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REVIEW

The Mental Healthcare Act 2017 and rights of persons with mental illness in India: a doctrinal and policy review

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Abstract

The Mental Healthcare Act 2017 (MHCA 2017) represents a paradigmatic change in India's response to mental health, moving from a primarily custodial model toward a human rights-based framework aligned with international standards, especially the UN Convention on the Rights of Persons with Disabilities (CRPD). This article provides a doctrinal and policy review of MHCA 2017 with particular emphasis on the rights of persons with mental illness (PwMI) and the practical challenges involved in translating these rights into everyday mental healthcare practice. Drawing on primary legislation, policy documents, and secondary literature, the paper traces the historical evolution of mental health law in India, analyzes the key mental healthcare-related rights and entitlements created under the MHCA 2017, and evaluates the extent to which the Act advances India's obligations under the CRPD. To avoid repetition of the statutory scheme, the article does not discuss every provision of the Act in equal detail; instead, it focuses on those rights and mechanisms most relevant to implementation, including access to mental healthcare, informed consent, advance directives, nominated representatives, community living, and Mental Health Review Boards (MHRBs). The analysis highlights that although the Act is progressive in its normative design, its implementation is constrained by inadequate public funding, shortage of trained mental health professionals, weak community-based services, uneven functioning of review boards, limited awareness among patients and families, and persistent stigma. Practice-level difficulties include delayed access to care, limited use of advance directives, uncertainty in documenting capacity and consent, family-dominated decision-making, lack of rehabilitation options after discharge, and difficulties in ensuring rights-based care in resource-constrained settings. The paper concludes that while MHCA 2017 creates a robust normative legal framework, its transformative potential remains under-realized without sustained investment, inter-sectoral coordination, and systematic monitoring. It offers targeted recommendations to strengthen implementation and better safeguard the rights and dignity of PwMI in India.

Keywords: Mental Healthcare Act 2017, persons with mental illness, human rights, mental health law, India, implementation challenges

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Introduction

In India, mental health problems constitute a major public health and human rights concern. The World Health Organization has reported that disability-adjusted life years due to mental health problems are 2,443 per 100,000 population, while the age-adjusted suicide rate is 21.1 per 100,000 population (1). A severe shortage of mental health professionals, low awareness, persistent stigma, and limited availability of community-based services contribute to an estimated treatment gap of 70–92% (2). Thus, the challenge is not only the legal recognition of mental health rights but also their effective translation into accessible, affordable, and rights-based care in everyday practice.

Mental health legislation in India has historically reflected changing social, medical, and legal attitudes toward persons with mental illness (PwMI). Early colonial laws, beginning with the Indian Lunacy Act of 1858 and related enactments, were largely custodial in character and focused on confinement, institutional control, and administrative management rather than treatment, autonomy, or rights (3). The Indian Lunacy Act of 1912 continued this institutional orientation, although it introduced a more formal administrative framework for mental hospitals (4). The Mental Health Act 1987, which came into effect in 1993, marked a gradual shift from a purely custodial approach toward a medical model of care (5). However, even this legislation remained limited in its rights-based orientation and did not adequately address autonomy, informed consent, community living, access to services, or accountability in mental healthcare delivery. The Mental Healthcare Act 2017 (MHCA 2017) therefore represents a significant legislative departure by recognizing mental healthcare as a statutory right, decriminalizing attempted suicide, and introducing mechanisms such as advance directives, nominated representatives, and Mental Health Review Boards (MHRBs) in alignment with international human rights standards (6).

