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Human Rights and Mental Health Care: Legal Challenges and Reforms in India

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ABSTRACT

Good mental health is an essential element of the right to life and to wellbeing, and it is increasingly recognised as a basic human right both in international human rights law and under the Constitution of India. Although legislation on mental health has improved considerably, millions of persons living with mental illness still struggle to obtain affordable and good quality care. Social stigma and discrimination, inadequate mental health infrastructure, an acute shortage of trained professionals, insufficient funding and the gap between urban and rural services are among the principal obstacles. The difficulty is greater for vulnerable groups such as women, children, persons with mental illness, prisoners, older persons and the economically poor, who may face several forms of exclusion from mental health services. Against that background, this paper critically analyses the relationship between human rights and mental healthcare in India by examining the constitutional, statutory and international frameworks that protect the rights of persons with mental illness. It assesses the role of Articles 14, 19 and 21 of the Constitution in securing equality, dignity, personal liberty and health, and the significance of the Mental Healthcare Act, 2017, which adopts a rights-based approach aligned with the Convention on the Rights of Persons with Disabilities. The study uses the doctrinal method, drawing on constitutional and statutory provisions, judicial decisions, Law Commission reports, government policy, academic literature and international instruments in order to assess the adequacy of the present legal regime. It also considers the leading judicial decisions that have widened the right to health and to human dignity, together with questions of institutionalisation, capacity, informed consent, confidentiality, community rehabilitation and non-discrimination. The paper identifies recurring implementation difficulties, including inadequate funding, weak enforcement of statutory safeguards, low awareness of legally protected rights, thin community mental health provision and persistent stigma. It argues that although a legal framework guaranteeing the right to mental healthcare exists, legislation alone cannot secure that right without institutional mechanisms, healthcare infrastructure, skilled professionals and supporting public health policy.

Keywords: *human rights, mental health care, challenges and reforms*

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I. INTRODUCTION

Mental well-being is among the major aspects of human well-being and is necessary to the realisation of dignity, equality, freedom and social justice. It refers to a state of emotional, psychological and social well-being that enables people to deal with the stresses of everyday life, make sound judgments, form effective relationships and be productive members of society. Over the past few decades there has been an increased realisation that mental well-being is a human rights question and cannot be separated from other basic rights. The right to mental health goes beyond a right to medical care and encompasses the right to live with dignity, freedom from discrimination, the right to informed consent, confidentiality, autonomy, inclusion in the community, and the right to equal access to quality healthcare facilities. The protection and promotion of mental health have therefore become key elements of national constitutions and of international human rights law. Worldwide, mental illnesses are among the main contributors to disease and disability, and conditions such as depression, anxiety disorders, bipolar illness, schizophrenia, addiction and stress-related disorders are found in every region.[1]

Urbanisation, changes in family structure, unemployment, poverty, economic instability, social isolation, armed conflict, natural calamities and public health crises have greatly increased the incidence of mental illness across the world. The mental health consequences of the coronavirus disease crisis produced a further crisis, which exposed the vulnerabilities of the health sector and the need for comprehensive mental health services. The psychological effects of the pandemic, including rising rates of anxiety disorders, depression, domestic abuse, loneliness and exhaustion among medical practitioners, showed that mental health problems are not merely medical problems but multidimensional questions of law, governance, public policy and human rights. Health, as defined by the World Health Organization, includes physical and social well-being and not merely the absence of disease or infirmity. Mental health therefore plays a very important role in total well-being, along with other aspects such as social inclusion. The right to health, physical and mental, has been recognised in several international human rights instruments, including the Universal Declaration of Human Rights, 1948, the International Covenant on Economic, Social and Cultural Rights, 1966 and the Convention on the Rights of Persons with Disabilities, 2006.[2]

[1] WORLD HEALTH ORGANIZATION, *World Mental Health Report: Transforming Mental Health for All* (2022).

[2] Universal Declaration of Human Rights art. 25, G.A. Res. 217A (III), U.N. Doc. A/810 (Dec. 10, 1948); International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3; Convention on the Rights of Persons with Disabilities art. 25, Dec. 13, 2006, 2515 U.N.T.S. 3; Constitution of the World Health Organization pmbl., July 22, 1946, 14 U.N.T.S. 185.

