

**EFFECTIVENESS OF THE MENTAL HEALTHCARE ACT, 2017 IN INDIA: “A STUDY WITH
SPECIAL REFERENCE TO WOMEN”**

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ABSTRACT

The Mental Healthcare Act, 2017 was enacted to reform India’s mental health system by adopting a rights-based and patient-centric approach. The Act recognizes mental healthcare as a legal right and aims to ensure affordable, accessible, and non-discriminatory mental health services while safeguarding the dignity, autonomy, and rights of persons with mental illness. One of its most significant reforms is the decriminalization of suicide attempts, replacing punitive responses with a therapeutic and rehabilitative framework. Despite its progressive intent, the effective implementation of the Mental Healthcare Act, 2017 remains uneven across India. Challenges such as inadequate infrastructure, shortage of mental health professionals, limited awareness of legal rights, and inconsistent enforcement at the state level continue to impede its objectives. These gaps disproportionately affect women, who face unique mental health challenges arising from gender-based violence, reproductive and perinatal issues, social stigma, and economic dependence. This research paper examines the extent to which the objectives of the Mental Healthcare Act, 2017 have been realized in practice, with special reference to women, and proposes legal and policy measures to ensure its effective and gender-responsive implementation.

INTRODUCTION

According to WHO, mental health conditions are among the leading causes of disability worldwide. In 2021, it was estimated that 1 in 7 people globally were living with a mental disorder, which equates to over 1.1 billion people. In India, about 11 in 100 people suffer from mental health disorders. WHO estimates that the burden of mental health problems in India is 2443 disability-adjusted life years (DALYs) per 100 000 population; the age-adjusted suicide rate per 100 000 population is 21.1. The economic loss due to mental health conditions, between 2012-2030, is estimated at USD 1.03 trillion. As the above act is replaced by Mental Health Act 1987 of ensuring accessible, affordable, and non-discriminatory mental healthcare while safeguarding the dignity, autonomy, and legal capacity of

persons with mental illness. Though the legislative parameter is changed towards patient centric behaviour, due to some hurdle women are still not able to take legislative protection under the concern act. This research paper try to find out availability of right as well as whether this availability is accessible by women or not and as well as assessing whether the Act adequately promotes women's mental health rights and access to care within India.

LITERATURE REVIEW

1. Adhyay- 17.8: Nourishing plant based foods with gratitude- classifies sattvic food as that which increases life, purity, strength, health, happiness, and satisfaction
2. Adhyay- 17.2: Conscious eating, speaking and thinking- This verse explains that faith (shraddha) of individuals is shaped by their inherent nature categorizing it into sattvic, rajasic, and tamasic, which influences a person's thoughts, speech, actions, and mental disposition, thereby directly affecting psychological balance and moral conduct.
3. Around 10.6% of Indian adults were living with a diagnosable mental health disorder as per the 2015–16 NIMHANS National Mental Health Survey, with a lifetime prevalence of 13.7% and higher rates in urban areas. Nearly 15% of adults require mental health intervention, reflecting a substantial treatment gap.
A 2019 NIMHANS study found mental health disorders to be more prevalent among women (20%) than men (10%), with women being more prone to depression and anxiety. Suicide rates are rising, with 1,71,418 suicides reported in 2023, of which 27.2% were women, highlighting serious gendered mental health concerns.
4. The mission includes conducting representative surveys, launching surveillance site, establishing cohorts for longitudinal studies and conducting implementation research. NMHC aims to estimate prevalence, access disability and care pathways, examine socioeconomic impact and characterize mental disorders in vulnerable populations. – National Mental Health Survey Mission.

OBJECTIVES

1. To assess the extent to which MHCA 2017 protects the mental health rights of women.
2. To identify implementation challenges that affect women adversely.
3. To recommend gender-responsive policy and implementation improvements

RESEARCH METHODOLOGY

This qualitative study reviews statutory provisions of MHCA 2017, scholarly literature, government reports, Court judgments, and empirical studies on mental health services for women. The analysis uses a **gender lens** to interpret legal safeguards, service access, and outcomes.

RESEARCH PROBLEM/ HYPOTHESIS

1. The Mental Healthcare Act, 2017 implementation inadequately addresses the specific mental health needs of women.
2. Judicial interpretations of the MHCA, 2017 have remain inconsistencies in enforcement and outcomes.
3. The MHCA, 2017 have enough institutional safeguards to ensure equitable mental healthcare outcomes for women.

