



INTERNATIONAL LAW  
JOURNAL

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**WHITE BLACK  
LEGAL LAW  
JOURNAL  
ISSN: 2581-  
8503**

*Peer - Reviewed & Refereed Journal*

The Law Journal strives to provide a platform for discussion of International as well as National Developments in the Field of Law.

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WHITE BLACK LEGAL is an open access, peer-reviewed and refereed journal provide dedicated to express views on topical legal issues, thereby generating a cross current of ideas on emerging matters. This platform shall also ignite the initiative and desire of young law students to contribute in the field of law. The erudite response of legal luminaries shall be solicited to enable readers to explore challenges that lie before law makers, lawyers and the society at large, in the event of the ever changing social, economic and technological scenario.

With this thought, we hereby present to you

# **LAWS AND POLICIES SURROUNDING INVOLUNTARY ADMISSION AND TREATMENT OF PERSONS WITH MENTAL DISABILITY AND IMPLICATIONS FOR THE RIGHT AND DIGNITY**

AUTHORED BY - DR. NITYA NAND PANDEY<sup>1</sup>  
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## **Abstract:**

This study examines the evolution of India's mental health legislation, focusing on involuntary admission and treatment provisions and their impact on the rights and dignity of persons with mental disabilities. Using an analytical and exploratory methodology that combines doctrinal legal research with comparative legislative analysis, the research traces the development from the colonial Indian Lunacy Act 1912 through the Mental Health Act 1987 to the current Mental Health Care Act 2017.

The study shows a major problem in India's laws: while progressive rights-based reforms were intended to protect vulnerable individuals, they have inadvertently created significant barriers to emergency psychiatric care. The study demonstrates how Section 19 of the Mental Health Act 1987 originally bridged the gap between legal formalism and clinical reality by allowing psychiatric hospitals to admit patients for assessment without cumbersome magistrate orders. However, the Mental Health Care Act 2017, despite introducing beneficial elements like rights-based approaches and advance directives, presents implementation challenges through restrictive admission thresholds requiring "substantial disorder with gross impairments" and rigid advance directive requirements that remain binding even during emergencies.

The research highlights a deeper tension between Western individualistic approaches, emphasising personal autonomy and traditional Indian family-centred healthcare decision-making. Resource limitations, including shortages of mental health professionals and infrastructure, further complicate emergency implementation. Through detailed examination of practical implications, the study identifies specific scenarios where legal provisions may

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inadvertently prevent access to necessary care, including situations involving voluntary patients seeking discharge, emergency interventions, and treatment of minors. The findings suggest that automatic review requirements create administrative burdens while exposing healthcare providers to retrospective legal liability. The study concludes that well-intentioned legal reforms have created unintended consequences that may undermine access to critical mental health services, particularly during emergencies, potentially harming the very individuals these laws seek to protect.

**Key words:** involuntary treatment, advance directives, involuntary admission, psychiatric hospitals, mental disability

### **Introduction:**

The WHO defines health as complete physical, mental, and social well-being, not just the absence of illness. True health requires working together all three components—body, mind, and social function.<sup>3</sup> Mental health extends beyond the absence of mental illness. It's defined as a state where individuals realise their abilities, manage daily stress, work productively, and contribute to their community. This means mental health involves reaching your potential, handling everyday challenges, engaging in meaningful work, and participating in community life. Mental health is fundamental to how we live, affecting our thinking, emotions, relationships, work, and happiness. This makes mental health care—promotion, protection, and recovery—essential for individuals, families, and communities worldwide.<sup>4</sup>

### **Understanding Disability:**

The WHO defines disability as "an umbrella term covering impairments, activity limitations, and participation restrictions." This includes problems with body or mind function, difficulties performing tasks, and challenges participating fully in life situations. Disability results from how a person's characteristics interact with their environment, often involving societal barriers that limit people with different abilities.<sup>5</sup>

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<sup>3</sup> WHO, *Mental health*, mental health overview (June 17, 2022), <https://www.who.int/news-room/factsheets/detail/mental-health-strengthening-our-response>.