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The constitutional approach adopted in India is strongly oriented towards human dignity and well-being. Although the Constitution does not recognise the right to health as a distinct fundamental right, judicial interpretation of Article 21 has brought both the right to live with dignity and the right to health within its scope. The Supreme Court has made it clear in several decisions that the right to life includes the right of access to healthcare, and that the State therefore carries a positive duty to provide a proper healthcare system. Articles 14 and 15 provide for equality and non-discrimination, and Article 19 guarantees freedoms that may be adversely affected by the institutionalisation of persons with mental disorders.[3]

For a long period, mental healthcare in India rested on principles of custody and institutionalisation, under which persons suffering from mental illness were treated as subjects to be confined rather than as persons with equal rights. Earlier Indian legislation was concerned more with the regulation of psychiatric institutions than with securing the rights of patients. This produced many instances of compulsory confinement, insufficient medical help, forced treatment, social exclusion and denial of legal capacity. The absence of a rights-based law contributed to stigma and discrimination, and to the reluctance of those affected to seek treatment and rehabilitation.

A crucial milestone was the enactment of the Mental Healthcare Act, 2017, which brought about major change in Indian mental health law. The Act treats access to mental healthcare as a legal right and places the rights of persons with mental illness at the centre of mental health governance. It provides for affordable and good quality mental health services, protects patients from cruel, inhuman and degrading treatment, recognises advance directives and nominated representatives, secures confidentiality and informed consent, and establishes Mental Health Review Boards for the protection of patients' rights.[4]

The human rights implications of mental healthcare extend beyond medical treatment to equality, privacy, liberty, autonomy, informed consent, legal capacity, work, education, shelter, social security and access to justice. Persons belonging to vulnerable groups, including women, children, older persons, persons with disabilities, prisoners, the homeless and other marginalised people, may face discrimination when they seek mental health services. The rise of gender-based violence, workplace stress, cyberbullying, substance misuse, displacement and socio-economic disparity has made the problem more complex and the need for legal protection greater than before. The connections between mental health and criminal law, labour law,

[3] INDIA CONST. arts. 14, 15, 19, 21; D.D. BASU, INTRODUCTION TO THE CONSTITUTION OF INDIA 286 (LexisNexis, 24th edn. 2020).
[4] Mental Healthcare Act, No. 10 of 2017, ss. 5, 14, 18, 20, 21, 22, 23, 73 (India).

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education, family law and the rights of persons with disabilities show that mental healthcare cannot be regarded from a purely medical point of view.[5]

The Indian judiciary has been one of the principal contributors to the protection of rights in mental healthcare through constructive constitutional interpretation. Judicial decisions have expanded the scope of the right to life, established the duty of the State to provide healthcare, underlined the principle of humane treatment of persons with mental illness, and required respect for their privacy and dignity. Those decisions have also insisted that a balance be struck between individual freedom and the interests of society, without violating the procedural norms that govern any deprivation of liberty.

This research employs doctrinal legal analysis to assess critically the relationship between human rights and mental healthcare in India. It examines constitutional provisions, statutes, judicial decisions, international human rights instruments, government policy, the recommendations of the Law Commission of India and academic studies in order to determine whether the present legal regime provides adequate safeguards for the human rights of persons with mental illness. It further seeks to identify the significant legal, institutional and policy barriers to the implementation of mental healthcare rights, and the degree to which India has complied with its national and international commitments.

The study argues that realising mental health as a basic human right requires more than legislative enactment. It calls for effective implementation, adequate financing, trained personnel, the availability of mental healthcare in the community, public education and continuing judicial oversight. A rights-based mental healthcare system should guarantee access to quality, affordable and non-discriminatory care for every person regardless of social or economic standing, while preserving autonomy, dignity and liberty. Stronger legal protection and institutional accountability are therefore imperative. This paper seeks to contribute to the continuing debate on the protection of human rights in the context of mental healthcare in India.[6]

II. International Human Rights Framework for the Protection of Mental Health

The international human rights framework recognises mental health as a vital aspect of the rights to life, dignity, equality and the highest attainable standard of health. That framework has

[5] *World Mental Health Report*, *supra* note 1.
[6] Office of the United Nations High Commissioner for Human Rights & World Health Organization, *Mental Health, Human Rights and Legislation: Guidance and Practice* (2023).

