

INVOLUNTARY COMMITMENT: A LEGAL AND ETHICAL EVALUATION OF RIGHTS-BASED LEGISLATION IN EMERGENCY PSYCHIATRIC CARE IN THE INDIAN CONTEXT

by

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ABSTRACT

Involuntary commitment—the practice of detaining and treating individuals with severe mental illnesses against their explicit consent—stands at a volatile crossroad between psychiatric medicine, legal frameworks, and human rights. In India, this practice underwent a monumental paradigm shift with the repeal of the Mental Health Act, 1987, and the implementation of the Mental Healthcare Act, 2017 (MHCA). The MHCA 2017 explicitly aligns Indian law with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), centering patient autonomy, the right to choose, and the restriction of coercive emergency care. This paper evaluates the legal and ethical dimensions of rights-based legislation governing emergency psychiatric care in India. It examines the operational challenges of "supported admission" as a substitute for involuntary commitment, evaluates ethical tensions between medical beneficence and patient autonomy, and highlights systemic barriers such as infrastructural deficits, societal stigma, and implementation gaps. Ultimately, the paper suggests a balanced pathway toward safeguarding human rights without compromising essential emergency medical care.

Keywords: Involuntary Commitment, Mental Healthcare Act 2017, Emergency Psychiatric Care, Patient Autonomy, Supported Admission, Human Rights.

1.Introduction

Emergency psychiatric care often presents severe clinical scenarios where an individual, due to an acute mental health crisis, may lack the immediate capacity to make informed decisions regarding their treatment. Historically, state interventions and psychiatric practices leaned heavily toward medical paternalism. Individuals deemed a danger to themselves or others were subjected to involuntary commitment—institutionalized without their consent under the guise of protection and treatment. In India, early post-independence legislation, such as the Mental Health Act of 1987, heavily favored institutionalization. It provided broad powers to magistrates and medical practitioners, often resulting in prolonged, legally sanctioned human rights violations inside psychiatric asylums. However, global human rights movements, particularly India's ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007, forced a structural reassessment of these coercive practices.

The culmination of this legislative evolution is the Mental Healthcare Act, 2017 (MHCA), which officially took effect in 2018. The MHCA 2017 fundamentally altered the landscape by recognizing mental illness through a rights-based lens rather than a purely clinical or custodial one. It legalizes mechanisms like Advance Directives and Nominated Representatives, effectively aiming to minimize involuntary interventions.

Despite these progressive strides, the practical application of rights-based legislation in emergency psychiatric care creates profound legal and ethical challenges. In a country with a massive population, severe shortages of mental health professionals, and deeply entrenched social stigmas, translating progressive statutory text into ethical clinical practice remains an ongoing struggle.

2. Legal Framework:

The Mental Healthcare Act, 2017

The MHCA 2017 fundamentally redefined how involuntary or coercive care is administered in India. The Act consciously avoids the archaic term "involuntary commitment," replacing it with the concept of "Supported Admission."

2.1 Supported Admission Under Section 89 and 90

When an individual lacks the capacity to consent to treatment during an acute emergency, the law allows a Nominated Representative (NR) to apply for admission on their behalf. However, this is tightly regulated:

- * **Criteria for Admission:** The individual must be determined to have a high probability of causing imminent harm to themselves or others, or be unable to care for themselves, leading to severe deterioration.
- * **Independent Evaluation:** The admission requires independent assessment by two medical practitioners (one must be a psychiatrist).
- * **Time Limitations:** Under Section 89, an initial supported admission is limited to a maximum of 30 days. Continuous review is required for extensions under Section 90.

2.2 Mental Health Review Boards (MHRBs)

To prevent the historical abuse of indefinite institutional confinement, the Act mandates the establishment of Mental Health Review Boards across districts. These quasi-judicial bodies act as oversight mechanisms. Patients or their representatives can appeal to the MHRB against involuntary admissions, ensuring a structural check against medical overreach or familial abandonment.

3. Ethical Evaluations: Beneficence vs. Autonomy

The core ethical dilemma of emergency psychiatric care in India revolves around the tension between two fundamental bioethical principles: Autonomy (the right of the individual to self-

determination) and Beneficence (the duty of the medical professional to act in the best interest of the patient).