<sup>4</sup> WHO, *Mental Health*, <https://www.who.int/india/health-topics/mental-health#:~:text=WHO%20estimates%20that%20the%20burden,estimated%20at%20USD%201.03%20trillion>. (last visited June 27, 2025).

<sup>5</sup> *disability definition*, disability definition (Oct. 8, 2018), <https://www.punarbhava.in/index.php/disability-register/what-is-disability>.

## **Types of Disabilities Recognised in India**

India's 2016 Rights of Persons with Disabilities Act recognises 21 disability types, ensuring access to government support.<sup>6</sup> These include:

- Vision and Hearing: Blindness, low vision, deafness, and hearing difficulties.
- Physical and Movement: Locomotor disability, dwarfism, cerebral palsy, and muscular dystrophy affecting mobility and muscle control.
- Brain and Nervous System: Chronic neurological conditions (Alzheimer's, Parkinson's, epilepsy, stroke effects), multiple sclerosis affecting nerve protection.
- Learning and Thinking: Intellectual disability, mental illness, autism spectrum disorder, and specific learning disabilities affecting communication and cognition.
- Blood and Genetic: Thalassaemia, haemophilia, and sickle cell disease - inherited blood disorders.
- Other Conditions: Leprosy-cured persons, speech disabilities, multiple disabilities, and acid attack victims.

These conditions vary greatly - some remain stable while others progressively worsen. Many are inherited, some lack cures, and progressive conditions often require frequent hospitalisation as they advance.<sup>7</sup>

### **The Role of Psychiatric Hospitals:**

Psychiatric hospitals are specialised facilities that treat severe mental health conditions through various forms of care. Some offer short-term or outpatient programs for lower-risk patients, while others provide long-term residential care for those needing ongoing support or structured environments. While most people voluntarily seek mental health treatment, involuntary hospitalisation may occur when individuals pose serious risks to themselves or others. This forced treatment is a last resort when immediate safety is threatened.

### **Legal Provisions of Mental Health Care Act 2017 Related to Admission, Treatment and Discharge of a Person with Mental Disability.**

Admission of a person with mental illness as an independent patient in a mental health establishment.

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<sup>6</sup> Rights Persons with Disabilities Act, 2016, Act No. (Act No. 4 2018), Apr. 19, 2017, 4 (India), <https://depwd.gov.in/acts/>.

<sup>7</sup> Supreme Handbook Concerning PERSONS WITH DISABILITIES Supreme Court of India 31 (2024), <https://ccpd.nic.in/handbook-concerning-divyangjan-supreme-court-of-india/>.

- **Independent Admission and Treatment (Section 85):** An "independent patient" is someone with mental health challenges who voluntarily seeks treatment because they understand their condition and can make informed care decisions with minimal assistance. Mental health facilities should prioritise independent admission whenever possible, respecting patients' autonomy, and only consider involuntary admission when patients genuinely cannot understand their situation or make safe decisions, making it unavoidable.<sup>8</sup>
- **Independent Patient Admission (Section 86):** Adults recognising mental health struggles can directly request admission to mental health facilities. Medical professionals admit them if their condition requires inpatient care, treatment will help, and they understand admission freely without pressure or needing significant decision-making support. Those unable to understand the treatment purpose and effects or requiring extensive decision-making help cannot be admitted independently. Once admitted, independent patients must follow facility rules but cannot receive treatment without informed consent, don't need family permission for admission, and can generally discharge themselves, preserving their healthcare autonomy.<sup>9</sup>
- **Admission of a minor (Section 87):** Legal guardians must apply for admission when minors need psychiatric hospitalisation. Two mental health professionals must independently confirm the child has a serious condition requiring inpatient care, that hospitalisation serves their best interests, other options are unsuitable, and community support has been exhausted. Children stay in separate, age-appropriate facilities meeting paediatric hospital standards, with guardians or trusted adults present throughout (female attendants required for girls if the guardian is male). Treatment needs guardian consent, and guardians can request discharge anytime. All admissions must be reported to the oversight Board within 72 hours. The Board can visit, interview children, and review records, with mandatory reviews for stays exceeding 30 days and every 30 days thereafter.<sup>10</sup>
- **Discharge of Independent Patients (Section 88):** Adults who voluntarily admitted themselves can leave immediately upon request, and staff must discharge them right away. Minors automatically gain adult independent patient rights when they turn 18

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<sup>8</sup> MENTAL HEALTHCARE ACT, 2017, No. [Act No. 20 2017], Apr. 7, 2017, 33 (India). Mental Healthcare Act, 2017, Act No. 10 Of 2017, Sec. 85.

