationships, service pathways, and institutional support.

This is particularly visible in mental health. A person with psychosocial disability may require not only diagnosis and treatment, but family mediation, housing support, entitlement access, documentation, community placement, legal aid, rehabilitation planning, and follow-up. These are not secondary matters. They determine whether legal rights remain abstract or become meaningful. A statute may grant a right to community living, but community living is not created by legislative language alone. It must be built through social institutions and professional action.

Psychiatric social work occupies a distinctive place in this context. Unlike a purely clinical profession, it is structurally oriented toward the interface between the person, family, institution, community, and state. It is equipped to work across hospital and home, court and clinic, welfare office and shelter. That interdisciplinary orientation makes it uniquely suited to a rights-based mental health framework. Indeed, recent regulatory developments under the National Commission for Allied and Healthcare Professions show growing recognition of medical and psychiatric social work as central to behavioural health and community care.¹⁰ What remains missing is a corresponding legal and policy recognition within the implementation architecture of the MHCA.

V. THE LEGAL ARCHITECTURE OF THE MENTAL HEALTHCARE ACT, 2017

The MHCA departs fundamentally from the Mental Health Act, 1987. The earlier law was largely institution-oriented and regulatory. The MHCA, by contrast, is explicitly rights-based. Several provisions are especially important.

¹⁰ The Mental Healthcare Act, No. 10 of 2017, s. 18 (India).

Section 18 guarantees every person a right to access mental healthcare and treatment from services run or funded by the appropriate government. Importantly, this is not framed merely as a right to institutional treatment. The section speaks of affordable, good-quality, and geographically accessible services available without discrimination. It also obliges governments to provide a range of services, including outpatient and inpatient care, halfway homes, sheltered and supported accommodation, family support services, home-based rehabilitation, and community-based rehabilitation establishments.¹¹

Section 19 recognises a right to community living. It requires that persons with mental illness should not continue to remain in mental health establishments merely because they are homeless, abandoned, or not accepted by their families. It obliges the state to support persons in living in, being part of, and not being segregated from society. This section is conceptually central. It reframes the locus of care from the institution to the community.¹²

Section 27 grants a right to free legal services for persons with mental illness in order to exercise rights under the Act. This provision is crucial because rights without mechanisms of assertion often become illusory.¹³ The importance of this section has been reinforced by the NALSA Scheme for legal services to persons with mental illness and persons with intellectual disabilities.¹⁴

The provisions dealing with advance directives and nominated representatives are equally important. They attempt to give practical expression to autonomy, supported decision-making, and person-centred care. These provisions bring the Indian statute closer to the rights discourse of the UNCRPD, although their implementation remains difficult in practice.

Section 98 on discharge planning is another under-discussed provision. It requires planning for reintegration and continuity of care rather than simple release from an institution.¹⁵ This is precisely where social work becomes indispensable. Discharge is not a medical event alone; it is a social, legal, and administrative transition.

Section 115 decriminalises the treatment of attempted suicide in substance, by creating a presumption of severe stress and directing the state to provide care, treatment, and rehabilitation rather than punishment.¹⁶ This too reflects the broader rights-oriented ethos of the Act.

¹¹ The Mental Healthcare Act, No. 10 of 2017, s. 19 (India).

¹² The Mental Healthcare Act, No. 10 of 2017, s. 27 (India).

¹³ NATIONAL LEGAL SERVICES AUTHORITY, NALSA (Legal Services to Persons with Mental Illness and Persons with Intellectual Disabilities) Scheme, 2024 (India).

¹⁴ The Mental Healthcare Act, No. 10 of 2017, s. 98 (India).

¹⁵ The Mental Healthcare Act, No. 10 of 2017, s. 115 (India).

¹⁶ The National Commission for Allied and Healthcare Professions Act, No. 24 of 2021 (India).

Taken together, these provisions show that the MHCA is not only a treatment law. It is a statute about community, dignity, welfare, review, and accountability. The legal question is therefore no longer whether India has adopted a progressive mental health law. It has. The harder question is whether India has built the social infrastructure necessary for that law to function.

