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Integrating Mediation into India's Mental Healthcare: A Comparative Legal Analysis

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ABSTRACT

Mental healthcare in India is undergoing a paradigm shift, illustrated by the Mental Healthcare Act, 2017, which moves from a custodial to a rights-based approach. The legislation protects people with mental illnesses, safeguarding their autonomy and their dignity and promoting non-discrimination. It also creates significant legal, ethical, and medical quandaries in cases of involuntary treatment, institutional care, and guardianship, disputes that sometimes encompass highly charged clashes among family members, patients, and mental health experts. Within this growing framework, mediation, an integral part of alternative dispute resolution (ADR), emerges as a potentially transformative mechanism for resolving conflicts with sensitivity and equity. Despite ADR's proven success in civil and family law matters, its integration into the domain of mental health jurisprudence in India remains highly underexplored. This paper analyses the sources and reasons for conflict in India's mental healthcare systems. It assesses the absence of institutionalised ADR mechanisms in the Mental Healthcare Act, 2017, and proposes a rights-based model of therapeutic jurisprudence that combines legal safeguards with clinical realities. It explores the potential for coordinated and structured mediation processes within mental healthcare systems, drawing upon comparative models from jurisdictions such as the United Kingdom and Australia, and proposes a hybrid dispute resolution model in which mediation is embedded as a mandatory pre-adjudication step within the Mental Healthcare Act framework. By adopting a rights-sensitive, therapeutically informed mediation framework, India can move from a fragmented and adversarial system to one that truly embodies dignity, autonomy, and collaborative care.

Keywords: *Mental Healthcare Act, Mediation in Healthcare, Alternative Dispute Resolution*

I. INTRODUCTION

Healthcare providers confront substantial challenges due to fast-emerging technologies and rising patient expectations. Differences between patients, their families, and medical personnel often occur in everyday practice.¹ Conflict resolution in healthcare settings may be difficult on

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¹ Danny W. H. Lee & Paul B. S. Lai, *The Practice of Mediation to Resolve Clinical, Bioethical, and Medical Malpractice Disputes*, 21 HONG KONG MED J 560 (2015), <https://doi.org/10.12809/hkmj154615>.

an ethical, emotional, and interpersonal level. The absence of skilled and timely management of disputes and disagreements can have devastating implications on healthcare facilities, their staff members, and, most importantly, patients. Conflicts in healthcare are often settled through the process of litigation, which is fundamentally contentious. Through legal procedures, both parties must specify the matter in dispute and offer supporting evidence to the court, after which the judge will rule in favour of one of the parties. However, the judicial process may not always result in equitable judgments due to structural constraints, including discrepancies in legal representation, insufficient or untrustworthy evidence and witnesses, and the possibility of bias.²

II. THE LAW AND MENTAL HEALTH CARE DISPUTES: AN ANALYSIS OF CONFLICT IN INDIA'S MENTAL HEALTHCARE SYSTEM

The Mental Healthcare Act (MHCA) of 2017 is a turning point in Indian public health law. It represents an important conceptual change, transitioning away from the institution-centric and custodial framework of the previous Mental Health Act of 1987 towards a progressive, rights-based model of treatment. The 2017 MHCA was drafted and approved with the sole goal of harmonising India's domestic legislation with its international commitments under the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which the country ratified in 2007.³ This new legislation substantially redefines the interaction between the state, healthcare providers, and individuals with mental illnesses, based on the concepts of human rights, personal autonomy, and dignity. However, the implementation of this ambitious legislative framework into the complicated and firmly established reality of India's healthcare ecosystem has not been without hitches. While the MHCA, 2017, represents a watershed moment in codifying patient rights, its implementation has uncovered and, in some circumstances, produced new and complex "fault lines" of conflict. Unlike prior laws, which were largely concerned with the processes which deprived a person of liberty (a negative right), the MHCA of 2017 introduces a positive "right to access mental healthcare" approach. This imposes a legal responsibility on the state to provide services of a specified standard and accessibility.⁴ As a result, when the state cannot fulfil this commitment owing to systemic issues such as chronic underfunding, significant personnel shortages, and deficient infrastructure, a

² J. Kassim & Puteri Nemie, *Mediating Medical Negligence Claims in Malaysia: An Option for Reform?* (2008), <https://www.semanticscholar.org/paper/Mediating-medical-negligence-claims-in-Malaysia%3A-an-Kassim-Nemie/eabe24ab85d8ee3461a3e8552eb929cf99d5ab8b>.