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moved in many ways from a medical orientation to a rights-based orientation, under which persons living with mental disabilities are recognised as equal bearers of rights who are entitled to respect, protection and the realisation of their basic freedoms. On that view mental healthcare must extend beyond clinical treatment to dignity, autonomy, non-discrimination, informed consent, liberty and inclusion in the community.

International bodies, in particular the United Nations and the World Health Organization, have contributed a great deal to the development of standards requiring States to provide accessible, affordable, acceptable and quality mental health services, free from abuse, neglect, arbitrary detention and cruel treatment. These standards form the basis of contemporary mental health legislation in many countries and have had a considerable influence on Indian legislation and on Indian constitutional interpretation.[7]

The Universal Declaration of Human Rights, 1948 laid the foundation of the international human rights system by affirming that all human beings are born with inherent dignity and equality of rights. Although the Declaration does not refer to mental health, Articles 1, 2, 3, 5 and 25, read together, form the foundation for the protection of persons with mental illness, since they secure equality, non-discrimination, liberty, security, protection from cruel treatment and access to medical services. The right to health was reinforced by the International Covenant on Economic, Social and Cultural Rights, 1966, which expressly recognises the right to the highest attainable standard of physical and mental health under Article 12. General Comment No. 14 of the Committee on Economic, Social and Cultural Rights emphasised that States must ensure the availability, accessibility, acceptability and quality of health services without discrimination. In the same vein, the International Covenant on Civil and Political Rights, 1966 protects the civil and political rights of persons with mental disorders by safeguarding them against arbitrary arrest, torture, cruel treatment and intrusion into their privacy. Its effect is to strengthen the proposition that mental illness is no ground for the denial of basic human rights.[8]

The adoption of the Convention on the Rights of Persons with Disabilities, 2006 was a groundbreaking development in international mental health law, for it transformed the approach from an institution-based one to a human rights-based one. The Convention treats persons with psychosocial disabilities as equal before the law and secures their rights to legal capacity,

[7] U.N. HUMAN RIGHTS COUNCIL, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, U.N. Doc. A/HRC/35/21 (Mar. 28, 2017) (by Dainius Puras).

[8] International Covenant on Economic, Social and Cultural Rights, *supra* note 2, art. 12; COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000); International Covenant on Civil and Political Rights arts. 7, 9, 17, Dec. 16, 1966, 999 U.N.T.S. 171.

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informed consent, liberty, independent living and access to healthcare. Alongside these treaties, the Constitution of the World Health Organization states that health is a state of complete physical, mental and social well-being, while the WHO Comprehensive Mental Health Action Plan 2013-2030 promotes the integration of mental healthcare into primary healthcare, the reduction of stigma, the development of community-based services and greater respect for human rights in mental healthcare. Together these instruments constitute an effective legal regime that requires States to respect the dignity and the human rights of persons with mental illness, and they influenced the enactment of the Mental Healthcare Act, 2017 in India.[9]

A. Universal Declaration of Human Rights

The Universal Declaration of Human Rights, adopted by the United Nations General Assembly on 10 December 1948, set the basis of the contemporary international human rights system. Although the Declaration does not mention mental health, several of its articles provide the normative underpinning for the protection of persons with mental illness. Article 1 proclaims that all human beings are born free and equal in dignity and rights, so that discrimination on the ground of a physical or mental condition is excluded. Article 2 secures the equal enjoyment of human rights without distinction of any kind, and Articles 3 and 5 secure the right to life, liberty and security of the person and prohibit torture and inhuman or degrading treatment.[10]

Article 25 of the Declaration affirms the entitlement of everyone to an adequate standard of living, including the medical care and social services that he or she requires. Although it was drafted long before mental healthcare emerged as a distinct field of international regulation, this article is now widely understood to guarantee mental as well as physical healthcare. The ideals of the Declaration have since shaped the development of constitutional law in many countries, including India through the interpretation of Article 21 of the Constitution.

B. International Covenant on Economic, Social and Cultural Rights

The International Covenant on Economic, Social and Cultural Rights is the most important international agreement recognising the right to health. Article 12 of the Covenant recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It also calls upon States Parties to take the legislative, administrative and financial measures necessary for its progressive realisation.

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[9] Michael L. Perlin, *International Human Rights and Comparative Mental Disability Law: The Universal Factors*, 34 SYRACUSE J. INT'L L. & COM. 333 (2007); WORLD HEALTH ORGANIZATION, *Comprehensive Mental Health Action Plan 2013-2030* (2021).