ANALYSIS AND INTERPRETATION

WHO- Right to Mental Health

So far as WHO is concern World Health Organization (WHO) doesn't have a single "convention" solely for mental health, its work heavily promotes mental well-being through the following practice:

1. United Nations Convention on the Rights of Persons with Disabilities (CRPD), guiding national laws, and implementing global plans like the Comprehensive Mental Health Action Plan, focusing on rights, non-discrimination, community care, and integration into general health systems. The CRPD emphasizes shifting from institutionalization to rights-based community inclusion, challenging involuntary treatment and promoting dignity for people with psychosocial disabilities.
2. Mental Health at work: Guidelines with the ILO to create safe, supportive workplaces, recognizing decent work as crucial for mental health.
3. UNFPA: Initiative psychosocial support with reproductive health services in humanitarian setting, ensuring that care for survivors is comprehensive, with specific protection for women and girls.

UNFPA and Ministry of Health and family welfare: Surakshit

Matritva Aashwasan Yojana (SUMAN), Pradhan Mantri

Surakshit Matritva Abhiyan (PMSMA) Midwifery Services

Initiative.

4. UN Women

Upholding the importance of attaining full mental health for all people, as recognized in General Assembly resolution 46/119 of 17 December 1991, entitled "The protection of persons with mental illness and the improvement of mental health care"

5. WHO Member States are committed to implementing the Comprehensive Mental Health Action Plan 2013–2030:

Aims to strengthen effective leadership and governance for mental health, provide comprehensive, integrated, and responsive community-based care, implement promotion and prevention strategies, and strengthen information systems, evidence, and research.

6. World Mental Health Report: Transforming Mental Health for All (2022), which calls for countries to adopt three paths to transformation:

1. Deepen the value and commitment to mental health — by governments, communities, and individuals, with stronger investment across sectors.
2. Reshape environments — in homes, schools, workplaces, and communities, to better protect and promote mental well-being.
3. Strengthen care systems — ensuring that the full spectrum of needs is met through community-based, affordable, and quality services.

7. United Nations System Mental Health and Well-being Strategy for 2024 and beyond is designed to assist the United Nations in creating a working environment that is conducive to good mental health and that ensures that support is available when it is needed

8. World Mental Health Day (10 October) aims to raise awareness of mental health issues around the world and to mobilize efforts in support of mental health.

9. World Meditation Day (21 December) focuses on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

EVOLUTION OF MENTAL HEALTH LEGISLATION

- 1987 – Enactment of the Mental Health Act, 1987, replacing the Indian Lunacy Act, 1912.
- 2007 – India ratifies the UN Convention on the Rights of Persons with Disabilities (UNCRPD), creating the need to align mental health laws with a rights-based approach.
- 2010 – Draft Mental Health Care Bill, 2010 introduced, emphasizing patient rights and deinstitutionalization.
- 2013 – Revised Mental Healthcare Bill, 2013 introduced in the Rajya Sabha, incorporating stakeholder and expert inputs.
- August 2016 – Mental Healthcare Bill passed by the Rajya Sabha.
- March 2017 – Mental Healthcare Bill passed by the Lok Sabha.
- 7 April 2017 – Presidential assent granted; the law becomes the Mental Healthcare Act, 2017.
- 10 July 2018 – MHCA, 2017 comes into force, replacing the Mental Health Act, 1987.
- 2018–Present – Establishment of Central and State Mental Health Authorities; gradual implementation, judicial interpretation, and policy integration across states.

RIGHT TO HEALTH IN INDIA IN RESPECT OF CONSTITUTIONAL PERSPECTIVE

1. **Preamble:** preamble guarantees of equality, dignity, liberty and social justice to every citizen of India. As vast interpretation of the verdict it also covers the mental health and wellbeing condition to women.

2. Fundamental Rights:

Art-14 : The State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.”Ensures equality before law and equal protection of laws, mandating non-discriminatory access to mental healthcare services for women.

Art-15(1): The State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, and place of birth or any of them.”

Women are not denied **mental healthcare services, employment, insurance, or legal protection** on the basis of sex. It mandates gender-neutral access to mental

health institutions and safeguards women with mental illness from exclusion, stigma, or unequal treatment by State authorities

Art 15(3): Nothing in this article shall prevent the State from making any special provision for women and children

Supports **women-specific mental health services**, such as counselling for survivors of domestic violence, maternal mental healthcare, and trauma-informed support systems.