Evidence from the National Mental Health Survey 2016 further underscores the urgency of strengthening mental healthcare in India. The survey reported a substantial burden of mental morbidity, with approximately 11% of the adult population affected (7). Anxiety and depressive disorders are major contributors, particularly among young adults aged 15–29 years, while the prevalence of mental health problems is also high among persons aged 60 years and above (8). Poor mental health has consequences beyond psychiatric morbidity; it affects physical health, family functioning, productivity, social participation, and suicide risk (9). The COVID-19 pandemic further intensified psychological distress and increased the demand for mental health support (10). Despite this burden, access to timely and quality mental healthcare remains uneven. In routine practice, patients and families often face long travel distances, high out-of-pocket expenditure, limited availability of specialists, lack of rehabilitation services, and poor awareness of available legal rights and entitlements. Mental health services are more visible in urban areas, yet rural and underserved communities continue to experience major gaps in access, continuity of care, and follow-up support (11, 12). These realities show that a rights-based law cannot be evaluated only by its statutory provisions; it must also be assessed by how effectively those provisions operate within India's resource-constrained health system.

Against this backdrop, the MHCA 2017 represents a major legislative milestone in India's efforts to move toward a rights-based and person-centered mental health system. At the same time, the Act raises important practical questions regarding implementation. For example, the right to access mental healthcare depends on the actual availability of affordable services; advance directives and nominated representatives require awareness and procedural clarity; MHRBs require adequate constitution and functioning; and the right to community living requires rehabilitation, housing, family support, and inter-sectoral coordination. Therefore, this review examines the MHCA 2017 not merely as a legal text but as a policy instrument whose success depends on implementation in clinical, institutional, and community settings.

This review aims to:

(i) Describe the objectives and key rights-based provisions of the MHCA 2017;

(ii) Explore the extent to which the Act protects the rights and dignity of PwMI and aligns with global and constitutional standards for mental health legislation;

(iii) Critically analyze practical, institutional, and policy-level barriers in implementing the Act; and

(iv) Suggest measures to strengthen rights-based mental healthcare delivery in India.

Overview of the MHCA 2017

The MHCA 2017 was notified on 7 April 2017 and subsequently brought into force on 29 May 2018, following approval by the President of India (13). The Act is divided into sixteen chapters and one hundred and twenty-six sections, and it emphasizes the dignity, autonomy, and rights of PwMI (14). It represents a major shift toward a rights-based approach and is broadly aligned with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), 2007 (15). For the purpose of this doctrinal and policy review, the Act is not discussed merely as a sequence of statutory provisions but as a legal framework whose effectiveness depends on how far its rights-based guarantees can be translated into mental healthcare practice.

The Act was introduced to protect the rights of PwMI. These include the right to access mental healthcare,

the right to dignity and non-discrimination, the right to confidentiality and privacy, the right to live in the community, the right to free mental healthcare for those who are homeless or below the poverty line and who are covered under notified schemes, and the right to receive information about one's treatment. The Act also aims to ensure access to quality care, promote community-based mental health services, and provide legal safeguards against abuse, neglect, and discrimination. However, these rights require more than statutory recognition. Their implementation depends on the availability of services, trained professionals, functioning review mechanisms, patient and family awareness, and coordination between health, social welfare, disability, and legal systems.

As per the Act, mental healthcare includes the diagnosis, treatment, and management of a person with mental illness, as well as counseling, support, rehabilitation, and promotion of mental well-being. A "mental health establishment" refers to any healthcare facility, including those practicing the Indian systems of medicine, that provides mental health services. In India, healthcare delivery follows a tiered system, where primary care is provided through sub-centers, primary health centers, and community health centers; secondary care is offered at district and sub-district hospitals; and tertiary care is delivered through medical colleges, speciality hospitals, and apex mental health institutes.

A major contribution of the MHCA 2017 is the recognition of autonomy and supported decision-making through mechanisms such as advance directives and nominated representatives. These provisions are intended to allow PwMI to participate meaningfully in decisions about their treatment and care. Yet, their real-world use remains limited in many settings because patients and families may be unaware of these options, professionals may be uncertain about documentation and legal procedures, and emergency care situations may create tension between immediate clinical decision-making and formal rights-based safeguards. Similarly, the creation of MHRBs provides an important procedural safeguard, particularly in relation to supported admissions, review of advance directives, and protection of rights. However, the effectiveness of these Boards depends on timely constitution, adequate staffing, accessibility to patients and families, regular sittings, and awareness among mental health professionals about when and how to refer matters for review.