<sup>9</sup> MENTAL HEALTHCARE ACT, 2017, No. [Act No. 20 2017], Apr. 7, 2017, 34 (India).

<sup>10</sup> Ibid.

while in the facility. However, mental health professionals can delay discharge for up to 24 hours if serious safety concerns exist, when patients can no longer understand decisions and need significant help, have recently threatened self-harm, been violent toward others, or cannot care for themselves safely. During this delay, staff must either transition them to supported admission or discharge them within 24 hours or when the safety assessment is completed, whichever comes first.<sup>11</sup>

- **Supported Admission for People with High Support Needs (Section 89):** When someone has a severe mental health crisis and needs significant decision-making help, they can be admitted for up to 30 days with support from their chosen representative or family. This requires two mental health professionals to independently confirm serious risk (self-harm threats, violence toward others, or inability to self-care safely) and that hospitalisation is the least restrictive option, considering any advance wishes. Treatment decisions involve the person when possible, supported by their representative. If someone needs extensive decision-making help, representatives can temporarily consent to treatment, with weekly reviews of the person's participation ability. Facilities must report admissions to oversight Boards within 3-7 days. Patients, representatives, or advocacy groups can request admission reviews, completed within seven days. Staff continuously monitor whether support levels remain necessary, transitioning to independent status or discharge when appropriate, with safeguards preventing unnecessary readmission.<sup>12</sup>
- **Admission and treatment of persons with mental illness, with high support needs, in mental health establishment, beyond thirty days (supported admission beyond thirty days) (Section 90):** When someone with severe mental health challenges needs hospital care beyond 30 days or readmission within a week of discharge, they can receive extended supported admission with additional oversight. Two psychiatrists must independently confirm consistent patterns of self-harm, violence, or inability to self-care safely, with hospital care being the least restrictive option, considering advance wishes. Facilities report longer admissions to oversight Boards within seven days. Boards have 21 days to review necessity and can require community treatment plans, ensuring people aren't kept in hospitals due to a lack of community services. Initial extended admissions are limited to 90 days, with possible extensions of 120 days,

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<sup>11</sup> MENTAL HEALTHCARE ACT, 2017, No. [Act No. 20 2017], Apr. 7, 2017, 35 (India).

<sup>12</sup> MENTAL HEALTHCARE ACT, 2017, No. [Act No. 20 2017], Apr. 7, 2017, 36 (India).

then 180 days with Board approval. Treatment involves the person, when possible, with representatives providing support or consent when needed. Staff review decision-making capacity every two weeks. Patients, representatives, or advocates can appeal decisions, and discharge occurs when criteria are no longer met, prioritising recovery and community return while ensuring safety and dignity.<sup>13</sup>