³ *MHCA 2017 – V: Rights of Persons with Mental Illness*, <https://mhca2017.com/index.php/act/chapter-v-rights-of-persons-with-mental-illness> (last visited Jan. 21, 2025).

⁴ Chandrashekar Hongally et al., *Liabilities and Penalties under Mental Healthcare Act 2017*, 61 INDIAN J PSYCHIATRY S724 (2019), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6482688/>.

shortfall in the provision of services becomes a breach of a statutorily protected right. This raises patient and carer discontent to a viable legal claim, significantly changing the form and scope of systemic conflicts.⁵

Chapter V of the MHCA, 2017, is the foundation of the rights-based approach embodied within the Act. It outlines a range of rights for People with Mental Illness (PwMI). These rights are not aspirational; they are legally enforceable and serve as the foundation for disputes.⁶ Those who work outside of law or healthcare are astonished to find that patients and their families do not always have the freedom to choose whether or not to get treatment or which kind of treatment to get. Different legal frameworks apply depending on whether the patient is an adult or a child, and the rights of different parties change according to the patient's competence or ability to make their own decision. The unifying theme is that if a patient is unable to make a choice, the law demands that a choice be made on their behalf in their best interests. When there is a disagreement, it is not always necessary to go to court; nevertheless, if the issue cannot be addressed in the best interests of the patient, the court will adjudicate. Outlined below are the principal domains in which conflicts frequently emerge:

1. **Capacity for informed and voluntary decision-making:** In India, the legal framework for healthcare decision-making remains fragmented, particularly concerning mental capacity and consent. While there is no comprehensive framework equivalent to the UK's Mental Capacity Act 2005, the Mental Healthcare Act, 2017 (MHCA) recognises the autonomy of persons with mental illness. Section 4 of the MHCA introduces a functional test for capacity, requiring that a person must be able to understand, appreciate consequences, and communicate a decision.⁷ Where a person lacks capacity, decisions must be made following their advance directive (if any) or by a nominated representative (Section 89(6)–(7)), and always in the person's best interests as per Section 17. Despite statutory recognition of supported decision-making, the participatory intent of the Act is inconsistently applied in practice. For adolescents, Indian law does not provide a uniform threshold for medical consent. The Indian Majority Act of 1875 sets the age of majority at 18, but judicial interpretations have occasionally recognised the capacity of minors to consent to treatment, particularly in emergencies. Unlike the Gillick competence test in the UK,

⁵ *Mental Health Care and Its Management*, PRS LEGISLATIVE RESEARCH (Report Summary, Standing Committee on Health and Family Welfare, Aug. 4, 2023), <https://prsindia.org/policy/report-summaries/mental-health-care-and-its-management> (last visited Jun. 21, 2025).

⁶ *MHCA 2017 – V: Rights of Persons with Mental Illness*, *supra* note 3.

⁷ The Mental Healthcare Act, No. 10 of 2017, INDIA CODE (2017), § 4.

there is no codified standard to assess minors' evolving capacities, though courts have considered maturity and understanding in specific cases.⁸ Parental consent generally governs medical decisions for minors, subject to judicial oversight when conflicts arise. The best interests principle, though not statutorily defined across all contexts, is embedded in Indian jurisprudence and reflected in laws such as the Guardians and Wards Act, 1890 and the Juvenile Justice (Care and Protection of Children) Act, 2015, where the welfare of the child is paramount. Indian courts, including in cases like *Aruna Shanbaug*⁹ and *Laxmi Mandal v. Deen Dayal Harinagar Hospital*,¹⁰ have highlighted the need to balance individual autonomy with welfare considerations in healthcare decisions. Professional guidelines issued by the Medical Council of India (now superseded by the National Medical Commission) mandate that informed consent must be obtained for treatment, but they do not offer comprehensive procedures for capacity assessment or handling disagreements between healthcare providers, patients, and families. When conflicts arise, recourse is often sought through judicial intervention, though mechanisms such as 'mediation' remain underutilised. While the MHCA endorses supported decision-making and patient autonomy, it does not provide structured frameworks for non-adversarial dispute resolution in clinical settings.

