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India's Mental Healthcare Act, 2017

Building Laws, Protecting Rights

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This book is dedicated to our families.

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Introduction

Abstract

Mental illness is common, complex and costly. Globally, almost 800,000 people die due to suicide every year and 79% of suicides occur in low- and middle-income countries. In addition, more than 300 million people suffer from depression, but most people affected by mental illness—75% in many low-income countries—do not have access to treatment they need. Many of these people live in India, a country of 1.3 billion people, one-sixth of the planet's entire population. In light of psychiatry's long-standing relationship with mental health law, legislative reform holds particular potential for improvement of mental health services and—arguably—achieving a positive right to mental health and mental healthcare in many countries, including India. Since the late 1900s there have been significant moves in this direction with the United Nations' (UN) Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care in 1991, culminating in the UN Convention on the Rights of Persons with Disabilities (CRPD) which came into effect in 2008. Against this background, it was apparent that mental health and disability legislation in many countries was in need of reform. Over the following years, it also became apparent that one country—India—was taking the most dramatic steps in this direction, seeking explicitly to align its disability and mental health laws with the CRPD. This process resulted in India's Rights of Persons with Disabilities Act, 2016 and Mental Healthcare Act, 2017, which form the focus of this book.

Keywords Mental health • Psychiatry • Legislation • Human rights • India • Suicide

Introduction

Mental illness is common, complex and costly. The World Health Organization (WHO) points out that almost 800,000 people die due to suicide every year, and for every completed suicide there are many more people who attempt to end their lives (WHO 2019a). Globally, suicide is the second leading cause of death among 15- to 29-year-olds, and 79% of suicides occur in low- and middle-income countries. In addition, more than 300 million people suffer from depression which is now the leading cause of ill health and disability worldwide (WHO 2019b).

Despite these figures, most of the people affected by mental illness—75% in many low-income countries—do not have access to the treatment they need (WHO 2019c). Many of these people live in India, a country with a population of 1.3 billion people. *The National Mental Health Survey of India, 2015–16* recently highlighted the magnitude of the challenges facing India in relation to mental health (Gururaj et al. 2016; Murthy 2017; Pradeep et al. 2018). This survey was a vast, invaluable joint collaborative project by nearly 500 professionals, comprising researchers, state-level administrators, data collection teams and various others from 12 states in India, coordinated and implemented by the National Institute of Mental Health and Neuro-Sciences (NIMHANS), a leading medical institution in Bangalore.

Researchers interviewed 39,532 individuals across 720 clusters in 43 districts of the 12 selected states in India, achieving a response rate of 91.9% at household level and 88.0% at individual level. Their key findings were stark:

- The overall weighted prevalence for any mental morbidity in India was 13.7% over a person's lifetime and 10.6% currently;
- Mental disorders were associated with poverty and living in urban areas;
- Depressive, neurotic and stress-related disorders were more common among women, while bipolar and alcohol use disorders were more common among men;
- The treatment gap for various mental disorders ranged between 70% and 92%, i.e. between 70% and 92% of people with various mental illnesses were not receiving the treatment they needed;
- In terms of specific mental illnesses, the treatment gap was 70.4% for bipolar affective disorder, 75.5% for psychosis, 85.0% for common mental disorders, 86.3% for alcohol use disorder and 91.8% for tobacco use.

This situation in relation to mental healthcare in India is attributable in significant part to the severe lack of resources devoted to mental health services (Duffy and Kelly 2019a). Less than 1% of India's national healthcare budget is allocated to mental health compared to 13% of the National Health Service budget in England (Campbell 2016). There are also substantial variations across different regions within India, with the highest treatment gaps generally seen in rural areas (Patel et al. 2016). Human resources are especially deficient, with just 0·3 psychiatrists per 100,000 people in India compared to 2.2 in China and 10.5 in the United States of

America (US) (WHO 2019d). There is a similar paucity of nurses working in the mental health sector in India, with just 0.8 mental health nurses per 100,000 people in India compared to 5.4 in China and 4.3 in the US.