- **Leave of Absence (Section 91):** The medical professional in charge can grant temporary leave to patients receiving supported care, allowing time away from the hospital for durations and under conditions deemed beneficial for their well-being and recovery.<sup>14</sup>
- **Absence without Leave or Discharge (Section 92):** If someone required to stay in a mental health facility leaves without permission, police can return them to the facility at medical staff's request to ensure their safety and continued care.<sup>15</sup>
- **Transfer of persons with mental illness from one mental health establishment to another mental health establishment (Section 93):** People in mental health facilities can be transferred to other facilities within the same state with oversight Board approval, or to another state with central authority permission. Patients and their representatives must be informed about transfers and given reasons for transparency and rights protection. Additionally, state governments can transfer individuals with mental health needs from detention facilities to appropriate mental health establishments, either within the state or to another state with agreement, ensuring proper mental health care regardless of legal status.<sup>16</sup>
- **Emergency Treatment (Section 94):** During mental health crises posing immediate danger, any licensed doctor can provide emergency treatment at healthcare facilities or in the community, with representative consent when available, to prevent death, serious harm, self-injury, harm to others, or significant property damage from mental illness. Emergency care includes safe transport to the nearest mental health facility for assessment, but treatment must relate directly to the immediate emergency and cannot include electroshock therapy. Treatment is limited to 72 hours or until proper facility evaluation, whichever comes first, extending to seven days during declared disasters, ensuring life-saving care while maintaining protections and consent limits.<sup>17</sup>

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<sup>13</sup> MENTAL HEALTHCARE ACT, 2017, No. [Act No. 20 2017], Apr. 7, 2017, 37 (India).

<sup>14</sup> MENTAL HEALTHCARE ACT, 2017, No. [Act No. 20 2017], Apr. 7, 2017, 39 (India).

<sup>15</sup> Ibid.

<sup>16</sup> Ibid.

<sup>17</sup> MENTAL HEALTHCARE ACT, 2017, No. [Act No. 20 2017], Apr. 7, 2017, 40 (India).

- **Prohibited Procedures and Restrictions on Psychosurgery (Sections 95-96):** Certain treatments are banned for people with mental illness: electroshock therapy without anaesthesia and muscle relaxants, sterilisation as mental health treatment, and chaining or restraining patients. Children are generally protected from electroshock therapy, though in rare cases it may be allowed with guardian consent and oversight, Board approval. Psychosurgery is heavily restricted, requiring the person's informed consent and Board approval, with Central Authority power to create detailed regulations. These protections ensure vulnerable people avoid harmful treatments while allowing necessary interventions when properly supervised with multiple consent and oversight layers.<sup>18</sup>
- **Restraints and seclusion (section 97):** People with mental illness cannot be placed in seclusion or solitary confinement. Physical restraints may only be used as an absolute last resort to prevent immediate harm and must be authorised by the treating psychiatrist. Restraints must be removed immediately when danger passes and cannot be used for punishment, deterrence, or due to staff shortages. Medical officers must document restraint type, justification, and duration in medical records, with nominated representatives informed within 24 hours. During restraint, continuous medical supervision is required in safe locations, with monthly reporting to oversight Boards. The Central Authority can establish additional regulations, and Boards can order facilities to stop using restraints if rules are persistently violated, prioritising safety and dignity with proper oversight and accountability.<sup>19</sup>
- **Discharge planning (section 98):** When someone is discharged from a mental health facility, transferred, or getting a new psychiatrist, the treating psychiatrist must create a proper discharge plan by consulting with the patient, their nominated representative, family/caregivers, future psychiatrist, and other relevant people to determine appropriate ongoing treatment. The psychiatrist must collaborate with all involved parties to develop a comprehensive plan outlining how treatment and services will continue after leaving the facility. This discharge planning process is mandatory for every discharge from any mental health establishment, ensuring no one leaves without a clear plan for continued care and community support.<sup>20</sup>

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<sup>18</sup> Ibid.

<sup>19</sup> Ibid.

<sup>20</sup> MENTAL HEALTHCARE ACT, 2017, No. [Act No. 20 2017], Apr. 7, 2017, 41 (India).

- **Research (section 99):** When conducting research with people with mental illness, researchers must obtain free and informed consent for studies involving interviews or interventions. For participants unable to consent but not resisting, researchers need State Authority permission based on nominated representative consent, but only if strict conditions are met: research cannot be done with consenting participants, it's necessary for mental health promotion, aims to gain relevant knowledge, has no conflicts of interest with full disclosure, and follows ethical guidelines with institutional approval. Researchers can study anonymised case notes of those unable to consent. Anyone giving consent (participant or representative) can withdraw at any time. These protections prevent exploitation of vulnerable individuals while allowing important mental health research.<sup>21</sup>