2. **Lack of Communication:** Conflict between physicians and patients often stems from poor communication and inadequate information sharing. When patients or their families feel neglected, uninformed about their condition or treatment, or believe their concerns are dismissed, the likelihood of disputes and litigation increases. Studies indicate that physicians who exhibit rudeness, disrespect, or poor communication are at greater risk of conflict. Additionally, some patients hesitate to ask questions out of fear of appearing disrespectful, further compounding communication barriers.¹¹
3. **Confidentiality vs. Systemic Constraints:** Maintaining patient anonymity in congested and under-resourced government hospital outpatient departments (OPDs) is often impossible. Overhearing personal narratives is prevalent, creating a contradiction between the ethical requirement of confidentiality and the physical

⁸ Adam Peter Bunting, *Guiding Principles in Medical Law: The Ability to Treat* (July 2005) (dissertation, University of Birmingham), <https://etheses.bham.ac.uk/id/eprint/968/>.

⁹ *Aruna Ramachandra Shanbaug v. Union of India*, (2011) 4 S.C.C. 454 (India).

¹⁰ *Laxmi Mandal v. Deen Dayal Harinagar Hosp.*, 2010 SCC OnLine Del 2234 (India).

¹¹ Vanita Bhavnani & Brian Fisher, *Patient Factors in the Implementation of Decision Aids in General Practice: A Qualitative Study*, 13 HEALTH EXPECT 45 (2010), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5060516/>.

limits of the clinical setting.¹² More often, confidentiality is breached not through deliberate disclosure but through systemic failures and new technological challenges. Section 23 of the Act¹³ imposes a clear responsibility on healthcare providers to protect confidentiality, although it is not absolute. The Act contains specified exceptions, such as the necessity to avoid injury, in the interest of public safety, or when directed by a court. The difficulty in interpreting these exceptions, especially what defines “public interest,” might cause disagreement.

4. **Clinical Judgment vs. Standardised Assessment:** Discrepancies often emerge between clinical judgment and psychometric test results, causing conflicts between patients and physicians. For example, individuals with substance use disorders sometimes underreport symptoms on dependency indices, despite contradictory accounts from family and observed behaviour. Similarly, some children underperform on assessments of IQ or learning disabilities, though their real-world functioning suggests otherwise.¹⁴
5. **Power Hierarchies and Therapist Disclosure:** Clients frequently perceive therapists as authoritative guides rather than equals, preferring a directive therapeutic relationship which becomes a centre point of disputes.
6. **Right to Refuse Treatment:** Perhaps the most contentious issue is the patient’s right to refuse treatment. The MHCA, 2017, protects the right of an autonomous patient to refuse a specific psychiatric treatment, even if it is deemed clinically advisable. This provision is a direct implementation of the UNCRPD’s emphasis on autonomy. However, it clashes with the clinical reality of conditions like schizophrenia, where a core symptom can be anosognosia or a lack of insight into one’s illness. Clinicians express profound concern that a patient who technically meets the criteria for capacity but lacks insight may refuse essential treatment, leading to higher rates of relapse, re-hospitalisation, and adverse long-term outcomes. This pits the legal principle of autonomy directly against the medical principle of beneficence, creating an ethical and clinical dilemma for the physician and a point of intense conflict with patients and families who may not understand why a “refusal” is being challenged.¹⁵

¹² Supreet Kaur Bhasin, Aditi Sharma, Triptish Bhatia & Smita N. Deshpande, *How To, or Not To Intervene – Some Ethical Dilemmas Encountered by Mental Health Professionals*, 7 GLOBAL BIOETHICS ENQUIRY 61 (2019).

¹³ The Mental Healthcare Act, No. 10 of 2017, INDIA CODE (2017), § 23.

¹⁴ Bhasin et al., *supra* note 12.

¹⁵ *Ethical Considerations of Involuntary Psychiatric Treatment*, <https://www.psychiatrictimes.com/view/ethical-considerations-of-involuntary-psychiatric-treatment> (last visited Jan. 22, 2025).

III. THE ROLE OF MEDIATION AS AN ALTERNATIVE DISPUTE RESOLUTION MECHANISM IN INDIA'S MENTAL HEALTHCARE SYSTEM

Alternative Dispute Resolution (ADR) refers to a variety of strategies used to resolve disputes outside of the formal, sometimes hostile, limits of traditional court litigation. These processes, which include arbitration, conciliation, and mediation, are distinguished by their secrecy, informality, and low stress levels for participants. Modern ADR traces its origins back to the 1970s when it originated as an experimental solution for overcrowded court systems and a more constructive method of settling complicated environmental conflicts.¹⁶ Its use has grown over time to include family law, workplace problems, and, most recently, healthcare.

