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Mental Health Law Paradigm: Scope of Rehabilitation and Interlinkages of Allied Laws

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ABSTRACT

The research paper discusses the Mental Health Act 2017. Examines the paradigm moves towards rights-based care, thereby identifying a gap in rehabilitation for different groups, like rape victims, survivors of sexual harassment, and other disabled individuals under other various acts allied with the Mental Health Act. It deeply absorbs the connection of the mental health paradigm with other national and international laws and guidelines. It criticizes the lack of interlinkage between the statutes of the Mental Health Act and execution, which leads to fragmented support, a lack of infrastructure, and the utilisation of resources and overlooked mental health problems and illnesses. Despite having advance directives for mental health and community integration, all the above-mentioned problems pertain. This paper proposed the reforms with respect to legislative changes for holistic integration, improvement in provisions for rehabilitation and deep association with constitutional rights under Article 21 to create a comprehensive mental health regime aligned with the international framework and goals for mental health

KEYWORDS

Mental health, Allied laws, Rape survivors, Article 21, Criticism of execution

1. INTRODUCTION

The very objective for enforcing the Mental Healthcare Act, 2017[1] (Hereinafter referred to as "MHC") was to create an expansive arena of rights pertaining to mental illness, wherein the same is defined under the MHC[2] containing; sociological values being made inclusive of factors like "disorder of thinking", "mood", "perception", "orientation", "behaviour" or "capacity to realise reality"; which in a broader sense are the universally accepted factors. Whereby the connotation of MHC is extended to all citizens of the Republic of India (Hereinafter referred to as "India/Indian"), the law laid therein touches the social capacity of any citizen and lets that citizen decide at any relevant time about the course of their own treatment. The generic purpose as reflected is to ensure that the communication and interaction between mentally ill citizens and others is protected, and the state extends mental healthcare-related benefits, whilst simultaneously regulating other factors around mental healthcare. As mental illness is well-discussed under the Mental health Act of 2017 that includes various categories of individuals need suffering from mental illness need due care, as Section 2 (1) (s) of the MHC itself states that *"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.*[3] Even after keeping the statute very descriptive and clear with respect to highlighting the individuals who need mental health care under Section 18, the definition is not inclusive of those citizens who have been victims and have been facing *"Post-Traumatic Mental Illness"* as protections enlarged under other allied laws, pertaining to mental illness, also have to be addressed. As such, deprived and victimised citizens, specifically rape victims and sexual harassment victims, would also require adequate care for mental health. Further the updated rules for mental health "Right of Person with Mental Illness Rule, 2018" under Rule 2(1) (e) talks about Hospital and community-based rehabilitation services, law again remains silent for the rehabilitation and care of female workers abused of sexual exploitation and rape victims and law doesn't provide any such provisions for protection of

[1] Mental Healthcare Act 2017.
[2] Mental Healthcare Act 2017, s 2(1)(o).
[3] Mental Healthcare Act 2017, s 2.

their rights and duty of state towards them to be fulfilled. Hence, at the outset, it is clear that there is a requirement for rehabilitation and interlinkages under the MHC.

It is pertinent to note that there were policies brought in place much before enforcing MHC; wherein even such policies were suggestive of the said enlarged rights, that there would be an environment facilitated; that citizens would be given wider rights to decide their own treatment, basis, their situation of crisis, realising their rational need instead of having any legislative imposition. Wherein the Central Mental Health Authority and State Mental Health Authority would focus on administering other factors and infrastructure to extend mental healthcare benefits. MHC statutorily lays down the entire model of these authorities, but is also inclusive of "Advance Directive" which renders any right citizens to approach these authorities without any discrimination; but on the same side, there is no specifically reserved right for victimised citizens.