The solution to these problems probably lies in a complex combination of overall economic progress, social change, revision of mental health policy and—the focus of this book—reform of mental health legislation. In 2017, the WHO placed particular emphasis on legal reform and rights as key ways to improve health and healthcare in a landmark report titled, *Advancing the Right to Health: The Vital Role of Law* (WHO 2017). This report paid particular attention to the problematic historical relationship between mental health and the law.

> Historically, laws have been used to structure the response to mental illness, but not always consistently with human rights. People with mental illness, like those with physical illness, require a full range of medical and social services. Instead, law has sometimes been used to incarcerate mentally ill people in sterile institutions and without the protection required under the rule of law (p. xiv).

The WHO report goes on to articulate a clear 'right' to physical and mental health.

> The right to health is a fundamental human right that is indispensable for human well-being, for well-functioning societies and economies and for the ability to exercise all other human rights. Without a basic level of health, it may be difficult or impossible for people to work, to attend school and obtain an education, to enjoy recreation, to fully participate in society and to enjoy other basic freedoms (p. 1).

The WHO presents a compelling case for the centrality of the right to health in terms of human well-being and human flourishing, but creating an explicit, legally binding right to health is not without complexity (Farmer 1999; 2003; Benatar 2013; Flood and Lemmens 2013; Kelly 2013). The right to health is, however, a concept that can evolve over time as social circumstances develop, economic conditions change and new understandings shape the contract between the individual and the state, revising expectations on both sides of the equation (Tobin 2012). Moreover, articulating rights to health, mental health, healthcare and mental healthcare *in law* can, at the very least, offer an important tool for advocacy and service improvement, especially for those who are most in need of care and, ironically, are often the least likely to receive it (Wolff 2012).

Against this background, the 2017 WHO report articulating the 'vital role of law' in 'advancing the right to health' was generally welcomed as a significant step forward of relevance not only to lawyers and the legal profession but also to policymakers and other influential actors in non-legal, health-related arenas (Lancet 2017; Gostin et al. 2019). The 2017 report held particular relevance for mental health, the branch of medicine, with—arguably—the deepest relationship to law owing to psychiatry's lengthy history of involuntary care (Shorter 1997; Harding 2000; Kelly 2016a). While most psychiatric treatments are provided on an outpatient basis, and most inpatient care is also voluntary, involuntary admission and treatment are still features of mental healthcare and both demand and require careful regulation and oversight by law (Kelly 2016b).

As such, law holds particular potential for reform in the context of psychiatry and—arguably—particular potential for articulating and achieving a positive right to mental health and mental healthcare (Dudley et al. 2012; Kelly 2015). Since the late 1900s there have been significant moves in this direction, commencing in earnest with the United Nations' (UN) *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* in 1991, which stated that 'all persons have the right to the best available mental healthcare, which shall be part of the health and social care system' (Principle 1(1)) (UN, 1991). In 1996, the WHO articulated 'ten basic principles' of mental health law, along similar lines, stating that 'everyone should benefit from the best possible measures to promote their mental well-being and to prevent mental disorders' (Principle 1) and 'everyone in need should have access to basic mental healthcare' (Principle 2) (WHO 1996).

In 2001, the WHO intensified its focus on this area by devoting its annual report to *Mental Health: New Understanding, New Hope*, and, in its recommendations, placing particular emphasis on legislation and the rights of the mentally ill (WHO 2001a; Kelly 2001). One of the WHO's ten key recommendations for action was that member states should 'establish national policies, programmes and legislation' in relation to mental healthcare, rooted in human rights.

> Mental health policy, programmes and legislation are necessary steps for significant and sustained action. These should be based on current knowledge and human rights considerations. Most countries need to increase their budgets for mental health programmes from existing low levels. Some countries that have recently developed or revised their policy and legislation have made progress in implementing their mental healthcare programmes. Mental health reforms should be part of the larger health system reforms (p. xii).

The report pointed to examples of 'human rights abuse in psychiatric hospitals' (p. 51) and recommended that 'policies should be drawn up with the involvement of all stakeholders and should be based on reliable information. Policies should ensure the respect of human rights and take account of the needs of vulnerable groups. Care should shift away from large psychiatric hospitals to community services that are integrated into general health services' (p. 76).