Mediation differs from other kinds of ADR because it takes a party-centric approach. Mediation is a planned procedure in which an unbiased third person, known as a mediator, fosters discussion and negotiation among opposing parties. The goal is to help the parties seek a consensual and mutually accepted settlement to their disagreement. Unlike arbitration, where a neutral arbitrator hears evidence and delivers a binding decision, or litigation, where a court imposes a judgment, the mediator in a mediation process cannot determine the case or enforce a settlement. The authority to create and agree on a solution rests solely with the disputants. Several basic elements govern mediation's efficacy. Firstly, participation in mediation is voluntary. Parties must freely agree to participate in the process, and they have the option to exit at any time if they believe it is not productive. This concept guarantees that parties have complete autonomy over the outcome of their dispute. Secondly, confidentiality is essential in the mediation process. All exchanges and documents discussed during mediation are strictly confidential and, with few legal exceptions, cannot be divulged or used as evidence in any later court or arbitral proceedings. This private shield enables parties to talk openly and honestly, without fear of public disclosure or legal bias.¹⁷ Impartiality forms the next principle in mediation. The mediator must be a neutral third party with no inherent interest in the resolution of the dispute. Impartiality is essential for fostering confidence and ensuring that the process is equitable. The mediator's function is to lead the process, and assist parties in finding common ground, rather than to take sides. This idea empowers the parties by allowing them to actively shape both the process and the outcome. This ownership of the resolution results in greater

¹⁶ *Alternative Dispute Resolution*, LII / LEGAL INFORMATION INSTITUTE, https://www.law.cornell.edu/wex/alternative_dispute_resolution (last visited Feb. 2, 2025).

¹⁷ *What Is Mediation?* – OATH, <https://www.nyc.gov/site/oath/conflict-resolution/what-is-mediation.page> (last visited Feb. 5, 2025).

satisfaction with the outcome and much better rates of compliance with the conditions of the settlement agreement.¹⁸

Mediation mostly begins with a joint session to establish an agenda and allow each side to be heard, followed by private, separate sessions (caucuses) with the mediator and each party. Caucuses provide a confidential environment for parties to disclose sensitive material while the mediator gently probes viewpoints and encourages concessions, ultimately bringing the parties to a mutually acceptable conclusion. The mediator's function is consequently one of facilitation rather than adjudication.¹⁹ A good mediator catalyses positive dialogue, assisting parties in moving beyond dogmatic stances and uncovering their underlying interests and needs. The mediator uses strategies such as active listening, reframing situations, and reality-checking to help clear up misconceptions, manage intense emotions, and create the trust required for collaborative problem-solving.²⁰

While the essential concepts of mediation are globally relevant, their aims are particularly significant in the emotionally charged and therapeutically sensitive environment of mental illness. The goal of dispute resolution in this context goes beyond simply adjudicating rights and liabilities; it extends into the realm of "therapeutic justice," in which the process of resolving a conflict is intended to contribute positively to the well-being and healing of the individuals involved. Many healthcare disagreements are the result of systematic communication failings and unfulfilled patient expectations, rather than outright carelessness. The mediation process enables a healthcare institution to go beyond the present disagreement and discover underlying systemic issues, such as defective communication protocols or insufficiently informed consent processes, so it functions as a quality improvement tool. For the patient, the act of being heard and having their feelings recognised by the provider can be deeply cathartic, in line with therapeutic jurisprudence. For the healthcare professional, it provides a non-confrontational platform to explain clinical difficulties and convey empathy, reducing the extreme stress and exhaustion associated with unresolved issues and the continual possibility of legal action. As a result, viewing mediation just as a tool for resolving court cases ignores its deepest significance in the healthcare ecosystem: it is a proactive tool for relationship repair, quality assurance, and therapeutic healing.²¹

¹⁸ *What Is Mediation?* – OATH, *supra* note 17.

¹⁹ P.O.N. Staff, *What Are the Three Basic Types of Dispute Resolution? What to Know About Mediation, Arbitration, and Litigation*, PON – PROGRAM ON NEGOTIATION AT HARVARD LAW SCHOOL (May 15, 2025), <https://www.pon.harvard.edu/daily/dispute-resolution/what-are-the-three-basic-types-of-dispute-resolution-what-to-know-about-mediation-arbitration-and-litigation/>.

²⁰ P.O.N. Staff, *supra* note 19.