Implementing the MHCA 2017 in a highly populated and diverse country such as India involves significant practical challenges. An estimated 70–92% of people with mental illness continue to face difficulties in receiving appropriate treatment because of lack of awareness, stigma, shortage of trained mental health professionals, inadequate infrastructure, and limited access to affordable services (2). These resource constraints restrict not only treatment availability but also rights-based implementation, including awareness programs, training of healthcare workers, documentation of consent and capacity, rehabilitation planning, and monitoring of mental health establishments. Thus, the implementation gap is not confined to tertiary psychiatric institutions; it is visible across the continuum of care, from early identification at the primary care level to emergency management, inpatient admission, discharge planning, family reintegration, and long-term community support.

Supplementary Table 1 provides a chapter-wise summary of the statutory focus and practical relevance of the MHCA 2017. To avoid repetition, the present section does not restate each chapter in detail. Instead, it highlights those components of the Act that are most important for understanding the gap between legal rights and implementation: access to mental healthcare, autonomy and decision-making, regulation of mental health establishments, MHRBs, admission and discharge procedures, protection from abuse and restrictive practices, and government duties in service delivery. Chapters dealing with advance directives, nominated representatives, rights of PwMI, government responsibilities, regulatory authorities, review boards, admission procedures, and safeguards against abuse collectively show the Act's ambition to transform mental healthcare from a custodial and institution-centered model to a rights-based and community-oriented system. The central policy question, however, is whether the health system has sufficient resources, workforce capacity, institutional preparedness, and accountability mechanisms to realize these statutory promises in routine practice.

Rights and protection-based approach in the MHCA, 2017

The MHCA 2017 takes a rights-based approach, focusing on protecting the dignity, autonomy, and equality of PwMI throughout their care journey.

Instead of viewing them as passive patients, the Act treats them as individuals with rights—people whose preferences, privacy, and participation in decisions about their own treatment must be respected. These rights broadly fall into four key areas: access to care and community living, autonomy and supported decision-making, dignity and non-discrimination, and protection from abuse, neglect, or restrictive practices.

At its core, the Act guarantees everyone the right to affordable, quality mental healthcare, including services provided or funded by the government. It also upholds the right to live in the community, maintain confidentiality and privacy, receive clear information about one's diagnosis and treatment, and be protected from cruel, inhuman, or degrading practices.

These provisions are important because they shift mental healthcare away from mere institutional custody and place a

clear responsibility on the state to build accessible, humane, and community-based services.

Protection against discrimination

The MHCA 2017 strongly emphasizes non-discrimination. It ensures that PwMI are not discriminated against on grounds of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, or disability.

The Act guarantees equal access to mental healthcare services—primarily through Section 18, read with the rights provisions in Sections 20 and 21—and upholds dignity in living conditions. This includes the right to wear one's own clothes (Section 20(2)(j)). It further provides access to housing, social support, legal services, recreation, education, religious practices, employment, and other essential community-based resources through several rights-based provisions, notably Sections 18, 19, 20, and 27.

Importantly, Section 19(2) explicitly states that no person should be segregated, excluded, or admitted to a mental health establishment solely because they are homeless, lack family support, or have been rejected by their family. This provision strongly affirms their right to live with dignity in the community.

Protection from any form of abuse

The MHCA 2017 offers strong safeguards to protect PwMI from all forms of abuse. It explicitly prohibits cruel, inhuman, or degrading treatment (Section 20) and ensures protection from physical, verbal, emotional, and sexual abuse inside mental health establishments (Section 20(2)(k)).