Wherein, after having rolled out such an expansive right, there is a legislative gap between MHC and other Statutes; bearing legal requisitions qua "Mental Health", wherein such other allied laws could also be catered through MHC, which is not the case and has been missed. Bringing in such dynamic inclusion by having interlinkages of other parallel acts would have created the most fertile mental health regime. Wherein many practical implications could have been saved, parallel to the rights extended under the MHC; Could also extend itself to prevent such other mental illnesses caused by technostress and non-dignified workplace culture; realizing that there are such amongst other flaws as left out under MHC alongside its shorter implication in against of such rights laid out for disabled citizens, its non-inclusive approach towards victims of sexual abuse and rape at the outset showcases larger legislative gaps that have been identified by the present authors have undertaken to give reasonable resolutions to address such gaps while writing the present research.

On the other hand, MHC extends itself to many other unique and salient features like the duties of police officers while engaging with a citizen suffering from any form of mental illness; compliance and reporting to the Magistrate, prisoners who are suffering from mental illness and the process of law to be followed while investigating a prisoner suffering from mental health.

2. MENTAL HEALTH LAWS IN INDIA

Mental health is considered an important foundation of public health and an essential determinant of the nation's socio-economic development, also when we speak about India; it is a country that is characterised by its heterogeneous population and vast socio-economic strata, with significant gaps in the treatment that are pre-existing, making the burden of mental illness tougher. Many other factors contributing to the cause of disturbing mental health have not been addressed; whereas on the brighter side, the complete infrastructure required for national needs has been laid. Further, calling for legislative attention for streamlining all such factors which could contribute to construct one holistic law, which would, in return, serve a larger public purpose.

The National Mental Health Survey (NMHS) 2015-16[4] stated that nearly 150 million people in India require active treatments and mental health care interventions. Yet, the gap in treatment remains increasingly high, with the majority of the population not receiving any appropriate care and attention.[5] The economic loss due to mental health issues and the condition of mental health in India between 2012 and 2030 is estimated to be over USD 1.03 trillion, which is exceptionally high. Hence, it is evident that MHC also requires it to serve as a social engineering tool to safeguard larger economic interests, being part of the same set of public interests.

Historically, mental health-related legislation in India was first governed by the archaic "India Lunacy Act, 1912" and after that "Mental Health Act, 1987", both of which were criticised for their custodial approach and constitutional focus. Both acts failed to uphold basic human rights of people with mental illness and ignored basic intricacies of the mental health issues. They failed to acknowledge the fundamental rights to accessible, affordable and quality mental health care provided in the country. With MHC coming into force, deliberate attention has been put into securing social interest and the same is reflected under MHC as many soft rights have been assured by opening window under a dedicated special legislation; such rights are as follows "Community Living", "Protection from Cruel, Inhuman and Degrading Treatment",

[4]National Mental Health Survey of India 2015-16 (National Institute of Mental Health and Neuro Sciences, Ministry of Health and Family Welfare) https://indianmhs.nimhans.ac.in/ accessed 20 December 2025.
[5]Ministry of Health and Family Welfare (MoHFW), *National Mental Health Survey of India, 2015–16* (n.d.) https://www.mohfw.gov.in/sites/default/files/National%20Mental%20Health%20Survey,%202015-16%20-%20Summary%20Report_0.pdf accessed 27 October 2025.

"Right to Confidentiality"; but the larger purpose therein is secured against availing services and ensuring that such adequate and fruitful service for treatment for mental health is received. This categorically spells out a gap, which suggests that the statute will ensure that there are licensed mental health practitioners, but at the same time, there is no right created for extensively protected victimised citizens who are protected under other allied acts; such protection, if it were to have been extended, would have saved the consequent cost of operating rehabilitation under other acts and infrastructure.

"Mental Health Law" paradigm shift was necessitated and affirmed by India's ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007.[6] The said ratification and international commitment with domestic judicial activism paved the way for the acceleration of legislative change. The most significant of these changes was the Mental Health Act 1987, which repealed the Mental Health Act 1987, which fundamentally redefined the legal structure and landscape of the mental healthcare laws of the country.[7]. There were operative guidelines and national policies in place which facilitated the purpose of studying the holistic need for such a shift in paradigm.