### **Revisiting Section 19 of the Mental Health Act 1987 And Other Legal Provisions Related to Admission, Treatment and Discharge of a Person with Mental Disability.**

**Understanding Involuntary Mental Health Admissions:** Sometimes, people with serious mental health conditions need involuntary hospitalisation. Each country has laws governing when and how this can occur. In India, rules changed significantly over time. The old Indian Lunacy Act of 1912 required court magistrates to issue "reception orders" after personally observing someone deemed "of unsound mind," with two doctors agreeing. This created problems because legal "unsound mind" definitions differ from medical mental illness diagnoses. Someone could have a mental illness according to doctors, refuse treatment, and deny being sick, but still not meet the narrow legal standard for involuntary admission. This put families in impossible situations—they observed concerning behaviour daily and sought psychiatric help, but their loved ones might appear normal to magistrates unfamiliar with them.

Recognising these challenges, India replaced the 1912 law with the Mental Health Act of 1987, including Section 19 for "admission under special circumstances." This allowed hospitals to admit people for observation and treatment without lengthy court processes, bridging the gap between legal definitions and medical reality when urgent treatment was needed.<sup>22</sup>

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<sup>21</sup>Ibid.

<sup>22</sup> K. Chandrasekhar, Jyoti Kapoor & Sridhar Anishetty, *Involuntary Hospitalization: The Conflict Zone of Psychiatry and Law (Revisiting Section 19 of Mental Health Act 1987)*, 40 *Indian J. Psych. Med.* 301-304 (2018), [https://doi.org/10.4103/IJPSYM.IJPSYM\\_244\\_18](https://doi.org/10.4103/IJPSYM.IJPSYM_244_18).

Medical treatment normally requires patient consent, but involuntary commitment allows treatment without agreement. For people with mental health conditions, giving consent is complicated because their ability to understand their situation and make decisions changes rapidly, especially during psychotic episodes when they lose touch with reality. Someone might agree to treatment in the morning but refuse it by afternoon, convinced nothing is wrong. This unpredictable awareness is why mental health laws sometimes allow treatment without traditional consent—waiting for clear agreement might mean missing critical opportunities to provide life-saving care when someone's mental state prevents them from recognising, they need help.<sup>23</sup>

Forcing mental health treatment based on decision-making capacity is highly controversial, with ongoing debates about what "capacity" means and its usefulness for these decisions. The UN Committee on the Rights of Persons with Disabilities recommends eliminating involuntary treatment and capacity tests. Most places currently use cognitive tests to determine if someone can consent to or refuse treatment. Mental health laws are shifting from asking "Is this person dangerous?" to "Can this person make informed decisions?" This philosophical change could significantly alter who receives involuntary treatment and how frequently. However, critics worry capacity assessments might sometimes excuse avoiding help, potentially leaving vulnerable adults at risk when they need intervention.<sup>24</sup>

Modern mental health laws typically require two elements for involuntary treatment: the person must have a mental disorder and pose a risk to themselves or others. The main ethical challenge balances autonomy (respecting patient wishes) versus beneficence (acting in the patient's best interest). True autonomous choices require intentional action, situational understanding, freedom from pressure, and clear thinking. When these aren't met, involuntary treatment might be justified. Healthcare should be patient-centred with strong rights while allowing professionals to act appropriately. However, informed consent and individual autonomy concepts don't apply equally in traditional and Eastern societies, representing two-thirds of the world's population, where families make collective decisions rather than individuals deciding alone. This creates tension between Western and Eastern mental health approaches. Ironically,

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<sup>23</sup> Ibid.

<sup>24</sup> Anirudh Kala & Kunal Kala, *Involuntary Admission and Treatment*, 31 Indian J. Soc. Psychiatry 130-133 (2015), [https://journals.lww.com/ijsp/fulltext/2015/31020/involuntary\\_admission\\_and\\_treatment.9.aspx10.4103/0971-9962.173293..](https://journals.lww.com/ijsp/fulltext/2015/31020/involuntary_admission_and_treatment.9.aspx10.4103/0971-9962.173293..)