Seven years later, in 2008, the UN *Convention on the Rights of Persons with Disabilities* (CRPD) came into effect, aiming 'to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity' (Article 1) (UN, 2006). In this context, 'persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'. The CRPD presented extensive measures designed to protect and promote rights, many of which have significant implications in the context of mental illness (Kelly, 2014).

Against this background, it was apparent that mental health and disability legislation in many countries was in need of reform (Gooding 2017). Over the following years, it also became apparent that one country—India—was taking the most dramatic steps in this direction, seeking explicitly to align its disability *and* mental health laws with the CRPD, despite the clear resource challenges it faces in

these areas (Sachan 2013; Patel et al. 2016). More specifically, India's Rights of Persons with Disabilities Act, 2016 received the assent of the President of India on 27 December 2016 and was commenced in effect on 15 June 2017. The purpose of the 2016 Act is 'to give effect to the United Nations Convention on the Rights of Persons with Disabilities and for matters connected therewith or incidental thereto'. The extensive legislation presents a broad range of rights-based provisions aimed at giving effect to the CRPD and improving the rights of persons with disabilities in India. It is an ambitious piece of legislation which we examine in some detail later in this book.

Also in 2017, on 7 April, India's Mental Healthcare Act, 2017 (MHCA) received Presidential assent and it was formally commenced on 29 May 2018. Like the 2016 Act, the 2017 legislation notes that 'it is necessary to align and harmonise the existing laws with' the CRPD and goes on to present a broad range of rights-based provisions explicitly informed by the CRPD, making India's MHCA one of the most interesting and potentially progressive pieces of mental health legislation in the world (Kalmegh et al. 2018; Duffy and Kelly 2019b; 2019c). Again, we discuss this in detail throughout this book.

Perhaps the most dramatic right articulated in the 2017 Act, however, is a right to mental healthcare. The legislation states that 'every person shall have a right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government' (Section 18(1)), i.e. 'services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers' (Section 18(2)). This extraordinary and historic measure in the 2017 Act creates a justiciable right to mental healthcare for India's 1.3 billion people, one-sixth of the planet's population.

Against this background, our book aims to provide a comprehensive context to the new Indian legislation, along with a detailed description of the 2017 Act itself and a rigorous analysis of it in the context of the CRPD and WHO standards for mental health law. This analysis is aimed at mental health professionals, legal professionals, non-governmental organizations and civil servants not only in India but also in other jurisdictions that seek to revise their legislation to bring it into line with the CRPD. We examine the difficult balance held by Indian legislators in adhering to the CRPD while still delivering practical, humane and implementable legislation. We also explore how the Indian legislation was shaped by the UN and WHO standards and examine areas where the Indian legislators deviated from these guidelines. We conclude with an update on implementation kindly contributed by Dr. Soumitra Pathare and Arjun Kapoor.

Writing legislation that is concordant with the CRPD will be a necessary task for many countries over the coming years, so in this book we not only lay out the example of India but also highlight key lessons for other jurisdictions from what is essentially the largest experiment ever undertaken in the field of rights-based mental health law.

Part I of our book starts by exploring 'Mental Health Law and the Role of International Standards'. Chapter 1 sets out the 'Background to Mental Health Law', noting that mental illness and its treatments have been subjects of speculation and concern since the start of recorded history. Overall, the treatment of people with mental illness has been highly variable. While there is historical evidence that mental illness sometimes elicited compassion, treatment, support and special legal consideration, there is much greater evidence that it was generally met with stigma, neglect, marginalization and gross injustice.

In terms of mental health legislation, the nineteenth and twentieth centuries saw a relatively clear evolution from custody and containment to care and human rights (at least in theory), as legislation developed to reflect both advances in the treatment of mental illness and broader changes in politics and society. Most recently, India's MHCA was written to accord with the CRPD but does not embrace the CRPD unquestioningly. Indian legislators have, for example, included pragmatic tools for the protection and treatment of the acutely mentally ill ('supported admission'). While some of these provisions might be at odds with certain interpretations of the CPRD, they have dramatically revised Indian mental health legislation to bring it into greater accordance with core CRPD principles. India's revisions are also cognizant of the potential negative consequences of an overly literal application of the CRPD. As a result, implementation of India's MHCA will hopefully demonstrate how low- and middle-income countries can realize modern, rights-based mental health law and provide an example for the rest of the world.