The smooth integration of MHC with other allied laws into the nation's current healthcare system is essential to fulfil the MHC's requirements. The primary policy tool aimed at shifting care from specialised asylums to easily accessible District Hospitals and Primary Health Centres, and the District Mental Health Program, which is run under the National Mental Health Program; whereas rehabilitation of victimised citizens has still been overlooked.

The previous policies, which were in place, supported a task-sharing model that teaches community health workers and general practitioners to treat common mental illnesses; a practical and cost-effective way to address the workforce shortage while effectively utilising the human resources already in place. Furthermore, a large portion of the vulnerable and impoverished population can receive treatment without incurring catastrophic costs thanks to the inclusion of mental health services in the Health and Wellness Centres and the Ayushman

[6] United Nations Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3 (UNCRPD).
[7] G Gururaj and others, *National Mental Health Survey of India, 2015–16: Summary* (NIMHANS Publication No 128, 2016).

Bharat – Pradhan Mantri Jan Arogya Yojana[8] health insurance scheme. This directly aligned such mental health policies with the national goal of reducing poverty; whereas, while these policies were steered to serve the larger public good as an interim arrangement, and had to study other requirements in parallel, there stands a gap, wherein there are inflicted offences causing mental illness, the nature of all such offences being against the state. Hence, the present MHC simply being used as a tool to address mental illness has a narrower scope for those citizens who have been perplexed and wronged against their will, who are otherwise covered and protected under different laws, but could have been given a special reservation under MHC, allowing them to utilise the infrastructure of the government as established under MHC. The said cause is highlighted since there is a dedicated *"Chapter XIII - Responsibilities of Other Agencies";* since there is a dedicated saving for other agencies, the allied requirements cropping out from other statutes could have been saved at the same time.

- **Sukdeb Saha v. State of Andhra Pradesh[9]**

MHC talks about various aspects to improve mental health concerns in India, including *"Advance Directives"*; whereby it's the right of the person with mental illness, and duty of the *"Mental Health Establishment"*, and other essential infrastructure, and even includes the establishment at the district level and helpline numbers, but the solution-based individual-level recognition remains absent in the whole legislation. Therefore, when the scenario as came-up with this case was out of the reach of legislative reach, and court established the 15 guidelines to prevent suicide and improve mental health in educational institutions. All fifteen points aligned around the students and the concern, which may be provocative for suicide and simultaneously establishing policies at the institutional level for betterment of mental health and mandate to provide counselling facilities at the institutional level so that the expert would be able to relate better with students and keep them mentally healthy. Continuous supervision and consultation with students, establishing policies and mandating several grassroots-level regulations and compliance facilitate the accurate aim of the MHC. Therefore, it can be derived that the act itself is not of that nature to include various aspects of individual suffering from mental health and fails in another major aspect of detecting the person suffering in various special cases like minors, Women, persons with disabilities, prisoners, etc.

[8] Ministry of Health and Family Welfare, 'Ayushman Bharat - Health and Wellness Centres' (Government of India) https://aam.mohfw.gov.in/home/aboutusaccessed 12 December 2025.
[9] Sukdeb Saha v State of Andhra Pradesh INSC 893 (SC) [para 35].

- **UGC Guidelines, 2025**[10]

Ministry of Home Affairs established a skeleton guidelines for mental health wellness and in compliance to MHC, whereafter University Grant Commission (Hereinafter referred to as "UGC") published the mental health guidelines for promotion of physical fitness, sports, students health, welfare, psychological and emotional well-being at higher educational institutions of India which promotes various activities as also inclusive of the academic curriculum and co-curriculum; alongside various mandates were established for the institutions to implement these guidelines in directive form. The guidelines focus on various baseline problems like depression amongst students, widespread anxiety disorders, various pressures from academics & peers, self-doubt by marginalised student groups, sleep deprivations, negative scores and performance, ill treatment by peers, etc., which lead to mental illness amongst students in higher educational institutions.