[10] Universal Declaration of Human Rights, *supra* note 2, arts. 1, 2, 3, 5.

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Through General Comment No. 14 (2000), the Committee on Economic, Social and Cultural Rights has made clear that the right to health includes healthcare for mental disorders and that States are obliged to secure access to health facilities without discrimination. The Committee developed what has come to be called the AAAQ framework, under which health facilities, goods and services must be available, accessible, acceptable and of good quality. The framework applies with equal force to mental healthcare and requires governments to provide adequate facilities, personnel, essential medicines, community-based care and legal protection.[11]

C. International Covenant on Civil and Political Rights

The Covenant on Civil and Political Rights augments the protection given by the Covenant on Economic, Social and Cultural Rights in that it protects the civil rights of persons with mental illness. Article 7 provides that no one shall be subjected to torture or to cruel, inhuman or degrading treatment, and so protects psychiatric patients against institutional abuse and against treatment forced upon them in the absence of legal safeguards. Article 9 protects against arbitrary arrest and detention, and Article 17 protects privacy against unlawful interference. The Covenant further provides for equality before the law and the equal protection of the laws, and thereby guarantees the legal personality of persons who suffer from mental illness unless a restriction is imposed in accordance with due process of law.[12]

D. Convention on the Rights of Persons with Disabilities

The Convention on the Rights of Persons with Disabilities, adopted by the United Nations in 2006, marks an important turning point in the protection of mental health rights. It effected a shift from the medical approach to disability to a human rights-based approach founded on dignity, autonomy, equality and inclusion. The Convention recognises persons with psychosocial disabilities as equal bearers of rights and obliges States to prohibit discrimination in all areas of life. Several of its provisions bear directly upon the right to mental healthcare: equal recognition before the law under Article 12, liberty and security of the person under Article 14, the prohibition of torture and of cruel, inhuman or degrading treatment or punishment under Article 15, the protection of physical and mental integrity under Article 17, independent living and full inclusion in the community under Article 19, and equal access to health services without discrimination under Article 25.

[11] *General Comment No. 14*, *supra* note 8, paras. 12, 17.
[12] International Covenant on Civil and Political Rights, *supra* note 8, arts. 7, 9, 16, 17, 26.

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India became a party to the Convention in 2007, and its principles contributed a great deal to the passage of the Mental Healthcare Act, 2017, including the concepts of the advance directive, the nominated representative, informed consent, confidentiality and protection against discrimination.[13]

E. WHO Constitution and the Right to Mental Health

The Constitution of the World Health Organization, adopted in 1946, describes health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. That definition changed the course of public health by treating mental well-being as an essential constituent of health. It further states that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief or economic or social condition. The Organization has consistently recommended the integration of mental healthcare within primary healthcare, the removal of stigma, the building of community mental health services, the prevention of suicide and equal opportunity of treatment.[14]

III. Judicial Interpretation of the Right to Mental Health

The Indian judiciary has made a significant contribution to the recognition of mental health as an essential element of the fundamental right to life and personal liberty under Article 21 of the Constitution. Although the Constitution contains no express provision for a right to mental healthcare, judicial interpretation has incorporated within Article 21 a broad conception of the right to life that covers health, dignity, privacy and treatment. The Supreme Court has adopted a purposive interpretation under which the right to life relates not merely to existence but to living with dignity, to good physical and mental health and to the availability of medical facilities. Judicial pronouncements have also emphasised equality under Article 14 and non-discrimination, holding that persons suffering from mental disorders enjoy equality before the law and are not to be deprived of liberty or dignity on account of their illness. One of the early decisions recognising the right to health was *Parmanand Katara v. Union of India* (1989), in which the Supreme Court held that the preservation of human life is of paramount importance and that every person is entitled to immediate medical treatment.[15]

Although the question in *Parmanand Katara* concerned emergency medical treatment, the reasoning of the Supreme Court has been applied to mental healthcare, since the provision of

[13] Convention on the Rights of Persons with Disabilities, *supra* note 2, arts. 5, 12, 14, 15, 17, 19, 25 (India ratified the Convention on Oct. 1, 2007).
[14] Constitution of the World Health Organization, *supra* note 2, pmbl.
[15] *Parmanand Katara v. Union of India*, AIR 1989 SC 2039 (India).