India's Mental Health Care Act 2017 and Mental Health Act 1987 borrowed heavily from European legislation, potentially conflicting with local cultural values.<sup>25</sup>

Mental health care in India has been poorly regulated despite various laws. Under the 1912 law, involuntary admissions required magistrate approval, but most hospital superintendents used a legal loophole (Section 4) to simplify admissions, essentially bypassing the law to help patients more easily. This practice continues today. The 1987 Mental Health Act created proper involuntary admission through relatives or friends (Section 19), but hospitals rarely used this official process, preferring informal workarounds instead. This meant the legal provision never received proper attention or clear interpretation in psychiatric practice. The pattern is clear: mental health professionals consistently find ways around complex legal procedures to provide care, even when proper legal channels exist.<sup>26</sup>

A recent court ruling created strict requirements for psychiatric admissions under Section 19: patients need a clear diagnosis and proof of "unsoundness of mind," three doctors must be physically present during admission regardless of time, phone consultations are prohibited, and patients must be sent elsewhere if the head doctor isn't available.

However, this creates serious real-world problems. Psychiatric hospitals are treatment centres where people seek help and sometimes need observation to determine if mental illness exists. During emergencies, especially nights/weekends, usually only one duty doctor is available, and forcing families to search multiple hospitals for the right doctor combination is cruel and potentially life-threatening for suicidal, delirious, or violent patients.

Psychiatric diagnosis often requires 24-72 hours of observation with multiple examinations, impossible on an outpatient basis. The law already provides safeguards through appeal processes. This well-intentioned court effort to protect rights creates impossible situations, forcing medical professionals to choose between rigid procedures and emergency care, ultimately harming those the protections were meant to help. Hospital doctors work different shifts, making it unrealistic to expect three doctors to physically examine patients simultaneously. Requiring all three doctors present at admission defeats Section 19's original

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<sup>25</sup> Ahmed Okasha, *Ethics of psychiatry practice: consent, compulsion, and confidentiality*, 13 *Current Op. Psychiatry* 693-698 (2000), <https://doi.org/10.1097/00001504-200011000-00038>.

<sup>26</sup> Amita Dhanda, *Legal Order and Mental Disorder* 34 (2000).

purpose.

Before the Mental Health Act 1987, families with uncooperative mentally ill relatives had to travel long distances for magistrate reception orders under the 1912 law, often struggling with complex procedures that left patients wandering untreated. Section 19 was introduced to allow families to take patients directly to psychiatric hospitals for emergency assessment without bureaucratic hassles.

The current court interpretation makes this unnecessarily difficult, reverting to outdated 1912 practices that contradict modern psychiatric advances. Today's medical practice routinely uses phones, video calls, and digital communication for consultations and telemedicine, actively promoted by the government.

Hospital admission for psychiatric observation isn't imprisonment—patients retain rights to visitors, food choices, communication, personal space, and safety. Simply admitting someone under Section 19 doesn't violate Article 21 rights, but this judgment's strict interpretation may force Indian psychiatrists into overly defensive practices, potentially harming mental healthcare delivery nationwide.<sup>27</sup>

### **Practical Implications**

- People who want to admit themselves for mental health treatment can only do so if they meet very strict criteria - they must have a "substantial disorder with gross impairments." This means that even if someone wants help and their doctor agrees they need hospital treatment, they might be turned away if their condition isn't severe enough according to these rules. This seems to go against people's basic right to choose the best treatment for themselves with their doctor's guidance. What's more, the Mental Health Review Board can't even check whether these voluntary admissions are appropriate.
- When someone who voluntarily admitted themselves wants to leave, but their doctor thinks they should stay, the doctor can hold them for 24 hours. During this time, the patient must be assessed for a different type of admission that requires a nominated representative's permission. But here's the problem: voluntary patients don't need a

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<sup>27</sup> The Mental Health Act 1987 (Act No. 14 of 1987) Published in the Gazette of India, (Extra), Part II, Section 1. 1987 May 22.

nominated representative when they first come in, and without one, this new type of admission can't happen. Patients who want to leave might hide information about potential representatives because they know revealing it could mean being kept in the hospital against their wishes.