The Act completely bans chaining in any form. It also prohibits unmodified electroconvulsive therapy (ECT without anesthesia and muscle relaxants) and ECT for minors (with a limited exception requiring guardian consent and prior approval of the MHRB). Psychosurgery is not absolutely banned but is strictly regulated with additional safeguards and consent requirements (Sections 95 and 96).

Physical restraints are permitted only in emergencies and only when they are the least restrictive option to prevent imminent harm to the person or others. The nominated representative must be informed about every instance of restraint within 24 hours, and periodic reporting is mandatory to prevent misuse (Section 97).

Independent (voluntary) admission

The MHCA 2017 promotes independent admission (commonly referred to as voluntary admission) as the preferred and default option. It allows a person with mental illness to be admitted if they have the capacity to make decisions about their mental healthcare and treatment or need only minimal support in doing so (Section 85).

For adults, admission is based on the individual's own informed request and consent (Section 86). Supported admission is permitted only when independent admission is not possible and the specific criteria for supported admission are met (Sections 89 and 90).

An independent patient is expected to follow the rules and regulations of the mental health establishment. They also have the right to request discharge at any time. The establishment must honor this request promptly, except in limited situations—for instance, when there appears to be a significant risk of harm to self or others, in which case the person may be held for up to 24 hours for assessment to determine if supported admission is needed (Section 88).

For minors, admission can only occur on an application by the nominated representative (usually a parent or guardian) and after independent assessments by two qualified mental health professionals (Section 87). If the nominated representative of a minor girl is male, the law requires the appointment of a female attendant during her stay in the establishment (Section 87).

Supported admission

Under the MHCA 2017, supported admission (often referred to as involuntary admission) is not permitted merely because a person has a mental illness. It is allowed only when the person lacks capacity—or has substantially impaired capacity—to make decisions about their mental healthcare and treatment and meets the specific clinical and risk criteria laid down in the Act (Section 89).

In such cases, the nominated representative makes an application for admission. The person is then independently examined by a psychiatrist and another mental health professional (or medical practitioner), who must both conclude that the mental illness is of such severity that the person poses a risk of harm to self or others or is unable to care for themselves to a degree that places them at serious risk.

A person admitted under supported admission cannot be treated as an independent patient, as they require high levels of support from their nominated representative in decision-making (Section 89).

An independently admitted (voluntary) patient who later wishes to leave can be held for up to 24 hours if the mental health professional believes they may cause serious harm to themselves or others or are unable to care for themselves. This short hold allows time for assessment to determine whether supported admission is needed (Section 88).

All supported admissions must be reported to the MHRB within 3 days for women and minors and within 7 days

for other adults. The Board reviews these admissions within prescribed timelines to ensure they remain justified.

Emergency treatment

The Act also allows emergency treatment without prior informed consent when it is immediately necessary to prevent death, irreversible harm to health, serious harm to self or others, or serious damage to property—provided the behavior flows directly from the mental illness. Such treatment is strictly time-limited and subject to safeguards (Section 94).

Changing from supported to independent admission

A person admitted under supported admission can shift to independent admission status once they regain the capacity to make decisions about their mental healthcare and treatment.

When the person is able to understand their condition and meaningfully participate in treatment decisions—and no longer meets the criteria for supported admission—their status should be reviewed promptly and converted to independent admission under Section 86.

Protection of minors under the MHCA 2017

The MHCA 2017 includes special safeguards for children and adolescents with mental illness.

A minor can be admitted to a mental health establishment only on an application by their nominated representative (usually a parent or guardian) (Section 87). To prevent misuse, the law requires that two mental health professionals—typically one psychiatrist and another mental health professional or registered medical practitioner—independently examine the minor (on the day of admission or within the previous 7 days). Both must certify in writing that:

- The minor has a mental illness severe enough to require admission,
- Admission is in the minor's best interests (considering their health, safety, and wishes where possible), and
- Less restrictive community-based options are not adequate.

The MHRB must be informed of every minor's admission within 72 hours. Once admitted, the child must be accommodated in a separate, child-friendly environment away from adults. If the nominated representative of a minor girl is male, a female attendant must be appointed.