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timely and proper treatment is an integral part of Article 21. In *Consumer Education and Research Centre v. Union of India* (1995), the Supreme Court observed that the right to health and to medical treatment is a fundamental right flowing from the right to life, and that the State is under a constitutional obligation to provide adequate health facilities so that the physical and psychological well-being of individuals is protected.[16] Judicial intervention has protected the rights of persons with mental illness more directly in decisions on dignity, institutional treatment and human rights.

The clearest authority is *Sheela Barse v. Union of India*, decided on 17 August 1993 on a petition that arose from the petitioner's own account of the jailing of the mentally ill. The Supreme Court examined the practice in West Bengal of committing to jail persons described in the committal records as non-criminal lunatics, and found that many of those so committed were not mentally ill at all, that no jail carried a psychiatrist on its permanent staff, that visiting psychiatrists attended irregularly, and that the team of clinical psychologists, psychiatric nurses and social workers which proper treatment requires was simply absent. The Court held that the admission of non-criminal mentally ill persons to jails is illegal and unconstitutional, directed that such admissions in West Bengal be stopped forthwith, required that the power of commitment be exercised by judicial magistrates rather than by executive authorities, ordered that mental health facilities be upgraded, and retained supervision by requiring that compliance be reported and monitored through the Calcutta High Court. The decision is therefore not merely a contribution to prison reform. It is authority that the confinement of a person in a jail on the ground of mental illness, in the absence of any criminal charge, violates Articles 14 and 21 of the Constitution.[17]

In *Veena Sethi v. State of Bihar* (1982), the Supreme Court expressed serious concern at the prolonged detention of persons with mental illness in prison without the treatment and rehabilitation to which they were entitled, and held that continued detention without proper medical treatment infringes the right to personal liberty and to human dignity.[18] In *Shikha Nischal v. National Insurance Company Ltd.*, the High Court of Delhi delivered a landmark judgment on the principle that mental illness cannot be treated differently from physical illness for the purposes of health insurance cover. Justice Prathiba M. Singh held that the exclusion of mental illness under a mediclaim policy violated Section 21(4) of the Mental Healthcare Act, 2017, under which every insurer shall make provision for medical insurance for the treatment

[16] *Consumer Education and Research Centre v. Union of India*, (1995) 3 SCC 42 (India).
[17] *Sheela Barse v. Union of India*, (1993) 4 SCC 204 (India).
[18] *Veena Sethi v. State of Bihar*, (1982) 2 SCC 583 (India).

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of mental illness on the same basis as is available for the treatment of physical illness. The Court observed that the denial of insurance cover to persons suffering from mental illness was discriminatory and defeated the object of the Act, and directed that insurers give effect to Section 21(4) from 29 May 2018, when the provision came into force. The Court also awarded the petitioner the costs of the proceedings, on the ground that she had been left with no course other than litigation to enforce a statutory right. The ruling is of considerable significance in recognising mental health services as a constituent of the rights to health, dignity, equality and non-discrimination.[19]

IV. Capacity, Consent and Autonomy in Mental Healthcare Decisions

The shift from a custodial model to a rights-based model turns, in the end, on the question of who decides. The Mental Healthcare Act, 2017 answers that question by beginning from a presumption of capacity. Section 4(1) provides that every person, including a person with mental illness, is deemed to have the capacity to make decisions regarding his mental healthcare or treatment if he has the ability to understand the information relevant to a decision on treatment, admission or personal assistance, to appreciate any reasonably foreseeable consequence of a decision or of the lack of a decision, and to communicate that decision by speech, expression, gesture or any other means.[20] Capacity under the Act is accordingly functional and decision-specific. It is to be assessed in relation to the particular decision at the particular time, and it cannot be inferred from a diagnosis, from the severity of the illness or from the fact that the choice made appears unwise to the treating professional. That is a decisive departure from the position under the Mental Health Act, 1987, in which the assessment of risk by a clinician or a magistrate effectively displaced the wishes of the person concerned.[21]

Capacity may fluctuate, and the Act provides for that contingency instead of treating the loss of capacity as a licence for substituted judgment. Chapter III confers on every person who is not a minor the right to make an advance directive in writing, stating the manner in which he wishes to be cared for and treated for a mental illness, the manner in which he wishes not to be so cared for and treated, and the individuals whom he wishes to appoint as his nominated representative. The directive is invoked only when the person ceases to have capacity to make mental healthcare or treatment decisions and remains effective until that capacity is regained; it does