Art 21: No person shall be deprived of his life or personal liberty except according to procedure established by law

3. Fundamental Duties

Article 51A (e): Renounce practices derogatory to the dignity of women

Article 51A h): Develop scientific temper, humanism, and spirit of inquiry

4. Directive Principles of State Policy

Article 38 – Social Order Based on Justice

Article 39(a), (e) & (f) – Adequate Livelihood and Protection from Abuse

39(a): Adequate means of livelihood – unemployment and economic Insecurity affect mental health.

39(e): Protect citizens, especially women, from abuse and exploitation causing psychological trauma.

39(f): Ensure healthy development of children – includes emotional and psychological development

Article 41 – Right to Work, Education and Public Assistance Article

43 – Living Wage and Decent Standard of Life Article 46 –

Protection of Weaker Section

Article 47 – Duty of the State to Improve Public Health

JUDICIAL APPROACH ON MENTAL HEALTH IN INDIA

1. Sheela barse v. Union of India (1986) 3 SCC 596
Mental health care and human treatment was recognised as a part of Art 21. In this case negligence in custody with mentally ill person was highlighted specifically with women.
2. Parmanand Katara v. Union of India (1989) 4 SCC 286
Parmanand Katara, a human rights activist, filed a writ petition under **Article 32** after a newspaper report revealed that a scooterist who suffered severe head injuries in a road accident was denied immediate medical treatment by a hospital. The hospital allegedly refused treatment because the case was **medico-legal**, insisting on completion of police formalities before providing emergency care. The petition raised concerns about the **right to emergency medical treatment** and the obligations of doctors and hospitals.
3. Shatrughan Chauhan v. Union of India (2014) 3 SCC 1
The petitioners were death row convicts who challenged the rejection of their mercy petitions by the President of India under **Article 72 of the Constitution**. They contended that there was an **inordinate and unexplained delay** by the executive in deciding their mercy petitions, during which they suffered severe mental agony and trauma. The petitioners argued that such delay violated their **fundamental rights under Articles 14 and 21**, and therefore their death sentences should be commuted to life imprisonment.
4. Common Cause v. Union of India (2018) 5 SCC 1
The petitioner, **Common Cause**, a registered society, filed a writ petition under **Article 32** seeking recognition of the **right to die with dignity** as part of **Article 21** of the Constitution. The petition sought legal validity for **passive euthanasia** and recognition of **advance medical directives (living wills)** for terminally ill patients who are unable to express informed consent.
5. Gaurav Kumar Bansal v. Union of India (2021)
The case arose during the **COVID-19 pandemic**, when shortages of essential medicines—particularly **Tocilizumab** and other drugs used in the treatment of COVID-19 patients—were reported across India. The petitioner, Gaurav Kumar Bansal, filed a **Public Interest Litigation under Article 32**, alleging that the inadequate supply and inequitable distribution of life-saving medicines violated the **right to life under Article 21**. The petition sought judicial directions to ensure availability, fair allocation, and price regulation of essential COVID-19 drugs.

The Supreme Court held that **access to essential medicines is an integral part of the right to health and right to life under Article 21**. It directed the Union Government to take necessary steps to ensure **adequate availability, equitable distribution, and price regulation** of essential COVID-19 medicines.

6. Sukdeb Saha v. State of Tripura & Ors. (2021) 2021 SCC OnLine Tri 159

The case arose after incidents of student suicides and mental distress in educational institutions in Tripura. The petitioner filed a Public Interest Litigation (PIL) highlighting the lack of mental health support systems, counselling services, and awareness mechanisms in schools and colleges. It was argued that academic pressure, stress, and absence of psychological assistance were endangering students' lives. The Tripura High Court held that mental health of students is an integral part of the right to life under Article 21, and the State cannot remain a silent spectator.

IMPORTANT PROVISION RELATING - "MENTAL HEALTH ACT, 2017"

7 April, 2017, 15 chapters 126 sections are provided

1. Sec- 2(S) - "mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by sub normality of intelligence
2. Important Provisions
Sec- 18 right to access mental healthcare services
Sec-19 Right to equality, non-discrimination, and protection of dignity Sec- 23
Confidentiality and privacy
3. List of rights identified under the Act Right to
access mental health
Right to community living
Right to protect from cruel, inhuman and degrading treatment Right to
equality and non-discrimination
Right to information Right to
confidentiality

Restriction on release of information in respect of mental illness Right to
access medical records

Right to personal contacts and communication Right to
legal aid

4. Government Responsibilities

State will take initiatives for registration, regulation and standards of mental health establishments. Ensure minimum standards of care, infrastructure and human resources aiming to prevent abuse and neglect.