Minors also continue to enjoy the general rights under the Act, including the right to education during treatment (Section 20). The Act strictly regulates certain procedures: unmodified ECT without anesthesia and muscle relaxants is prohibited for everyone, and ECT for minors is generally not allowed except in exceptional cases with informed consent of the guardian and prior approval of the MHRB (Section 95). Additionally, children are protected from all forms of physical, verbal, emotional, and sexual abuse within mental health establishments (Section 20(2)(k)).

Rights of persons with mental illness

Chapter V of the MHCA 2017 clearly lays down the rights of PwMI. These rights form the foundation of the Act and apply across all aspects of care.

Every person with mental illness has the right to access quality mental healthcare without discrimination on grounds of gender, sex, sexual orientation, religion, culture, caste, class, disability, or any other status (Section 18).

They also have the right to live in the community and cannot be segregated or excluded solely because of their mental illness or lack of family support (Section 19).

The Act guarantees protection from cruel, inhuman, or degrading treatment, including physical, verbal, emotional, and sexual abuse within mental health establishments (Section 20). It further upholds the right to equality and non-discrimination in all matters relating to mental healthcare (Section 21).

Other important rights include:

- The right to receive clear information about one's diagnosis, treatment, and care in a language and manner the person can understand (Section 22).
- The right to confidentiality and privacy of personal and medical information (Section 23).
- The right to make an advance directive regarding future treatment preferences (Section 5).
- The right to appoint a nominated representative to assist in decision-making when needed (Section 14).

Right to privacy and dignity

The MHCA 2017 recognizes privacy and dignity as fundamental rights for PwMI.

The Act guarantees the right to live in safe, clean, and respectful conditions. It protects privacy during all aspects of treatment and ensures strict confidentiality of personal information and medical records (Section 20 read with Sections 22 and 23).

Every person has the right to wear their own clothes (Section 20(2)(j)) and to be provided with adequate, nutritious food, clean sanitation facilities, sufficient living space, and basic personal hygiene items. Special provisions are made for women during menstruation to ensure comfort and dignity (Section 20(2)(h)).

The Act strictly prohibits forced labor in mental health establishments. If a person chooses to work voluntarily, they must receive fair wages in accordance with minimum wage laws (Section 20(2)(f)).

Additionally, every person has the right to access and inspect their own medical records (Section 25).

Right to informed consent

The MHCA 2017 strongly emphasizes the right to informed consent in all mental healthcare decisions.

An independent patient cannot be given any treatment without their informed consent. They have the full right to accept or refuse treatment (Section 86(5)). They can also seek admission to a mental health establishment on their own, without needing approval from family members or their nominated representative (Section 86(6)).

If an independent patient later loses the capacity to make decisions about their care, the medical officer must seek consent from the nominated representative, and the process shifts to supported admission as per the Act (Section 89).

For minors, treatment can only be provided with the informed consent of the nominated representative (Section 87(7)).

Even during supported admission, the Act requires that treatment should respect the person's wishes to the greatest extent possible. Treatment must be guided by any valid advance directive or given with the person's informed consent, supported by their nominated representative (Section 90(11)).

This framework ensures that every person with mental illness retains as much control as possible over decisions about their own treatment, even when they need high levels of support.

Right to quality and standard treatment

The MHCA 2017 places strong emphasis on the right to quality mental healthcare that is available, accessible, affordable, and acceptable.

The government is responsible for ensuring that good-quality mental health services are provided across the country (Section 18). Every mental health establishment must be registered under the Act and is required to prominently display its registration certificate (Section 70).

The Act lays down clear minimum standards for facilities and services. These include daily cleaning and disinfection of all areas (including toilets and bathrooms), adequate and separate toilets and bathrooms for male and female patients, proper disposal of sanitary napkins, sufficient water supply, regular cleaning of linen, pest control, and safe disposal of biomedical waste.