[19] *Shikha Nischal v. National Insurance Company Ltd.*, W.P. (C) No. 3190 of 2021 (High Court of Delhi, Apr. 19, 2021); Mental Healthcare Act, *supra* note 4, s. 21(4).
[20] Mental Healthcare Act, *supra* note 4, s. 4(1).
[21] V. Namboodiri, *Capacity for Mental Healthcare Decisions Under the Mental Healthcare Act*, 61 INDIAN J. PSYCHIATRY S676 (Supp. 4, 2019).

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not apply to emergency treatment; and it may be revoked, amended or cancelled by the person who made it. Where a directive is disputed, the Mental Health Review Board has power to review, alter, modify or cancel it, and a medical practitioner or mental health professional is not liable for the unforeseen consequences of following a valid directive. Section 14 confers the corresponding right to appoint a nominated representative in writing, subject to that person's written consent and to his competence to discharge the functions assigned by the Act.[22]

These arrangements answer to Article 12 of the Convention on the Rights of Persons with Disabilities, to which India is a party. Article 12 recognises persons with disabilities as persons before the law, affirms that they enjoy legal capacity on an equal basis with others in all aspects of life, requires States to provide access to the support they may need in exercising that capacity, and requires safeguards that respect the rights, will and preferences of the person, are proportionate, apply for the shortest time possible and are subject to regular review. In its first general comment the Committee on the Rights of Persons with Disabilities read the article as requiring States to abolish substitute decision-making regimes and to replace them with supported decision-making founded on the will and preferences of the person rather than on an assessment of best interests.[23] Measured against that standard the Indian position is transitional. The presumption of capacity, the advance directive and the nominated representative are genuine instruments of supported decision-making, yet a functional capacity test is a test that can be failed, and the point at which it is failed remains the point at which a person's own choice may be displaced. It is precisely such assessments that the universal legal capacity reading of Article 12 rejects, and the tension between the two positions has not been resolved by the Act.[24]

The practical worth of these provisions depends on conditions that a statute cannot secure by itself: an accessible register of advance directives, professionals trained to assess capacity rather than to assume its absence, Review Boards that function and are within reach of the persons who need them, and awareness among patients and families that the rights exist at all. Where those conditions are absent, informed consent is reduced to a signature on an admission form and autonomy becomes formal rather than real. Capacity, consent and autonomy are therefore not peripheral to the human rights analysis of mental healthcare in India. They are the provisions through which the rights-based promise of the Act is either kept or lost.

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[22] Mental Healthcare Act, *supra* note 4, ss. 5-13, 14.

[23] Convention on the Rights of Persons with Disabilities, *supra* note 2, art. 12; COMMITTEE ON THE RIGHTS OF PERSONS WITH DISABILITIES, *General Comment No. 1: Article 12: Equal Recognition Before the Law*, U.N. Doc. CRPD/C/GC/1 (Apr. 11, 2014).

[24] Amita Dhanda, *Legal Capacity in the Disability Rights Convention: Stranglehold of the Past or Lodestar for the Future?*, 34 SYRACUSE J. INT'L L. & COM. 429 (2007).

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V. Legal Challenges in the Protection of Mental Health Rights in India

Although the Mental Healthcare Act, 2017 is an important move towards a rights-based approach to mental healthcare, several legal challenges have been identified in giving effect to the rights it confers. Notwithstanding the incorporation of the right to mental healthcare and of human rights standards in the Act, its implementation has been poor for administrative, financial and structural reasons. The result of that inconsistency is that many persons do not receive appropriate mental health services. The principal legal challenges are set out below.[25]

A. Inadequate Implementation of the Mental Healthcare Act

The primary difficulty is the failure to implement the Act properly. Although it imposes statutory responsibilities on the Central and State governments to provide mental health services, most States have been slow to frame rules and to constitute Mental Health Authorities and Mental Health Review Boards. The absence of monitoring systems and the limited capacity of institutions have rendered the enforcement of the rights conferred by the Act ineffective. Many statutory protections therefore remain confined to the text of the legislation and do not reach the persons living with mental illness for whose benefit they were enacted.