²¹ Kostadin Yordanov Dimitrov & Tsonka Miteva-Katrandzhieva, *Exploring Patient Awareness and the Feasibility of Mediation in Healthcare: A Pilot Study in Bulgaria*, 13 HEALTHCARE 629 (2025), <https://www.mdpi.com/2227->

IV. THE LEGAL AND REGULATORY LANDSCAPE IN INDIA

Chapter V of the Mental Healthcare Act, 2017, provides for the rights of persons with mental illnesses.²² It provides for non-discrimination, the right to protection from inhumane treatment and other guarantees. To implement these rights, the MHCA creates a specialised grievance redressal mechanism called the ‘Mental Health Review Boards’ (MHRBs), which are formed by the State Authority under Chapter XI.²³ Any individual with a mental illness, their appointed representative, or a registered non-governmental organisation (NGO) who is dissatisfied with a decision made by a mental health facility or thinks their rights have been infringed may apply to the MHRB. The Act states that hearings before the Board are considered “judicial proceedings,” and the Board is authorised to undertake enquiries, request the presence of witnesses, and impose penalties of up to five lakh rupees on a mental health establishment that fails to comply with its orders or directions.²⁴ Appeals from the MHRB’s ruling are directly to the High Court. Despite these strong rights, the operation of MHRBs has faced major obstacles. Research and criticisms have continually shown practical and conceptual constraints. The statutory six-member composition of the Board is viewed as ambitious and difficult to establish, resulting in delays in their creation across jurisdictions. Although the Act fixes the quorum at three members, it is unclear which combination of members must make up that quorum to adjudicate, and the newly established Boards face a lack of both personnel and financial resources.²⁵ This has resulted in an overburdened area of operation, jeopardising the Boards’ capacity to deliver prompt and effective redressal and creating a significant gap between the Act’s legal promise and its practical reality.²⁶ This points to a more fundamental contradiction within the MHCA’s design. The Act is built on a progressive philosophy of collaborative care, dignity, and patient autonomy, seeking to treat mental illness with the same empathy and support as physical illness. Yet, resolving disputes that arise within this supportive framework mandates a formal, quasi-judicial, and inherently adversarial process. The MHRB structure, with its “judicial proceedings,” decision-making by an external authority, and appeals to the High Court, mirrors the very litigation model that is widely recognised as stressful, damaging to

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²² *MHCA 2017 – V: Rights of Persons with Mental Illness*, *supra* note 3.

²³ *MHCA 2017 – XI: Mental Health Review Boards*, <https://mhca2017.com/index.php/act/chapter-xi-mental-health-review-boards> (last visited Jun. 22, 2025).

²⁴ *MHCA 2017 – XI: Mental Health Review Boards*, *supra* note 23; see The Mental Healthcare Act, No. 10 of 2017, INDIA CODE (2017), §§ 77, 78, 80(11), 82(4), 83.

²⁵ Snehil Gupta, Maitreyi Misra & Neeraj Gill, *Mental Health Review Board under the Mental Health Care Act (2017), India: A Critique and Learning from Review Boards of Other Nations*, 81 INT J LAW PSYCHIATRY 101774 (2022), <https://doi.org/10.1016/j.ijlp.2021.101774>.

²⁶ Gupta, Misra & Gill, *supra* note 25.

relationships, and ill-suited for the emotional complexities of healthcare conflicts. This procedural design is profoundly misaligned with the Act's therapeutic ethos. By channelling all grievances into a confrontational forum, the Act forces vulnerable patients and their physicians into a position that can exacerbate the patient's distress and irrevocably destroy the therapeutic relationship it is meant to protect. The legislative gap, therefore, is not a simple omission of the word "mediation." It is a systemic flaw where the Act provides modern rights but relies on an archaic model of dispute resolution, thereby undermining its core objectives. This makes the case for integrating a collaborative process like mediation not just a matter of improving efficiency but of philosophical and therapeutic necessity to fulfil the true spirit of the MHCA.