Chapter 2 continues by exploring the 'United Nations and Mental Health Law', noting that, since its foundation in 1945, the UN has taken many steps to improve the well-being of people with mental illness. This has occurred through the Universal Declaration of Human Rights (1948), various other core international human rights instruments, the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991) and the Human Rights Council. While the Universal Declaration of Human Rights and the other initial human rights instruments related to mental illness only indirectly, the Convention on the Rights of the Child (1989) provided more detailed consideration of the topic.

In 2006, the CRPD included mental illness under the umbrella of disability and this inclusion is currently transforming mental health legislation internationally. While much of this change is positive, protecting the rights and maximizing the agency of people with mental illness, there are concerns that an excessively rigid interpretation of the CRPD could reduce access to treatment and lead to stigmatization and criminalization of the mentally ill. The 1991 UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care were, by contrast, written with more nuanced consideration of the needs of people with mental illness, but lacked the legal weight of the CRPD. Within the Human Rights Council, the Special Rapporteurs and the Working Group on Arbitrary Detention also often consider the needs of people with mental illness. Despite these measures, however, more is needed.

Chapter 3 of the book moves on to examine 'the World Health Organization and Mental Health Law' and notes that, since 1948, the WHO, too, has done much to

shape the evolution of mental health law. Their initial measures were often indirect, but they have recently assertively articulated the importance of legislation in health, including mental health. The inclusion of mental disorders in the International Classification of Diseases (ICD) since 1949 has helped standardize mental health nomenclature in legislation (WHO, 1949). Later iterations of the ICD, including descriptions of conditions, further improved diagnostic reliability. In 1996, the WHO's Mental Health Care Law: Ten Basic Principles was one of the organization's earliest attempts to directly shape mental health legislation (WHO, 1996). From 2001, Project Atlas helped to identify countries without mental health legislation and countries with grossly outdated laws (WHO 2001b). The WHO has sought to address these deficits recently as part of the WHO Mental Health Action Plan 2013–2020 (WHO 2013).

The most direct attempt at influencing international mental health law came in 2005 with the WHO's Resource Book on Mental Health, Human Rights and Legislation. This provided extensive consideration of what should be addressed in mental health law and policy, and examined coercive treatments in detail. With the publication of the CRPD in 2006, the WHO Resource Book was withdrawn. Even so, the Resource Book remains the most comprehensive consideration of the legislative needs of people with mental illness. QualityRights is now the CRPD-concordant WHO publication relating to mental health, including mental health legislation, and it contains an evaluation toolkit and teaching modules, among other resources.

Part II of the book focuses on 'Mental Health Legislation in India'. Chapter 4 presents a 'History of Mental Health Legislation in India', noting that, throughout the 1900s, mental health legislation in India was significantly shaped by the British. The Lunatic Removal Act, 1851 aimed to facilitate the repatriation of British offenders with mental illness. In 1858, three additional pieces of legislation were introduced: the Lunacy (Supreme Courts) Act, the Lunacy (District Courts) Act and the Indian Lunatic Asylum Act. To these, the Military Lunatic Act was added in 1877. These pieces of legislation were consolidated in 1912 under the Indian Lunacy Act, which drew heavily on the English Lunatics Act, 1845.

Shortly after Indian independence in 1947, a modern mental health act was drafted, but this legislation took over 35 years to be adopted, finally becoming the Mental Health Act, 1987. There were concerns about the content of this legislation from the outset, as many of its provisions were over 35 years old and the delivery of mental health services had changed significantly over that time. In 2007, India's ratification of the CRPD provided further impetus for updating the legislation. The demands of the CRPD required that existing legislation be replaced rather than revised, owing to the extent of the changes needed. The passage of the Rights of Persons with Disabilities Act, 2016 also had significant implications for people with psychosocial disabilities, owing to the inclusion of mental illness in the definition of disability in the CRPD.