Guidelines establish indicators to observe these problems amongst students and institutions; these institutions were directed to provide due and adequate mental health wellness support and care for them by engaging and appointing the requisite professionals in their institutions. With respect to these problems and indicators provision established in the guidelines, UGC also provided some targets to achieve by the implication of these policies at the institutional level and try to meet the credentials established globally by the international organisations like WHO. Therefore, the guidelines although provides the statute under the umbrella of MHC only but this may also indicate that other common causes as left unattended from other allied statutes were rehabilitation is required is left unattended in furtherance to improve MHC and this leaves an open question; and scope for deeper routed rehabilitation for all other forms of unattended mental health patients who would also need state attended and state rendered treatment to suffice the constitutional right as vested under Article 21. It is undeniable that all necessary care has been undertaken while drafting and enforcing the Act, but the larger needs could have been well accommodated.

[10] University Grants Commission, 'Framework Guidelines for Emotional and Mental Wellbeing of Students in HEIs' (UGC, 2025) https://cdnbbsr.s3waas.gov.in/s3bc88bb2c377261b0336312714b96fcfd/uploads/2025/05/20250514154970 8982.pdf accessed 02 December 2025.

- **Sikha Nishal v National Insurance Company, Delhi HC**[11]

MHC governs and regulates the subject matter of mental health in India; the act is aligned with the sustainable development goals as framed for mental health, thereby all criterions of "Mental Health" have been well adopted and major concerns at universal level have been taken care of; it is also to be noted that MHC is by far the most effective and dynamic mental health care legislation across all jurisdictions and therefore creates a positive effect of globalization in the domestic arena, parallelly setting out an example for all the developed nations to understand the scope of mentally ill citizens and their rights that have been made inclusive in it.

It is further very pertinent to note that when the dispute of the above captioned matter reached Court; inclusion of mental health under the criteria of health become questionable to claim the insurance; whereafter the decision of Court opened door ways of jurisprudence around mental health; wherein the Court was pleased to allow the prayers as sought by the petitioners therein and stated that mental health is supposed to be inclusive of health and is synonymous to physical health; hence mental illnesses would stand covered under the insurance.

This landmark judgement establishes the principle with respect to mental health and insurance laws, but also became a pillar for further development of the mental health law regime in India. This judgement further came to be preferred in various judgements where the mental health criteria came up with the equal importance of physical health. The Court's final judgement could be quoted as a new principle of law, stated as follows: ***"Insurer must treat physical and mental illness equally",*** which is the generic objective caused and perpetuated by enforcing MHC.

Yet again the cause of the present research is quoted, that since the precedents of Indian Courts are recognizing all parameters to illustrate and promote the importance of mental health; the law should be enlarged in such a manner to the victims of bodily harms and such other victims subjected to verbal assaults, wherein such victims should be allowed with dynamic protection under MHC wherein the state extends all guarantees of Article 21[12] utilising the resources and

[11] Shikha Nischal v National Insurance Company Limited & Anr, 2021 SCC OnLine Del 2577 (Del HC, 19 April 2021), W.P.(C) 3190/2021. https://delhihighcourt.nic.in/app/case_number_pdf/2021:DHC:1402/PMS19042021CW31902021_193334.pdf

[12] Constitution of India 1950, art 21.

infrastructure deployed to govern MHC, which in turn would render a far more glorified identity to advancements under the mental health law regime in India.