VI. REVIEW OF LITERATURE

A substantial body of scholarship has recognised the progressive character of the MHCA. Duffy and Kelly showed that the Act significantly improved India's alignment with the World Health Organization's checklist on mental health legislation, and later emphasised the importance of its rights-based framework and its relationship with the UNCRPD. Math described the MHCA as an aspirational law and highlighted its shift toward autonomy, rights, and access. Chadda likewise recognised its significance in moving towards community care and rights protection.¹⁷

A second body of literature focuses on the costs and administrative burdens of implementation. Math and others estimated that effective implementation of the Act would require very substantial public expenditure, especially given the scale of service deficits and institutional responsibilities. Jagadish and colleagues also highlighted challenges in relation to implementation preparedness and board structures. These studies are valuable because they show that progressive law without adequate financing risks becoming symbolic.¹⁸

A third stream of literature examines practical concerns raised by the psychiatric profession. Recent scholarship records dissatisfaction among psychiatrists regarding procedural burdens, review systems, and certain statutory requirements.¹⁹ These concerns cannot be dismissed, but neither should they dominate the analysis. A rights-based mental health statute will necessarily shift some power away from purely clinical authority and toward accountability, participation, and review. The proper response is not to dilute rights, but to build better interdisciplinary systems that reduce implementation strain.

A fourth and especially relevant body of literature concerns community care, homelessness, and rehabilitation. Hans and Sharan have argued for stronger community-based mental health services in India and emphasised the need to move beyond institution-centred care.²⁰ Narasimhan and others, drawing from the work of The Banyan, demonstrated that responsive

¹⁷ Duffy & Kelly, *supra* note 3; Math et al., *supra* note 7.

¹⁸ Jagadish, Ali & Gowda, *supra* note 8.

¹⁹ S. Malhotra et al., *Amend the Mental Health Care Act 2017: A Survey of Indian Psychiatrists (Paper 1)*, 66 INDIAN J. PSYCHIATRY 829 (2024); N.A. Uvais & K. Joag, *Perceptions Regarding the Indian Mental Healthcare Act 2017 Among Psychiatrists: Review and Critical Appraisal in the Light of CRPD Guidelines*, 11 CAMBRIDGE PRISMS: GLOBAL MENTAL HEALTH e39 (2024).

²⁰ G. Hans & P. Sharan, *Community-Based Mental Health Services in India: Current Status and Roadmap for the Future*, 2 CONSORTIUM PSYCHIATRICUM 63 (2021).

community systems can address the nexus between poverty, homelessness, and severe mental illness.²¹ Gowda and colleagues found that reintegration of homeless persons with mental illness after treatment is often possible, especially where clinical improvement is combined with social rehabilitation.²² Work emerging from organisations such as Iswar Sankalpa also shows the importance of community clinics, assisted living, and welfare-linked support for homeless persons with psychosocial disabilities.²³

The NHRC's 2023 Advisory is especially important in consolidating many of these concerns.²⁴ It called for registration of establishments, the constitution and functioning of review boards, greater availability of community facilities, legal aid access, and strengthened human resources, including psychiatric social workers. That advisory is notable because it reveals that the implementation challenge is not merely theoretical. It is already institutionally recognised.

The existing literature therefore establishes three propositions. First, the MHCA is normatively progressive. Secondly, implementation is uneven and resource-intensive. Thirdly, community models can work when care is combined with housing, welfare support, and follow-up. What it does not sufficiently do is centre social work as the institutional bridge across these propositions. That is the original contribution of this paper.

VII. WHY IMPLEMENTATION REMAINS PARTIAL

The first reason for partial implementation is structural unevenness across states. Publicly available state materials suggest differing levels of progress in relation to State Mental Health Authorities, MHRBs, mobile units, district programmes, and community services. This patchwork is not surprising in a federal system, but it becomes problematic where rights depend on geography.

Secondly, the workforce remains inadequate. Community care cannot be built only through psychiatrists, especially in a country with vast treatment gaps and uneven professional distribution. The shortage of trained psychiatric social workers, clinical psychologists, and allied personnel continues to weaken implementation.

Thirdly, there remains a strong institutional bias in practice. Even where the law recognises community living, actual service delivery often continues to privilege hospital-based or crisis-

²¹ Narasimhan et al., *supra* note 9.