- Some people with serious mental illnesses who can't make proper decisions about their care still can't be admitted if they don't meet the strict "danger" criteria. For example, someone with severe depression who has lost the ability to make good decisions but hasn't recently done anything to harm themselves or others, and can still take basic care of themselves, would be turned away from hospital treatment even though they need help.
- The law only considers risk to a specific individual, not broader public safety concerns. For instance, imagine a former soldier with paranoid delusions about police who has military training and harbours vengeful thoughts toward law enforcement. Even though a psychiatrist might reasonably worry this person poses a serious threat to any police station, if he hasn't hurt anyone in the past 30 days or made any specific person afraid, he can't be admitted. If he were admitted and appealed to the Review Board, they would have to let him go because the law doesn't recognise this type of broader risk assessment.
- While the law claims to treat mental and physical illnesses equally, children with mental health problems face discrimination. Unlike kids with physical illnesses who can be admitted for assessment or intensive treatment, children with mental illness must meet the same severe criteria as adults before they can receive inpatient care. This means they can't be hospitalised for comprehensive evaluations or intensive psychological interventions unless their condition has become extremely serious.
- The Mental Health Review Board has the power to look back and decide that someone was wrongly admitted in the first place, which is very different from how these systems work in other countries. In most places, review boards only check whether someone currently needs to stay in the hospital, not whether the original admission was correct. If our Review Board decides an admission was inappropriate, it means the entire hospital stay becomes "unlawful detention" or "illegal confinement." This puts hospitals and doctors in a very difficult legal position and is quite different from international standards.

- The law doesn't specify how many times someone can appeal their admission during a single hospital stay, which could lead to repeated disruptions in treatment.
- Since the Review Board automatically examines every supported admission, doctors must prepare detailed reports justifying each one, adding a significant administrative burden.
- If someone has written instructions (called advance directives) about what treatment they don't want, these must be followed even in emergencies. For example, if someone wrote that they never want to be hospitalised or given antipsychotic medications, doctors can't provide this treatment even if the person becomes severely ill and can't make decisions. The only option is to appeal to the Review Board, which can take up to 90 days to decide. During this time, the person might suffer unnecessarily while waiting for a decision. Even their nominated representative can't override these advanced instructions.
- Moving patients between hospitals requires special approval from authorities, even for simple reasons like wanting to be closer to family or needing better medical facilities. This bureaucratic requirement can delay important medical care when patients need to be transferred quickly for intensive care or specialised treatment.
- The law says police can be asked to bring back patients who leave without permission, but this only clearly applies to prisoners receiving mental health treatment. It's unclear whether this applies to other types of patients, creating confusion about what to do when someone leaves the hospital unexpectedly.
- Emergency medical treatment can be given for 72 hours or until someone is properly assessed at a mental health facility, whichever comes first. However, it's unclear whether this applies to people already in the hospital. Patients in mental health facilities often need emergency treatment for both physical and mental health crises, but the law seems to suggest this emergency provision only applies until someone reaches the facility, not while they're already there. This could leave hospitalised patients without necessary emergency care when their representative isn't immediately available to give permission.
- Electroconvulsive therapy (ECT) for children requires both guardian consent and Review Board approval. ECT isn't considered emergency treatment, so if someone has written advance instructions refusing it, doctors can't provide this treatment even if the person later becomes unable to make decisions and their representative agrees to it. The

doctor would have to ask the Review Board to review the advance directive, which takes time.

- The law completely prohibits seclusion, which eliminates the option of using quiet, low-stimulation rooms to help calm agitated patients. Even though brief periods in calmer environments can help prevent aggressive situations, these might be interpreted as illegal seclusion.
- People who admit themselves voluntarily and then leave against medical advice might not get proper discharge planning. Similarly, voluntary patients who refuse to participate in planning their discharge might also leave without adequate preparation. This can lead to chaotic, inadequate care once they return to the community, potentially making their conditions worse.<sup>28</sup>

### **Methods and Materials:**

This research adopts an analytical and exploratory methodology, integrating doctrinal legal research with comparative legislative analysis. The analytical dimension focuses on tracing the historical development of laws governing the involuntary admission and treatment of persons with mental illness, while the exploratory aspect critically revisits theoretical frameworks concerning mental disability rights.