3. MENTAL HEALTH ACT AND OVERPLAY OF DISABILITY ACT

- **Rights of Persons with Disabilities Act, 2016** [13]

India has extended its statutory rights for disabled people by introducing Rights of Person with Disability Act 2016 (Hereinafter referred to as "RPwD"), extending to 21 disabilities under RPwD, surprisingly autism and cerebral palsy and other mental disabilities are inclusive of RPwD; all other pre - existing disabilities with a condition of more than 40% impalement has been imposed to invoke implications and rights as reserved under RPwD. Whereas, surprisingly, the mental health illnesses as enacted under the disability act would only have extension to the Mental Health Act only if they have occurred with other mental disorders as mentioned under MHC, which creates a shadowing effect and policy-based confusion under both the acts. Whereas, the mental health illnesses as covered under RPwD have a one per cent reservation in govt jobs, which is not available under the MHC. Whereas on the other side, citizens suffering from autism and cerebral palsy and other mental disabilities do not get the right of "Advance Direction" as extended in Section 5 of MHC, which is a deprivation of right, which could, in return, not only affect those affected citizens but also the families of such citizens. "Advance Directive" in itself is one of the most remarkable features of MHC. If the same is extended to those affected citizens under RPwD, it would create a just and fair balance amongst these soft laws, as extended by way of statutory laws in a globalising era.

- **Digital Mental Health Gaps**

The Legislative gaps as seen under MHC are now covered by way of other bills; one amongst such other bills is the "Right to Disconnect Bill of 2025". Wherein the need for such a dedicated legislation constructing an additional right specifically to disconnect oneself from their respective work-related responsibilities, keeping in mind their respective mental health, is backed by the data of Tele-Manas, which has handled more than 1.8 million calls until 2025, wherein such calls have specifically indicated significant and practical gaps between regulatory and day-to-day practices of an exploitative nature affecting mental health. Wherein there are

[13] Rights of Persons with Disabilities Act 2016.

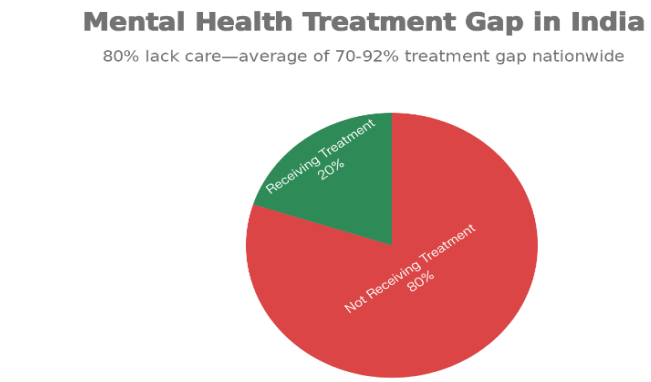
53 Tele-manas cells operated across 36 States and Union Territories, surprisingly, out of the total number of calls on date 18/12/2025, 8.1% of calls have been made indicating suicide tendencies. It is important to note that all these factors have yet to be addressed under the Mental Healthcare Act. There is a perpetual need for Right to Disconnect, as the same could be interpreted from the definition of mental illness. As and when the ability to make decisions is curtailed, it would be addressed as mental illness; and prolonged work exposure without due and adequate rest may cause symptoms and may later also turn into mental illness.

MHC at large is a dedicated legislation qua mental health care, whereas it is also suggestive of promoting programmes as laid under Section 29 of MHC; wherein the verbiage of the relevant provision suggests *"Mental Health and Prevention Programmes"* hence the act is suggestive and accommodative of many factors, and such other values could also be promoted using the infrastructure as established under MHC, making it more dynamic and more inclusive. Hence, it could be rightly said that MHC could have a larger effect on many other legislations if appropriate linkages are constructed amongst allied laws.

4. "INDIA'S MENTAL HEALTH CHALLENGE: BREAKING DOWN THE STATISTICS"