²² G.S. Gowda et al., *Clinical Outcome and Rehabilitation of Homeless Mentally Ill Patients Admitted in Mental Health Institute of South India: 'Know the Unknown' Project*, 30 ASIAN J. PSYCHIATRY 49 (2017).

²³ ISWAR SANKALPA, *The Nowhere People: Naya Daur, A Community-Based Care and Support Programme for the Homeless Mentally Ill* (2011).

²⁴ NATIONAL HUMAN RIGHTS COMMISSION, *supra* note 6.

based responses. Halfway homes, supported accommodation, and community rehabilitation services remain far less developed than the statute envisioned.

Fourthly, the rights machinery itself is under-utilised. Advance directives, nominated representation, legal aid, and review mechanisms require awareness, institutional support, and procedural assistance. These are not self-executing rights. Without persons who can explain, facilitate, document, and follow up on them, such rights remain formal.

Fifthly, intersectoral coordination remains weak. Mental health is not only a health-sector issue. It implicates housing, social justice, disability policy, policing, legal services, local government, and labour. Section 32 of the MHCA itself anticipates this by requiring government coordination. Yet in practice, such coordination is often episodic rather than systemic.

Finally, there remains insufficient transparency in implementation. India still lacks a robust and easily accessible public monitoring architecture showing state-wise data on authorities, review boards, registration, rights complaints, supported accommodation, discharge outcomes, and legal aid referrals. A rights-based statute without rights-based monitoring is vulnerable to symbolic compliance.

VIII. SOCIAL WORK AS THE MISSING IMPLEMENTATION LINK

The core claim of this paper is that social work is the missing implementation link in India's mental health law. This claim may be defended at both doctrinal and functional levels.

At the doctrinal level, the MHCA repeatedly gestures toward work that is properly the domain of social work. Community living, family support, home-based rehabilitation, legal aid facilitation, nominated representation, discharge planning, and reintegration into society are all functions that require sustained relational and institutional engagement. The law therefore presupposes, even if it does not fully name, a profession capable of carrying out these tasks.

At the functional level, psychiatric social work is uniquely suited to rights implementation for at least six reasons.

First, social workers can operationalise supported decision-making. Advance directives and nominated representatives require explanation, documentation, mediation, and review. These are neither exclusively legal nor exclusively clinical tasks. They demand a professional who can work with the person, the family, clinicians, and institutions.

Secondly, social workers are central to discharge planning. Section 98 cannot be implemented meaningfully unless someone assesses family willingness, housing options, financial capacity,

welfare entitlements, and continuity of community care. Mere discharge without social planning risks re-abandonment or re-institutionalisation.

Thirdly, social workers are essential in homelessness intervention. The problem of homelessness among persons with mental illness is not resolved by admission alone. It requires identity restoration, documentation, family tracing, shelter linkage, rights protection, and long-term follow-up. Community organisations in India have repeatedly demonstrated this.

Fourthly, social workers can connect persons with legal aid. Section 27 guarantees free legal services. But many rights violations first appear as practical problems: overstay in an institution, absence of review, denial of documents, lack of community placement, or family conflict. Social workers are often the first professionals positioned to identify these issues and facilitate referral to legal services authorities.

Fifthly, social workers can bridge health and welfare systems. A person with mental illness may need not only treatment, but disability certification, pensions, ration access, housing support, livelihood linkage, or community-based rehabilitation. This is precisely the area in which the interdisciplinary training of social work becomes indispensable.

Sixthly, social workers can support rights-monitoring and community follow-up. A rights-based law cannot be sustained by episodic adjudication alone. It requires routine observation of whether the person remains in the community, has access to medication, is protected from abuse, and can access grievance mechanisms. That form of monitoring is closer to social work practice than to classical adjudication.

In this sense, social work should be understood not as the soft side of mental healthcare, but as the institutional mechanism that turns formal rights into social realities.

IX. COMMUNITY MODELS AND EMERGING STATE PRACTICE

The strongest evidence for the argument of this paper comes from practice itself. NGO-led and state-linked community models show that social reintegration becomes possible when mental healthcare is not confined to clinical intervention.

The work of The Banyan is perhaps the most important example in India. Its community-based and housing-linked interventions demonstrate that treatment, supported accommodation, rehabilitation, and community inclusion can be integrated in practice.²⁵ This is important because it disproves the assumption that long-term institutionalisation is the inevitable response to severe mental illness and social abandonment.