Chapter 5 examines India's Rights of Persons with Disabilities Act, 2016 which received the assent of the President of India on 27 December 2016 and was commenced in effect on 15 June 2017. The purpose of the Act is 'to give effect to

the United Nations Convention on the Rights of Persons with Disabilities and for matters connected therewith or incidental thereto'. Key provisions cover 'rights and entitlements'; 'education'; 'skill development and employment'; 'social security, health, rehabilitation and recreation'; 'special provisions for persons with benchmark disabilities' and 'high support needs'; 'duties and responsibilities of appropriate governments'; 'registration of institutions for persons with disabilities and grants to such institutions'; 'certification of specified disabilities'; 'Central and State Advisory Boards on Disability and District Level Committee'; 'Chief Commissioner and State Commissioner for Persons with Disabilities'; 'Special Court'; 'National Fund for Persons with Disabilities'; 'State Fund for Persons with Disabilities' and 'offences and penalties'.

Overall, India's 2016 Act presents a broad range of rights-based provisions aimed at giving effect to the CRPD and improving the rights of persons with disabilities in India. It legally underpins many economic and social rights and emphasizes respect for inherent dignity; individual autonomy; full and effective inclusion and participation in society; respect for difference; acceptance of persons with disabilities; equality of opportunity; accessibility and respect for the evolving capacities of children with disabilities. Concerns centre on the 2016 Act's interactions with India's MHCA, methods of assessing and certifying disabilities, the position of families of persons with mental illness and specific concerns about neurodevelopmental disorders.

Chapter 6 of this book moves on to examine the content of India's MHCA, which received Presidential assent on 7 April 2017 and was commenced on 29 May 2018. This Act seeks explicitly to align India's mental health legislation with the CRPD (UN 2006). Key provisions of the new legislation cover 'preliminary' matters and definitions; 'mental illness and capacity to make mental healthcare and treatment decisions'; 'advance directive'; 'nominated representative'; 'rights of persons with mental illness'; 'duties of appropriate government'; 'Central Mental Health Authority'; 'State Mental Health Authority'; 'finance, accounts and audit'; 'mental health establishments'; 'Mental Health Review Boards'; 'admission, treatment and discharge' (including 'independent admission', 'admission of a minor', 'supported admission' and 'supported admission beyond 30 days'); 'responsibilities of other agencies'; 'restriction to discharge functions by professionals not covered by profession'; 'offences and penalties' and other 'miscellaneous' matters, including *de facto* decriminalization of suicide.

Overall, Chap. 6 argues that the 2017 Act presents a broad range of provisions which, if implemented, will affect virtually every element of mental health services in India. Many of the changes are clearly informed by the 2017 Act's explicit aim to meet the requirements of the CRPD. The legislation has stimulated considerable discussion in the psychiatry literature and while one line of discourse is that the new legislation was not needed in the first place, and that amendments to the Mental Health Act, 1987 would have sufficed, there is nonetheless an acceptance that the new Act will have practical and legal implications in practice and needs to be understood.

Part III of the book considers 'India's Mental Healthcare Act, 2017 and International Human Rights Standards'. Chapter 7 begins by exploring areas of concordance and non-concordance between Indian legislation (especially the MHCA) and the WHO *Checklist on Mental Health Legislation* (WHO 2005). Overall, India's MHCA and Rights of Persons with Disabilities Act, 2016 have done much to bring India's legislation in line with the WHO Checklist. As a result, India currently meets 68.0% (119/175) of the WHO standards, at least in theory (Duffy and Kelly 2017). This far surpasses many other countries whose legislation has been compared to these standards; legislation in England and Wales, for example, meets 54.2% of the standards and legislation in Ireland meets 48.2% (Kelly 2011).

Regarding the 56 WHO standards that remain unmet in India, Chap. 7 notes that eight standards relate to areas in which direct comparison is not possible and 10 relate to areas of well-justified non-concordance, with the Indian legislation embracing the principles of human rights in a more pragmatic, insightful way than the WHO in these instances. Many of the remaining standards are not addressed directly in Indian legislation but provision exists for them to be addressed in policies relating to mental healthcare, general healthcare and social care. When areas of complex comparison are excluded from the analysis and areas of justified non-concordance are considered concordant, Indian legislation meets a remarkable 77.2% (129/167) of the WHO standards, consistent with its aims to protect and promote the human rights of the mentally ill. While further work is certainly needed, India's MHCA already offers a valuable model for other countries seeking to update their mental health laws, once it is adequately resourced.