- **Infrastructure**

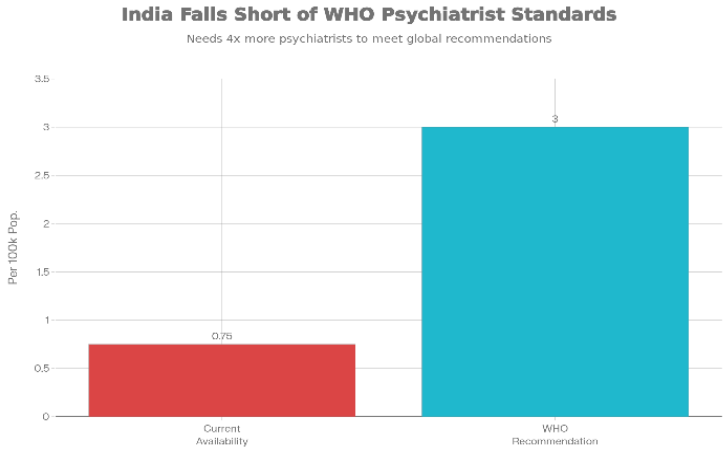
MHC brought in a revolution by opening the doors of the mental health care regime like never before; it added the value of care to it, yet the value of rehabilitation was overlooked. After the enforcement of MHC, possibly all states and Union Territories complied with the requisite and essentials of MHC as endowed upon each state body; and thereby MHC was effectuated in the sense of laying out its functional infrastructure, budgetary allocations were also made in reference to the context of mental health care. Even after making such dynamic moves, a major shift in India's mental health care regime is not observed, as there is less awareness and there are very few programmes floated by respective state governments. In a report published by the Press Information Bureau with the Ministry of Health and Family Welfare on 7 February, 2025 descriptively mentioned the current scenario of mental healthcare in India. The following diagram represents statistics of the data provided in the report:



Diagrammatic representation of data about 70% to 92% of people with mental disorders do not receive proper treatment due to a lack of awareness, stigma, and a shortage of professionals.[14]

- **Professional experts**

The report further discusses the treatment gap with the prospective availability of professional experts, which is one of the major reasons, based on India's heterogeneous population. Another major reason circling the same issues is the number of professionals available in ratio with the citizens requiring mental health treatment; as per the criteria of the WHO recommendation, there is a requirement of having a certain number of professionals for a certain strength of population. The following diagram is a graphical representation of the shortage of psychiatrists:



According to the Indian Journal of Psychiatry, India has 0.75 psychiatrists per 100,000 people, whereas the WHO recommends at least 3 per 100,000.[15]

[14] 'Advancing Mental Healthcare in India' (Press Information Bureau, 7 February 2025) https://mohfw.gov.in/?q=en/pressrelease-206accessed 20 December 2025.
[15] Ibid.

5. SUSTAINABLE DEVELOPMENT GOALS ON HEALTH

With the advent of modernisation and sensitisation towards health, the definition of health is made expansive on contributing values and depreciating values, but on the other hand, it has also been made inclusive of mental health. There were several criteria laid under the definition of health established by WHO, which further discusses evolving global mental health concerns. Having the same made inclusive of the core 17 Sustainable Development Goals, having[16] "Health" is the 4th SDG, whilst considering the same as an important aspect of Sustainable Development Goal.

MHC is inclusive of all the factors required to be considered and taken care of, while formulating municipal law, whereas MHC is miles ahead of many developed nations; as the WHO guidelines suggest, focus on improving mental health, focusing on treatment of such classified disorders, improving and maintaining mental health in various situations, post-trauma depression treatment and counselling, suicide rate reduction, etc. Sustainable goals are now not only associated with the growth and sustainability of the state but also the people of the nation. The global sustainable development goals set a frame for India's domestic regime for sustainable development. India, while ensuring larger health care is extended to its citizens, has also focused on giving autonomy of treatment and kind of treatment to its citizens by law, as laid under Section 5 of MHC, addressed as "Advance Directive", which makes it evidently clear that India has focused and developed a law larger than its required purposes.