To promote transparency, the Central or State Mental Health Authority must maintain a publicly accessible digital list of all registered mental health establishments (Section 71). In addition, every mental health establishment is required to prominently display the contact details of the concerned MHRB and provide free access to complaint forms and telephone facilities. This makes it easy for patients or their families to request a review of admission or treatment (Section 72).

Implementation challenges and gaps

The MHCA 2017 signifies a considerable paradigmatic shift toward a rights-based approach within the Indian mental healthcare system; however, the Act's implementation warrants careful evaluation and scrutiny (6). In routine clinical practice, several implementation difficulties are commonly encountered, primarily because the right to access mental healthcare is frequently limited by the uneven distribution of services. Many districts continue to depend on a small number of psychiatrists or tertiary centers, while primary care facilities often lack adequate training, essential medicines, and psychosocial support. From a service-delivery perspective, the challenge is not merely legal awareness but the absence of operational pathways; for a person in crisis, a legal right to treatment may exist, but the nearest functional service often remains geographically or financially inaccessible.

Field-level experience suggests that implementation is further shaped by the practical limitations of rights-affirming provisions such as advance directives. In our clinical experience, patients and families are often unaware of these provisions, and discussions about these rights rarely occur unless actively initiated by clinicians. In busy outpatient settings, the documentation of treatment preferences is frequently perceived as a secondary administrative burden, especially when clear institutional protocols are absent. Furthermore, the nominated representative mechanism, intended to support decision-making, faces unique complexities within the Indian family structure.

Practice-based observations indicate that while families play a central role in care and supervision, significant ethical tensions arise when a patient's preference diverges from family expectations or when a representative is overburdened, leaving clinicians to navigate a difficult balance between autonomy, safety, and family involvement.

The practical enforceability of rights is also weakened by the inconsistent presence and administrative capacity of MHRBs. In practice, patients and families may not know how to approach the Board and clinicians frequently experience delays or a lack of clarity regarding documentation and review procedures. This is particularly evident during emergency presentations in crowded casualty departments. Without regular training and standard operating procedures, clinicians must make rapid decisions about risk and capacity, which can lead to a risk of either excessive caution—resulting in delayed care—or overly defensive admission practices.

Ultimately, the gap between legal deinstitutionalization and actual social reintegration remains a significant hurdle. The right to community living cannot be realized through hospital-based services alone; it requires a robust network of supported housing, vocational rehabilitation, and social welfare linkages. Where these are absent, discharge from the hospital does not translate into genuine community inclusion. Resource limitations, persistent social stigma, and inadequate inter-sectoral coordination between health, legal aid, and housing systems frequently impede the practical realization of rights. Consequently, a significant disparity persists between the legal guarantees enshrined within the Act and the everyday experiences of PwMI and their families.

Implications for clinical practice

For psychiatrists and other mental health professionals practicing in India, the MHCA 2017 requires a decisive shift away from a predominantly paternalistic model—where clinicians act in what they perceive to be the patient's "best interests"—toward a rights-based model grounded in autonomy and informed consent (16). Within this framework, the rights of the individual are central, and clinicians are expected to discuss clinical options transparently, support the patient's understanding, and respect their choices to the greatest extent possible. Practice-based observations indicate that this transition requires moving away from global assumptions of incapacity toward nuanced, point-in-time assessments that honor the patient's voice even during periods of significant distress.

The Act translates this philosophy into concrete clinical obligations, requiring the routine assessment and meticulous documentation of decision-making capacity at admission and at key points throughout care. In our clinical experience, this means that advance directives should be actively discussed and reviewed during treatment planning rather than viewed as a static administrative requirement. When a patient's decision-making capacity is impaired, the nominated representative must be involved in a manner consistent with the person's prior preferences and the best interpretation of their will and wishes. Throughout, clinicians must pay meticulous attention to conditions of care, including privacy, dignity, and non-discrimination.