Chapter 8 moves on to consider the 'Incorporation of the United Nations' Convention on the Rights of Persons with Disabilities into Indian Law through the Rights of Persons with Disabilities Act, 2016 and the Mental Healthcare Act, 2017'. This chapter examines the extent to which Indian legislation meets CRPD requirements relating to 'equality and non-discrimination' (CRPD Article 5), 'women with disabilities' (Article 6), 'children with disabilities' (Article 7), 'awareness-raising' (Article 8), 'accessibility' (Article 9), 'right to life' (Article 10), 'risk and humanitarian emergencies' (Article 11), 'equal recognition before the law' (Article 12), 'access to justice' (Article 13), 'liberty and security of person' (Article 14), 'freedom from torture or cruel, inhuman or degrading treatment or punishment' (Article 15), 'freedom from exploitation, violence and abuse' (Article 16), 'protecting the integrity of the person' (Article 17), 'liberty of movement and nationality' (Article 18), 'living independently and being included in the community' (Article 19), 'personal mobility' (Article 20), 'freedom of expression and opinion, and access to information' (Article 21), 'respect for privacy' (Article 22), 'respect for home and the family' (Article 23), 'education' (Article 24), 'health' (Article 25), 'habilitation and rehabilitation' (Article 26), 'work and employment' (Article 27), 'adequate standard of living and social protection' (Article 28), 'participation in political and public life' (Article 29) and 'cultural life, recreation, leisure and sport' (Article 30).

Overall, Indian legislation addresses the great majority of CRPD requirements in these areas although certain areas could be improved (e.g. political rights, liberty of movement and nationality). Careful monitoring of the implementation of India's new pieces of legislation will be especially important, both for India and for other countries seeking to bring their legislation in line with the CRPD. Globally, India has taken the strongest steps to date towards legislating for social rights in this way, including, in particular, rights to free healthcare and rehabilitation.

Chapter 9 focuses more closely on the 'Compliance of India's Mental Healthcare Act, 2017 with the United Nations' Convention on the Rights of Persons with Disabilities'. More specifically, this chapter notes that the MHCA has the distinction of being the first piece of major mental health legislation explicitly written in order to comply with the CRPD and, despite various limitations and areas of non-compliance that are discussed in detail in this chapter, both the MHCA and the Rights of Persons with Disabilities Act, 2016 have done much to realize the principles of the CRPD in Indian law. Where practices outlined in the MHCA appear to contravene the CRPD, protections have usually been put in place, chiefly mediated by Mental Health Review Boards. Instances of non-concordance with the CRPD generally result from efforts to balance competing CRPD rights with each other, and this balancing act is often directly reflected in the text of the MHCA.

The two most significant areas of potential non-concordance with the CRPD relate to the role of capacity in the MHCA and the lack of sufficient protection during emergency treatment. These limitations may, however, reflect pragmatic compromises in a setting of limited resources, especially as some of the other provisions described in the MHCA might already prove too ambitious to be implemented in the first place. Overall, while India's MHCA might not be entirely in line with the interpretations of the UN Committee on the Rights of Persons with Disabilities (2014), the vast majority of its provisions are compatible with the CRPD itself.

Chapter 10, titled 'Adhering to Conventions: Intentional Grey Areas or Shirking Responsibility?', notes that mental health legislation is going through a period of transformation, driven largely by international guidelines and conventions, including the WHO *Resource Book on Mental Health, Human Rights and Legislation* (WHO 2005), the UN *Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (UN, 1991) and the CRPD (UN, 2006). As argued in previous chapters, India's Rights of Persons with Disabilities Act, 2016 and MHCA exceed the levels of concordance with international standards seen in other jurisdictions owing to their extensive inclusion of social rights and attempts to limit coercive measures.