India took a step toward institutionalising alternative dispute resolution (ADR) with the enactment of the Mediation Act, 2023, its first standalone legislation on mediation. The Act promotes and facilitates mediation, particularly institutional and pre-litigation mediation. It enforces mediated settlement agreements (MSAs) through a statutory framework. It also establishes the Mediation Council of India (MCI) as a central regulatory authority. The Act defines "mediation" broadly, subsuming conciliation and online mediation within its scope, thereby integrating the conciliation provisions of the Arbitration and Conciliation Act, 1996. Given that disputes in the healthcare sector such as medical negligence and service deficiencies are civil, they fall within the Act's purview. Section 5 provides for voluntary pre-litigation mediation, and Section 27 makes MSAs enforceable as if they were a judgment or decree of a court, enhancing both the finality and enforceability of mediated outcomes; neither provision, however, was among those brought into force on 9 October 2023.²⁷

The Indian judiciary has championed ADR as a means to address the judicial backlog and enhance access to justice. In *Jacob Mathew v. State of Punjab*²⁸ the Supreme Court set a demanding threshold for establishing criminal medical negligence, and in the more recent *Neeraj Sud v. Jaswinder Singh*²⁹ it applied the *Bolam* test to set aside a finding of negligence in a consumer claim, in each case safeguarding medical personnel against frivolous lawsuits. While this protects doctors, it also emphasises the enormous difficulty and adversarial burden placed on genuine victims within the traditional court system, implicitly strengthening the case

²⁷ Divyansh Singh Sisodiya & Satyam Dwivedi, *The Role of ADR in Resolving Disputes Related to Medical Negligence*, 9 INTERNATIONAL JOURNAL OF LAW AND SOCIAL SCIENCES (IJLS) 34 (2023), <https://doi.org/10.60143/ijls.v9.i1.2023.82>; see The Mediation Act, No. 32 of 2023, INDIA CODE (2023), §§ 3(h), 5, 27; MINISTRY OF LAW AND JUSTICE, Notification S.O. 4384(E) (Oct. 9, 2023) (bringing into force §§ 1, 3, 26, 31–38, 45–47, 50–54 and 56–57 only).

²⁸ *Jacob Mathew v. State of Punjab*, (2005) 6 S.C.C. 1 (India).

²⁹ *Neeraj Sud v. Jaswinder Singh*, 2024 INSC 825 (India).

for a non-adjudicatory alternative such as mediation, where the focus is not on proving “gross negligence” but on resolving the conflict and addressing the patient’s grievance.³⁰

V. MEDIATION MODELS FROM OTHER COUNTRIES FOR IMPLEMENTATION IN INDIA: A COMPARATIVE ANALYSIS

Examining established mediation programmes in other countries provides valuable insights and a practical blueprint for how India can integrate mediation into its healthcare system. International models demonstrate that a well-structured, specialised mediation service can effectively resolve disputes while promoting patient safety and preserving relationships.

In researching mediation models in other countries, the first one to be studied is that of the United Kingdom (UK). One of the applicable models for India is provided by the National Health Service (NHS) in the United Kingdom. Claims involving clinical negligence against the NHS are handled by NHS Resolution, an independent agency of the Department of Health and Social Care. Promoting ADR, which includes a specialised mediation service intended to settle conflicts out of court, is a key component of its approach. The purpose of the NHS mediation programme is to assist patients, their families, and NHS employees in collaborating to settle disputes and lawsuits. The procedure offers access to an impartial, certified mediator chosen from a varied panel and places a strong emphasis on early intervention. The philosophy promotes candid communication and education in addition to resolving disputes. Mediators are adept at managing emotional situations which are frequently more significant to the harmed party than monetary compensation.³¹ The UK approach, in which mediation is one of several dispute resolution tools, has proven highly effective, with NHS Resolution reporting that 77% of claims in 2021–22 and 81% in 2023–24 were resolved without court proceedings.³² This reflects a substantial shift away from adversarial litigation, reducing time, cost, and stress for all parties. In one clinical negligence case initially valued at £500,000, private meetings, a joint session involving an apology, and shuttle negotiations led to an £80,000 settlement plus costs,

³⁰ mappingadr, *Healthcare Mediation in India: A Pound of Cure for Adversarial Litigation?*, MAPPING ADR (Apr. 12, 2024), <https://jgu.edu.in/mappingADR/healthcare-mediation-in-india-a-pound-of-cure-for-adversarial-litigation/>.

³¹ *Mediation Services for the NHS*, IPOS MEDIATION, <https://mediate.co.uk/nhs/> (last visited Apr. 19, 2025).