MHC has not just addressed contemporary needs but has made it extensive beyond the required contours, whereas there are certain factors which have to be looked into, such being not addressed in SGD's; which are more centric on *"Post Trauma Mental Illnesses";* wherein the most important factor to be noted is, that Indian legal framework has various provisions, saving such specific requirements, but are not interlinked with MHC, and the purposes of the present research is to suggest that on carrying out such changes it would make the Indian mental health care regime, truly focused on care and rehabilitation. As India had realised such needs way before, even before the same could have been suggested under an SGD, the National Mental Health Program in 1982 was launched in India, much before MHC could be enforced. Wherein the said policy primarily focused on improving the mental health of the Nation. MHC includes

[16] United Nations, 'Sustainable Development Goals' (UN, 2015) https://sdgs.un.org/goalsaccessed 20 December 2025.

the protection of the list of rights under Chapter - V and respective duties of government in Chapter - VI; also inclusive of several aspects of establishment of authorities at various vertical levels of implementation and its administration in this respective sector of mental health care; to facilitate larger usages amongst its citizens whilst making authorities responsible of other allied factors in course of its execution; ensuring contribution in betterment of the society with the aim of better mental health. The Ministry of Health and Family Welfare (Hereinafter referred to as "MoHFW") is steering the entire administration under MHC; additionally, MoHFW also focuses on several contemporary and evolving aspects with respect to mental health from the grassroots level for the implementation to the higher authority level for framing various policies for mental health betterment in India. MoHFW has established the National Mental Health Program and District Mental Health Program, including the helpline service for immediate action to be taken to understand the state of mind for providing optimal solutions and counselling for the needy individual suffering from mental health concerns.

6. CONTEMPORARY ISSUES RELATED TO MENTAL HEALTH IN INDIA

- **Mental Health of Rape Victims and Sexual Harassment**

It is very pertinent to note that under Section 396 of Bharatiya Nagrik Suraksha Sanhita 2023[17]There is a special right for compensation for rehabilitation reserved for rape victims, covering *"Post Traumatic Mental Illnesses";* whereas if the same is interlinked and brought under one roof, that is MHC, the suggested consequence would not only save state cost and consequences, but the state would be able to justify its duty while guaranteeing protection of rights as enshrined under Article 21. The Rehabilitation, as discussed under Section 18 of MHC, would also reach its logical end, for the said purposes, specific changes under Section 18 of MHC are required, which draw necessary linkages.

While steering the present research specifically in the direction of rape victims and coverage of *"Post Traumatic Mental Illnesses"* rights under MHC brings out an estranged realisation that there is no protection by way of a separate provision under the MHC for rape victims. Whereas Rape victims even otherwise have the right for immediate psychological aid and counselling, which would be useful for their rehabilitation, protection against refusal of treatment, have specific rights for dignity and not discriminatory treatment, yet such are

[17] Bharatiya Nagarik Suraksha Sanhita 2023, s 396.

covered by separate provisions under the MHC, which would not just render them the most appropriate mental health care, but ensure appropriate physical treatment under one roof. Whereas the existing protection available for rape survivors under the act was also extended by the Hon'ble Apex court of India by way of *Nipun Saxena v. UOI, 2018*[18]*, Delhi domestic workers union v. UOI, 2010* [19]*and Lilu v. State of Haryana, 2013*[20] wherein the Hon'ble apex court categorically held that the two-finger test theory violates dignity, privacy, but also mental health, which is explicitly not covered under MHC; the suggested coverage would be to have such rape victims examined, treated and taken care of as per the norms extended under MHC, whilst making other relevant interlinkages. Presently, there are indirect protections extended under section 20 of MHC.

Sexual Harassment at Workplace (Prevention Prohibition and Redressal) Act of 2013 (Hereinafter referred to as "POSH") and the MHC Act 0f 2017 are both very silent over the fact that the complainant under the POSH and the inquiry committee can both suffer from *"Vicarious Trauma"* as there is no statutory mandate under both the acts to have a mental health professional on board of the inquiry committee present at all times during the course of proceedings. Whereas both the laws could be interlinked and the audit as specified under Section 21 of POSH, wherein Annual Reports have to be submitted to the District Officer, the same compliance could be brought under direct executive control of the state authority as established under MHC, saving costs and infrastructure.