²⁵ Narasimhan et al., *supra* note 9.

Similarly, the work of Iswar Sankalpa in Kolkata illustrates how assisted community living, clinics, and support for homeless persons with psychosocial disabilities can build alternatives to institutional dependence.²⁶ These models are not simply charitable experiments. They are implementation lessons for the state.

Publicly visible state practices also offer important illustrations. Delhi's mobile mental health units indicate an effort to take services to homeless and homebound persons rather than waiting for them to enter institutions. Maharashtra's publicly described mental health programme architecture suggests attempts to distribute services across districts and facilities. Tamil Nadu's public policy attention to homeless persons with mental illness and reintegration initiatives points towards a more direct engagement with the statutory idea of community living. Kerala's public materials suggest movement in relation to rules and review structures.

These examples should not be romanticised. They remain partial, uneven, and often under-documented. But they confirm an important proposition: where care is linked with community outreach, follow-up, social support, and interdisciplinary coordination, the rights under the MHCA become more operational. This significantly supports the hypothesis of this paper.

X. RECOMMENDATIONS

If the MHCA is to move from statutory promise to social reality, several reforms are necessary.

First, social work must be formally embedded within the implementation architecture of the Act. State rules, programme guidelines, and staffing norms should expressly recognise social workers and psychiatric social workers as core implementation actors in discharge planning, community placement, supported decision-making, legal aid referral, and follow-up.

Secondly, each district mental health programme should include a dedicated rights-and-community-care cell. Such a unit should handle discharge planning, community placement, homelessness intervention, legal aid linkage, welfare entitlements, and family reintegration.

Thirdly, legal aid under section 27 should be institutionalised through regular mental health legal aid clinics in government establishments and district programmes.²⁷ The NALSA Scheme provides an important normative basis for such institutional design.

Fourthly, supported accommodation and halfway homes must be expanded, but in ways that resist reproducing custodial logic under a different name. Community living must remain the guiding principle.

²⁶ ISWAR SANKALPA, *supra* note 23.

²⁷ The Mental Healthcare Act, No. 10 of 2017, s. 27 (India); NALSA Scheme, *supra* note 13.

Fifthly, social work education should include a robust mental health law component. The new curriculum framework for medical and psychiatric social work creates an important opening in this regard.²⁸ Future professionals must be trained not only in counselling and casework, but in rights, capacity, supported decision-making, disability law, legal aid, and community rehabilitation.

Sixthly, public monitoring of implementation should be improved. There should be a national and state-level dashboard on authorities, boards, complaints, review timelines, community placements, and social-care infrastructure.

Seventhly, intersectoral coordination must be made routine. Health, social justice, disability, housing, local government, police, shelters, and legal services institutions must not operate as disconnected silos. Social workers are well placed to function as the point of coordination among these institutions.

Finally, reform should avoid the temptation to treat professional inconvenience as a reason to dilute rights. Some procedural burdens under the MHCA are real. But the answer lies in better systems, not weaker rights.

XI. CONCLUSION

The Mental Healthcare Act, 2017 changed the legal imagination of mental health in India. It moved the field away from custody and toward rights, community, autonomy, dignity, and accountability. That is its greatest achievement. But a progressive legal imagination is not enough. Rights must travel through institutions, professions, families, welfare systems, and communities before they become real.

This paper has argued that the central weakness in the present phase of implementation is not simply the lack of funds, psychiatrists, or rules, although all of those matter. The deeper weakness is the absence of a clearly institutionalised bridge between the statute and the social world in which persons with mental illness actually live. That bridge is social work.

The hypothesis of this paper is therefore substantially confirmed. The MHCA is transformative in normative design, but only partially transformative in practice because the community-care state around it remains underdeveloped. Where community-linked services, outreach, rehabilitation, and social support exist, the law becomes more meaningful. Where they do not, rights remain formal and fragile.

²⁸ The National Commission for Allied and Healthcare Professions Act, *supra* note 16.

The future of India's mental health law depends on whether the state is willing to treat social work as central to rights implementation. If it does, the promise of community living under the MHCA may yet become real. If it does not, the law risks being remembered as progressive in text but incomplete in life.