The study systematically examines statutory provisions and policy frameworks spanning different eras, beginning with the Indian Lunacy Act of 1912 and progressing to contemporary legislation, including the Mental Healthcare Act, 2017. This examination aims to understand the evolution of admission procedures and treatment standards over time. As a doctrinal and non-empirical study, this research is primarily theoretical. It relies extensively on secondary sources such as textbooks, legal commentaries, peer-reviewed law journals, and credible online resources.

### **Data Analysis:**

The study shows a major problem in India's mental health laws. While these laws were meant to protect people with mental illness, they have made it harder to get emergency mental health care. This could end up hurting the very people the laws were supposed to help. The old Mental

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<sup>28</sup> Dr Manoj Kumar Therayil, MHCA2017 XII: ADMISSION, TREATMENT AND DISCHARGE, <https://mhca2017.com/index.php/act/chapter-xii-admission-treatment-and-discharge#practice-implications> (last visited June 21, 2025).

Health Act 1987 had Section 19, which tried to make things easier. Before this, under the very old Indian Lunacy Act 1912, families had to get permission from a magistrate (judge) before someone could be admitted to a mental hospital. Section 19 allowed hospitals to admit people for check-ups without needing a judge's permission first. This made sense because families often notice worrying behaviour changes that need quick medical attention within 24-72 hours, and mental health emergencies don't wait for business hours when courts are open.

The new Mental Health Care Act 2017 brought some good changes like focusing more on patients' rights, helping people make their own decisions, creating review boards, and allowing people to write advance instructions about their care. But it also created new problems. The new law makes it much harder to admit someone to a hospital - they have to have "a serious mental disorder with major problems" before they can be admitted. This might prevent some people who need help from getting it.

The law also says that if someone has written instructions about their treatment, these must be followed even in life-threatening emergencies, with very few exceptions. The law also requires automatic reviews of all cases, which creates extra paperwork and makes doctors worry about getting in legal trouble later. This shows a big clash between Western ideas (which focus on individual choice) and traditional Indian family values (where families make healthcare decisions together). On top of all this, India doesn't have enough mental health doctors and hospitals, making it even harder to handle emergencies properly.

### **Conclusion:**

This comprehensive analysis of India's mental health legislation reveals the complex interplay between legal reform, clinical practice, and cultural values in addressing mental disability rights. While the evolution from the Colonial Indian Lunacy Act 1912 to the Mental Health Care Act 2017 represents significant progress in recognising the rights and dignity of persons with mental disabilities, the study demonstrates that legislative advancement does not automatically translate to improved healthcare delivery.

The research underscores the critical need for balanced legislation that protects individual rights while ensuring accessible emergency mental health care. The current legal framework's emphasis on stringent admission criteria and rigid advance directives, though well-intentioned,

may inadvertently deny timely intervention to those in crisis. This paradox highlights the importance of involving mental health professionals, families, and communities in legislative processes to ensure laws reflect both clinical realities and cultural contexts.

Moving forward, India's mental health policy must address the fundamental tension between Western individualistic models and traditional family-centred approaches to healthcare decision-making. Future reforms should consider flexible implementation mechanisms that can accommodate emergencies while maintaining necessary safeguards against abuse. Additionally, substantial investment in mental health infrastructure and professional training is essential to support any legal framework effectively.

The research concludes that effective mental health legislation must balance individual autonomy with the need for accessible emergency care, recognising cultural contexts and practical realities of psychiatric practice. Future policy development should prioritise creating frameworks that protect patient dignity while ensuring timely access to care, incorporating input from all stakeholders, including patients, families, mental health professionals, and legal experts, to bridge the gap between legal theory and clinical practice.

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