Nevertheless, various ethical issues still arise in the Indian legislation, relating to (a) medical ethics in resource-scarce environments; (b) beneficence and definitions (e.g. the definition of disability); (c) autonomy and capacity and (d) the evidence base for care. There are, in addition, three notable and intentional deviations from the CRPD in the areas of (1) capacity and limited guardianship; (2) coercive treatments and (3) migration, citizenship and nationality. Overall, the Indian legislation seeks to balance idealism with pragmatism and to navigate six key tensions

between (i) autonomy and dignity; (ii) restriction and ineffectual treatment; (iii) universal and personalized treatment options; (iv) ideal and pragmatic treatment; (v) the individual and society and (vi) involvement and privacy. Each of these tensions is explored in this chapter. Future research could usefully focus on better understanding coercion from the perspectives of all stakeholders and finding ways to avoid and reduce it, especially as India's new legislation is implemented over the coming years.

Part IV of the book, titled 'Where now?', provides an 'Implementation Update on Mental Healthcare Act, 2017' (Chap. 11), kindly contributed by Dr. Soumitra Pathare and Arjun Kapoor (Sachan 2013; Shields et al. 2013; Pathare et al. 2015; Bhugra et al. 2016a; Bhugra et al. 2016b; Bhugra et al. 2017; Kapoor and Pathare 2019; Mahomed et al. 2019). Dr. Soumitra Pathare is a Consultant Psychiatrist and Director, Centre for Mental Health Law and Policy, Indian Law Society, Pune. He was appointed by the Ministry of Health and Family Welfare, Government of India to provide technical assistance in the drafting of the MHCA. He was also appointed as a member of the policy group for drafting India's National Mental Health Policy, 2014. He currently leads the Centre's projects and is Principal Investigator of the Suicide Prevention and Implementation Research Initiative (SPIRIT).

Arjun Kapoor is a human rights lawyer and psychologist. He is currently a Research Associate and Project Manager at the Centre for Mental Health Law and Policy, Indian Law Society and is developing the Centre's law and policy unit with a specific focus on capacity building of stakeholders for implementation of the MHCA. He was previously appointed as a Law Clerk and Research Assistant to the Supreme Court of India and has experience in developing socio-legal interventions on access to justice and legal empowerment in India.

In Chap. 11, Dr. Soumitra Pathare and Arjun Kapoor point out that the MHCA has a broad mandate which places obligations on various stakeholders to ensure mental healthcare through rights-based approaches. However, this mandate is likely to be unfulfilled without effective implementation. Since its enforcement, the MHCA's implementation has progressed at a very slow pace (as of time of writing, December 2019). Many State Governments are yet to establish the State Mental Health Authority and Mental Health Review Boards which play a crucial role in the implementation of the MHCA. The legislation has also been subject to judicial scrutiny by the Supreme Court of India and High Courts in matters of public interest for adjudicating important questions of constitutional law and monitoring implementation of the MHCA at the central and state levels.

The MHCA is confronted with several challenges for its speedy and effective implementation. Mental health professionals have expressed resistance to various provisions of the MHCA including advance directives, nominated representatives and modified electroconvulsive therapy. At the bureaucratic level, there is a lack of political commitment to address mental health as a legitimate health concern on a par with physical health. Further, poor intersectoral coordination between different government departments and an inadequate trained mental health workforce are other significant barriers to the MHCA's implementation.

It is thus incumbent upon civil society to assume a proactive role in advocating for mental health as a priority on the national agenda to address systemic gaps, infrastructural deficits and human resource challenges, and to compel Governments to fulfil the MHCA's mandate.

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Abbreviations

AD	Advance directive
APA	American Psychiatric Association
ASHA	Accredited social health activists
BCE	Before Common Era
CRPD	Convention on the Rights of Persons with Disabilities
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive therapy
ESSENCE	Enabling Translation of Science to Service to Enhance Depression Care
EU	European Union
ICD	International Classification of Diseases
MHCA	Mental Healthcare Act, 2017
NIMHANS	National Institute of Mental Health and Neuro-Sciences
NR	Nominated representative
POCSO	Protection of Children from Sexual Offences Act, 2012
PTSD	Post-traumatic stress disorder
RPWDA	Rights of Persons with Disabilities Act, 2016
SPIRIT	Suicide Prevention and Implementation Research Initiative
UK	United Kingdom
UN	United Nations
US	United States of America
WHO RB	World Health Organization's *Resource Book on Mental Health Legislation*
WHO	World Health Organization

List of Tables