To implement these requirements in everyday practice, mental health services need sustained training in capacity assessment and supported decision-making. Ultimately, close collaboration with legal services, social work teams, and community-based agencies is essential to ensure that clinical practice is not only therapeutically effective but also ethically robust and legally compliant.

Recommendations

Effective implementation of the MHCA 2017 requires moving beyond the recognition of rights to practical, everyday mechanisms that work on the ground.

- Develop simple, standardized operating procedures in all mental health establishments for key processes such as capacity assessment, supported admission, advance directives, nominated representatives, confidentiality, and referrals to MHRBs.
- Provide regular, practical training to psychiatrists, medical officers, nurses, psychologists, social workers, police personnel, and primary care providers on rights-based care, with special emphasis on objective capacity assessment. Parallel training for caregivers on patient rights is equally important.
- Display information about patient rights prominently in local languages across outpatient departments, inpatient wards, emergency services, and community clinics.
- Strengthen the functioning of MHRBs by ensuring clear contact details, time-bound review processes, and simple, patient-friendly complaint mechanisms.
- Expand and strengthen district-level mental health services with adequate availability of essential medicines, crisis intervention, rehabilitation, supported housing linkages, and robust follow-up systems.
- Promote intersectoral collaboration between health, social welfare, housing, education, labour, and legal services to support community living and social inclusion of PwMI.
- Allocate adequate and sustained budgets based on proper needs assessment and econometric analysis to reduce treatment gaps and ensure equitable access, especially in underserved states and districts.
- Establish robust systems for routine data collection and public reporting on key indicators—including access to care, use of coercive practices, functioning of Review

Boards, availability of medicines, and financing—to enable continuous monitoring and accountability.

Targeted research on implementation challenges, culturally adapted tools for capacity assessment and supported decision-making, and the effectiveness of community-based services should also be prioritized to inform future amendments and guidelines.

Future directions for policy and research

Despite the progressive framework of the MHCA 2017, there remains very limited econometric and policy research on its actual implementation and impact at national and state levels.

A recent study on funding trends for the District Mental Health Program (DMHP) presented a mixed picture: while the enactment of the Act was associated with higher average national approvals, it also coincided with a slowing growth trajectory and persistent cross-state inequalities in mental health financing (17). Rather than triggering sustained acceleration, the MHCA 2017 appears to have stabilized funding at a higher level.

This highlights the urgent need for stronger institutional mechanisms—such as transparent allocation formulas, regular monitoring of fund disbursement and expenditure, and targeted support for lagging states—so that the rights promised in the Act are backed by equitable and reliable financing on the ground.

More broadly, there is a pressing need for rigorous, ongoing evaluation of the MHCA 2017's effects on access, coercion, and quality of care across different states. Equally important is research on culturally adapted capacity assessment tools, practical models of supported decision-making in low-resource settings, and the real-world effectiveness of community-based services.

Such evidence will be crucial to guide future amendments, rules, and guidelines, ensuring the law better reflects the lived realities of PwMI and their caregivers.

Conclusion

The MHCA, 2017, represents a significant shift towards a rights-based framework for mental healthcare in India. By codifying entitlements to access, quality, dignity, and protection from inhuman and degrading treatment and by introducing instruments such as advance directives and nominated representatives, the Act seeks to place the autonomy and preferences of PwMI at the center of care. At the same time, emerging evidence on financing and implementation suggests that, while the Act has helped stabilize mental health funding at a higher level, it has not yet overcome deep cross-state inequalities nor fully translated legal rights into everyday practice. Bridging this gap will require sustained investment in services, robust institutional mechanisms that link legal entitlements to resources, and a concerted focus on training, supervision, and accountability. Ultimately, the promise of the MHCA 2017 will be realized only if its principles are embedded in routine clinical work and supported by equitable, adequately funded community-based systems so that the rights it guarantees are experienced as tangible improvements in the lives of PwMI and their families.

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