³² *NHS Medical Negligence Bill Hit £2.8 Billion in 2023–24*, MEDICAL SOLICITORS, <https://www.medical-solicitors.com/news/nhs-resolution-statistics-2023-24/> (last visited Jun. 5, 2025); see also NHS RESOLUTION, *NHS Resolution Continues to Drive Down Litigation: Annual Report and Accounts Published for 2021/22* (July 20, 2022), <https://resolution.nhs.uk/2022/07/20/nhs-resolution-continues-to-drive-down-litigation-annual-report-and-accounts-published-for-2021-22/> (77% of claims resolved without court proceedings in 2021–22); NHS RESOLUTION, *NHS Resolution Continues Trend of Resolving More Cases Without Need for Litigation* (July 23, 2024), <https://resolution.nhs.uk/2024/07/23/nhs-resolution-continues-trend-of-resolving-more-cases-without-need-for-litigation/> (81% in 2023–24).

thereby entirely avoiding trial.³³ NHS Resolution leverages data from claims and mediations to enhance patient safety system-wide. For example, a thematic review of 101 suicide-related claims revealed recurring failures: poor family communication, flawed risk assessments, and inconsistent monitoring.³⁴ These insights informed recommendations to prevent future harm. Thus, the mediation scheme not only resolves disputes but also functions as a critical mechanism for quality improvement and risk management. India is ideally suited for the NHS model. Similar to the public health sector in India, the NHS experiences scale and resource restrictions as a sizable, publicly financed healthcare system. The NHS Resolution programme offers a tried-and-true model for setting up a sizable, institutionalised mediation service that can effectively and amicably manage a huge number of claims. It proves that mediation can be effectively included in a public healthcare system not just as an “alternative” but also as the main and preferred means of resolving disputes.

In the 1980s, the United States pioneered the use of mediation in medical malpractice cases.³⁵ The American Health Law Association (AHLA) provides robust ethical guidelines for mediators, which could serve as a model for developing professional standards in India. Spain has legally regulated mediation in civil and commercial matters and, since 3 April 2025, has required parties to most civil and commercial disputes to attempt an appropriate means of dispute resolution, of which mediation is one, before a claim is admitted. This reflects a growing international consensus on the value of front-loading dispute resolution with a collaborative process. The Spanish approach sees mediation as a mechanism to protect the doctor-patient relationship and avoid the personal and economic costs of litigation.³⁶

Australia and Canada are the other countries to have been researched. These countries have led the way in creating integrated juvenile healthcare services and community-based mental health initiatives. They provide comprehensive mediation training and certification programmes, including courses specifically designed to address family and community conflicts. Their emphasis on community-level, non-adversarial treatments offers a wealth of best practices for

³³ CENTRE FOR EFFECTIVE DISPUTE RESOLUTION, *National Health Service Mediation Scheme: Case Study 2* (2019), <https://web.archive.org/web/20221022151119/https://www.cedr.com/wp-content/uploads/2019/10/NHS-case-study-2.pdf>.

³⁴ NHS RESOLUTION, *Learning from Suicide-Related Claims: A Thematic Review of NHS Resolution Data* (Sept. 2018), <https://resolution.nhs.uk/resources/learning-from-suicide-related-claims/>.

³⁵ Lee & Lai, *supra* note 1, at 560.

³⁶ Pilar Munuera Gómez & Immaculada Armadans Tremolosa, *Health Mediation as an Alternative Means of Conflict Resolution in the Practice of Medicine in Turbulent Times: An Update*, 162 MEDICINA CLÍNICA (ENGLISH EDITION) 29 (2024), <https://doi.org/10.1016/j.medcle.2023.07.016>; see now Ley Orgánica 1/2025, de 2 de enero, de medidas en materia de eficiencia del Servicio Público de Justicia, art. 5 (B.O.E. 2025, 3) (Spain), <https://www.boe.es/eli/es/lo/2025/01/02/1/con>.

creating a supportive mediation ecosystem in India, even if precise data on patient-provider mediation programmes is less centralised than in the UK.³⁷

VI. CONCLUSION AND RECOMMENDATIONS

The analysis reveals a clear and compelling case for integrating mediation into India's mental healthcare system. The existing legal framework is characterised by a significant disconnect: the Mental Healthcare Act, 2017, provides progressive rights but an adversarial redressal mechanism, while the Mediation Act, 2023, provides a collaborative process but lacks the necessary specialisation and contains problematic exclusions. To bridge this gap and create a truly rights-based, therapeutic system of dispute resolution, a multi-pronged approach involving legislative reform, policy direction, and institutional capacity-building is required.