B. Limited Access to Mental Healthcare Services

The availability of mental healthcare in India is highly uneven. Facilities are concentrated in urban areas, so that people in rural and remote areas are left without access. The shortage of professionals, including psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses, has widened that disparity further. Many persons with mental health problems consequently remain without proper treatment for long periods, and their constitutional rights to health and to dignity are thereby violated.[26]

C. Persistent Stigma and Discrimination

Social stigma remains one of the major impediments to the realisation of mental health rights. Persons suffering from mental disorders are regularly subjected to discrimination in employment, education, housing, healthcare and social relations. The fear of social exclusion deters people from consulting specialists, which in turn results in later diagnosis and in the

[25] Upendra Baxi, The Future of Human Rights 198 (Oxford University Press, 3d edn. 2008).
[26] Melur Sukumar Gautham et al., *The National Mental Health Survey of India (2016): Prevalence, Socio-Demographic Correlates and Treatment Gap of Mental Morbidity*, 66 Int'l J. Soc. Psychiatry 361 (2020).

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worsening of their condition. Although the Mental Healthcare Act prohibits discrimination, the means of legal redress and the measures for raising awareness remain insufficient.[27]

D. Inadequate Financial Allocation for Mental Healthcare

The realisation of the right to mental healthcare depends largely upon adequate funding by government. In India, expenditure on mental health remains a very small proportion of the total health budget, and the position is not peculiar to this country: public spending on mental health is low across States generally and is particularly meagre in low and middle income countries. Under-funding hinders the creation of facilities, the recruitment of qualified personnel, the supply of essential medicines and the provision of rehabilitation and other community-level programmes. The shortage of funds severely limits the capacity of government to discharge its legal and constitutional responsibilities in this field.[28]

E. Weak Community-Based Mental Health Services

Community treatment and rehabilitation are among the key principles established by the Mental Healthcare Act. In many parts of the country, however, community mental health services are poorly developed. Rehabilitation centres, counselling services, halfway homes, crisis centres and similar programmes are not sufficient to meet the growing demand. Many individuals are therefore still admitted to psychiatric hospitals, although international human rights standards point in the opposite direction.

F. Shortage of Trained Mental Health Professionals

There is a serious shortage of skilled mental health professionals in India, including psychiatrists, psychologists, psychiatric nurses and social workers. The shortage affects the quality, the availability and the continuity of care. Delayed diagnosis, overcrowded facilities, overworked professionals and poor counselling services have become common, and the shortage is most acute in rural and tribal areas.

VI. Conclusion

The right to mental well-being is a necessary element of human dignity, equality and respect for basic human rights. This study shows that the right to mental well-being is inherently linked with the constitutional guarantees of equality, freedom, privacy and life under Articles 14, 19 and 21 of the Constitution of India. The instruments of international human rights law, in particular the Universal Declaration of Human Rights, the International Covenant on Economic,

[27] National Institute of Mental Health and Neuro Sciences, *National Mental Health Survey of India, 2015-16: Prevalence, Patterns and Outcomes* (NIMHANS Publication No. 129, 2016).
[28] World Health Organization, *Mental Health Atlas 2020* (2021).

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Social and Cultural Rights, the International Covenant on Civil and Political Rights and the Convention on the Rights of Persons with Disabilities, have had a considerable influence on the formulation of a rights-based framework for mental healthcare. The protection of mental health as a human right requires an integrated approach comprising legislation, adjudication, administration and public participation. Improving the provision of mental healthcare in India calls for greater public funding, the development of community mental health programmes, the integration of mental healthcare within primary healthcare, the engagement of trained professionals, the effective working of Mental Health Review Boards, and awareness programmes directed against stigma and discrimination. The same efforts are necessary to protect the human rights of vulnerable groups such as women, children, older persons, prisoners, homeless persons and persons with disabilities.

Technological development in digital health must also be accompanied by stringent legal protection of privacy, confidentiality and informed consent, and by respect for the presumption of capacity on which the Mental Healthcare Act, 2017 rests. The importance of mental well-being as a basic right cannot be understated, for it is necessary to the constitutional principles of justice, equality, freedom and human dignity. A genuinely rights-based mental healthcare system will be possible only through the proper implementation of existing law, the allocation of resources, institutional accountability and respect by society as a whole for the dignity of every person. That would not only meet India's legal obligations but would also contribute to the development of a healthcare system that takes care of the mental well-being of everyone.

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