5. Authority

5.1 Central Mental Health Authority (CMHA)

The Central Mental Health Authority is constituted by the Central Government under the Mental Healthcare Act, 2017. It functions as the apex regulatory and advisory body for mental health services at the national level.

Key Functions:

- Register and supervise Mental Health Establishments under central jurisdiction
- Develop standards for mental health services and professional conduct
- Advise the Central Government on mental health policy and programmes
- Maintain a national register of mental health establishments
- Promote mental health awareness and human rights-based care

Significance:

Ensures uniform standards, policy coordination, and protection of rights across India.

5.2 State Mental Health Authority (SMHA)

The State Mental Health Authority is established by the State Government to regulate mental healthcare services within the State.

Key Functions:

- Register, inspect, and regulate mental health establishments in the State
- Ensure compliance with minimum standards of care and treatment
- Supervise implementation of the Mental Healthcare Act, 2017
- Advise the State Government on mental health planning and infrastructure
- Facilitate community-based mental healthcare services

Significance:

Acts as the primary implementing and monitoring authority at the state level, ensuring accessibility and quality of care.

5.3. Mental Health Establishment (MHE)

A Mental Health Establishment includes any health facility, public or private, where persons with mental illness are admitted, treated, or cared for.

Includes:

- Psychiatric hospitals and nursing homes
- General hospitals with psychiatric units
- Rehabilitation and de-addiction centers

Obligations:

- Mandatory registration with CMHA or SMHA
- Provision of safe, humane, and quality treatment
- Respect for patient rights, dignity, and confidentiality
- Prohibition of inhuman practices such as chaining or seclusion

Significance:

Ensures regulated, rights-based, and ethical mental healthcare delivery.

CHALLENGES IN IMPLEMENTATION FOR WOMEN

Basically following three challenges increasing the mental illness of women in India are as follows:

1. Anxiety- Nearly **50% of Indian women** report experiencing chronic stress

due to work-life imbalance, financial pressures, and societal expectations. **47% struggle with insomnia, 41% report social isolation, and 38% feel high anxiety related to career and finances**

2. Suicide- Women accounted for around **36.6% of all suicide deaths** in India, with youth aged *18–39 years* being especially vulnerable
3. Overall mental disorder- WHO and national surveys indicate that about **10% of India's population** suffers from mental health conditions, many of whom are *women*, with treatment gaps as high as 70–92% nationally.
4. Postpartum mental health- A study among rural women found **5.6%** experienced postpartum depression or anxiety
5. Service access and treatment gap - A study among rural women found **5.6%** experienced postpartum depression or anxiety
6. Government mental health helplines like **Tele-MANAS** received **over 39,000 suicide-related calls**, reflecting rising help-seeking behaviour but also the large scale of distress.

CONCLUSION

The analysis reveals that although the Mental Healthcare Act, 2017 represents a progressive, rights-based framework, its implementation has not adequately addressed the specific mental health needs of women. The gender-neutral design of the Act overlooks the socio-cultural, economic, and structural barriers uniquely faced by women, resulting in gaps in access, quality, and continuity of care. While judicial interpretations have contributed to strengthening mental health rights in principle, inconsistencies in enforcement and outcomes persist due to uneven awareness, limited institutional capacity, and lack of uniform implementation across states. Although the MHCA, 2017 contains institutional safeguards, these mechanisms have not been sufficiently gender-responsive to ensure equitable mental healthcare outcomes for women in practice.

SUGGESTIONS

1. **Gender-Sensitive Implementation:** Incorporate explicit gender-responsive guidelines within MHCA implementation to address women-specific mental health needs, including those related to violence, caregiving burdens, and reproductive health.

2. **Strengthening Institutions:** Enhance the capacity of Central and State Mental Health Authorities with dedicated gender experts and monitoring mechanisms.
3. **Judicial and Administrative Consistency:** Promote uniform interpretation and enforcement of MHCA provisions through judicial training and standardized protocols.
4. **Integrated Service Delivery:** Integrate mental health services with reproductive, maternal, and community health programs to improve accessibility for women.
5. **Awareness and Capacity Building:** Increase awareness among women about their rights under the MHCA and train healthcare professionals in gender-sensitive mental healthcare.

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