It is neither practical nor required to completely replace the 'Mental Health Review Board' (MHRB) framework. The most practical and efficient course of action is to use a hybrid model that incorporates mediation as a required initial step inside the current MHRB framework. A complaint lodged with an MHRB under Section 28 of the MHCA would automatically be submitted for mediation under this proposed model before the start of any official adjudicatory processes. A minimum of one mediation session with a qualified and certified healthcare mediator would be necessary for the parties to attend. The further course of action would be determined by the outcome of this session. A Mediated Settlement Agreement (MSA) would be signed by the parties if mediation was successful. According to the Mediation Act, 2023, this MSA would be enforced as a court order and have legal power behind it. The MHRB's only responsibility would be to document the settlement and end the case. If mediation fails or is judged inappropriate, the mediator would file a report of non-settlement if the parties are unable to agree following a sincere attempt at mediation, or if the mediator decides that the case is inappropriate for mediation (for example, because of an unmanageable power imbalance, doubts about a party's capacity to consent, or proof of outstanding misconduct that calls for formal investigation). The complaint would then be sent to the MHRB for a formal adjudicatory hearing. The advantages of both methods are used in this tiered approach. With a collaborative, non-adversarial method better suited to the nature of healthcare issues, it frontloads the dispute resolution process and can settle the great majority of cases quickly and peacefully. It guarantees that the right to adjudication is not terminated by maintaining the MHRB as a last-resort venue for unresolvable conflicts or matters needing a formal verdict.

³⁷ Hila Tuaf & Hod Orkibi, *Community-Based Programs for Youth with Mental Health Conditions: A Scoping Review and Practical Implications*, 11 FRONT. PUBLIC HEALTH 1241469 (2023), <https://www.frontiersin.org/journals/public-health/articles/10.3389/fpubh.2023.1241469/full>.

To enable this hybrid model and create a robust legal ecosystem for healthcare mediation, the following policy and legislative actions are recommended:

1. **Legislative Amendments:** Amend the Mental Healthcare Act, 2017, so that the obligatory first-step mediation procedure described above is expressly included in the regulations governing the operation of MHRBs. The process for referring someone to mediation, choosing mediators, and the MSA's legal standing might all be covered in a new section. Then, amend the First Schedule to the Mediation Act, 2023. Item 2 of that Schedule excludes from mediation disputes relating to claims against persons with mental illness. This does not reach a grievance brought by a patient, but it does exclude any dispute in which a claim is made against the patient, and it should be replaced with a more nuanced provision that allows for mediation with appropriate safeguards, such as the mandatory presence of a nominated representative or support person and the use of mediators with specialised training in mental health.
2. **Institutional Support and Specialisation:** Policy frameworks should promote the creation of in-house mediation cells in both public and private hospitals to address patient grievances promptly and prevent escalation. Additionally, the Mediation Council of India (MCI) should establish a dedicated healthcare mediation wing tasked with formulating ethical guidelines, practice standards, and specialised training programmes, drawing on international models such as the American Health Law Association (AHLA).
3. **Creation of Specialised Mediator Training:** The MCI is required to create and accredit a specialised training and certification programme for healthcare mediators in partnership with the National Medical Commission, top law schools, and mental health specialists. In addition to general mediation skills, this curriculum has to provide lessons on patient rights under the MHCA, 2017 legal framework, the doctor-patient interaction and medical ethics, the basics of mental health issues, and approaches for de-escalation and communication that are informed by trauma.
4. **Public Awareness and Cultural Change:** The cultural predilection for litigation and a lack of knowledge about the advantages of alternative dispute resolution (ADR) pose a serious obstacle to mediation. To inform patients, their families, and medical professionals about mediation as a positive, private, and powerful alternative to going to court, a national awareness campaign backed by the government and civil society is required.

5. **Empowering Civil Society and NGOs:** As important participants in the implementation process, NGOs should be publicly acknowledged and partnered with by the government and the MCI. NGOs can be hired to provide community-level training and awareness campaigns, assist and advocate for patients, and mediate disputes. It will be essential to give these organisations financial and institutional assistance to establish a decentralised, easily accessible mediation ecology that targets the most disadvantaged groups.

By adopting this comprehensive and integrated approach, India can move beyond a fragmented and philosophically inconsistent legal framework. It can build a system of dispute resolution for mental healthcare that is not only more efficient and cost-effective but is also more humane, therapeutic, and truly aligned with the principles of dignity, autonomy, and justice that lie at the heart of the Mental Healthcare Act, 2017.