7. LIMITATIONS, CONCLUSION AND SUGGESTIONS

It is evident from Report no. 74, that the legislative intent was only to replace the old Mental Health Act of 1987 with MHC, whereas standing committee drafted one of the far most advanced mental healthcare legislations, making it the easiest accessible statutory right, wherein additional infrastructure qua facilitating and trotting such rights under MHC, there are separate funds which are allotted for making mental health care inclusive of welfare activities. But with scope and room for improvisation, certain dynamic interlinkages amongst allied laws, and sharing of such infrastructure created under MHC for regulating other allied laws, is the comprehensive suggestion rendered hereunder, based on evaluation across several other allied

[18] Nipun Saxena v Union of India (2018) 10 SCC 161.
[19] Delhi Domestic Working Women's Forum v Union of India (1995) 1 SCC 14.
[20] Lillu @ Rajesh v State of Haryana (2013) 14 SCC 401.

laws, positioning of precedents laid by the Courts and other domestic and international policies and ratified treaties. Such suggestions are based on understated observations.

Section 18 (d) under MHC specifically states and addresses the extension of rehabilitation, wherein the right is definitely extended to all citizens; but there is a scope of specific and special reservation for victims; when MHC itself extends itself to prisoners, it should parallel extend to victims of severe bodily harm, and such other victims who have been verbally abused and assaulted. It is a definite requirement as rehabilitation is a right for such victims. i.e., Rape Victims and Victims under POSH; such rehabilitation is guaranteed under Article 21 of the Indian Constitution. Deliberating on an existing right, stating it to be not specific, is for reasons caused by other specific reservations under Chapter XIII of MHC. The wider usage of infrastructure as extended under MHC, such as Section 21 (a) and (e), shall be exclusively extended to rape victims; in a larger sense referred to as *"Post Traumatic Mental Illnesses",* which shall address more intensive care whilst accommodating their mental health treatments. MHC, being one of the finest health care legislations, could extend more dynamic and comprehensive needs as well.

Whereas MHC doesn't extend its attention to those who are intellectually disabled from birth and are suffering from autism and cerebral palsy, denying rights as reserved under MHC[21]The said interlinkage could have constructed a larger web of rights. Definition of "Mental illness" under Section 2 (1) (s) of MHC[22] talks about the inclusion of individuals' needs, care for their betterment of mental health, but the inclusivity and interlinkage with other allied laws, bearing references to mental illnesses, persists as one of the most pivotal needs to be redressed. RPwD considers various important aspects for the protection of specific individuals, but the synchronisation of MHC lags as it doesn't talk about care of: individuals suffering from cruelty and inhumane treatment; victims of rape, verbal and sexual abuse, violence and exploitation, etc.

More pertinently, where the RPwD talks about the constitutional coverage by the way of section 3, wherein rights to equality and right to life with dignity are extended even as statutory rights; MHC could extend the coverage of Article 21 and could have control over all other

[21] Steadman D and others, 'The Case for Removing Intellectual Disability and Autism from the Mental Health Act' (2021) British Journal of Psychiatry 1 https://doi.org/10.1192/bjp.2020.183accessed 20 December 2025.

rights which are yet to be protected in a constitutional sense. Thus, the said void under the largest possible scope and extent, applicability in MHC, still cuts out that one final leg of improvisation, wherein it could statutorily accommodate rehabilitation of victims' mental health.

To provide a better solution to the mental health regime, the focus of the specific legislation for mental health needs to be in coherence with the allied laws in a way to create a solution-based regime, not only to fulfil the national and international requirements of this jurisprudence of law. Also, considering this perspective of health within the umbrella of fundamental principles of the Grundnorms. Making the legislation before other international jurisprudence is not only a landmark to achieve, but it is also required to take cognisance of ground-level loopholes and problems. Therefore, the execution of the law, making and keeping an eye on development in the provided field of law, is also required. It may be suggested to create a regime which is in synchronisation with all the branches of government, and not only keep questioning the other required authorities over problem-solving motives.