3.1 The Absolute Rights Approach vs. Clinical Reality

The UNCRPD advocates for an absolute rights approach, arguing that involuntary commitment based on a mental health diagnosis is inherently discriminatory. The MHCA 2017 attempts to honor this by introducing Advance Directives (Section 5), allowing individuals to state how they wish to be treated (or not treated) during future mental health crises.

However, in emergency situations—such as acute psychosis, severe manic episodes, or active suicidal intent—a patient's capacity to process reality is heavily compromised. Clinicians argue that rigidly prioritizing autonomy in these moments can lead to a "right to be sick" or a "right to die," directly violating the principle of beneficence and the right to health.

3.2 The Indian Sociocultural Dynamic

Unlike Western models of highly individualized care, the Indian healthcare system relies heavily on family networks. The MHCA 2017 shifts significant gatekeeping power to the Nominated Representative, who is often a family member. Ethically, this can cut both ways:

* Positive: Family members offer a continuous support system that understands the patient's baseline personality and triggers.

* Negative: Due to intense social stigma or financial strain, families may misuse "supported admission" pathways to institutionalize difficult or non-conforming relatives, particularly elderly individuals or women in property disputes.

Case Studies: Legal & Clinical Challenges to the Mental Healthcare Act, 2017

The implementation of rights-based psychiatric legislation in India has led to landmarks and foundational disputes in Indian constitutional and family law. The following notable legal

case studies demonstrate how the Mental Healthcare Act, 2017 (MHCA) has been wielded, interpreted, and challenged by Indian courts.

Case Study 1: Sukdeb Saha v. State of Andhra Pradesh & Ors. (Supreme Court of India, 2025)

* The Legal Question: Is the provision of mental healthcare an optional state policy, or is it an absolute constitutional guarantee?

* The Context: Following the tragic death of a 17-year-old student at a highly competitive coaching institute, the Supreme Court expanded its jurisprudence on the Right to Life (Article 21).

* The Judgment: The Supreme Court explicitly ruled that mental health is a constitutional guarantee under Article 21. It relied heavily on the statutory obligations of the MHCA 2017, declaring that the state has an absolute mandate to ensure affordable, quality mental healthcare and trauma-informed environments. The court ordered all states to form district-level monitoring committees to actively curb institutional stress.

* Significance: This case serves as a judicial bridge, turning a statutory right under the MHCA into a non-negotiable fundamental human right.

Case Study 2: Ankur Abbot v. Ekta Abbot (Delhi High Court, 2023)

* The Legal Question: Does an individual with an ongoing psychiatric illness retain an absolute statutory right to an inquiry, and is judicial discretion permitted when a claim of illness is formally entered into record?

* The Context: A petitioner suffering from Bipolar Affective Disorder (BPAD) and Generalized Anxiety Disorder (GAD) sought procedural exemptions and protections under Sections 105 and 116 of the MHCA 2017.

* The Judgment: The Delhi High Court ruled that the MHCA 2017 is a special Act with overriding power over other current laws (via Section 120). The court noted that the phrase "the Court shall refer the same for further scrutiny" in Section 105 is strictly mandatory. It creates a binding, automatic statutory right for the individual that leaves the presiding judge with zero personal discretion.

* Significance: This case established that courts cannot bypass the protections of the MHCA for the sake of fast-tracking standard civil or criminal litigation; the rights-based inquiry must take absolute priority.

Case Study 3: Navtej Singh Johar & Ors. v. Union of India (Supreme Court of India, 2018)

* The Legal Question: Can an individual's non-heteronormative identity be treated as a pathology, and how does medical non-discrimination influence basic civil rights?

* The Context: While primarily celebrated for reading down Section 377 of the Indian Penal Code to decriminalize homosexuality, the Supreme Court's logical framework relied heavily on the text of the MHCA 2017.

* The Judgment: The Supreme Court cited Sections 18 and 21 of the MHCA 2017, which legally demand equal, non-discriminatory access to healthcare regardless of sexual orientation. The Court observed that because Indian statutory law now recognized that homosexuality is not a mental disorder, the state could no longer utilize penal codes to penalize or marginalize LGBTQIA+ individuals.

* Significance: This represents a unique application where a mental health statute was successfully utilized to expand general, nationwide civil liberties and strike down colonial-era criminal laws.

Case Study 5: Retrospective Exemption from Prosecution (Kerala High Court, 2024)

* The Legal Question: Can the humane, rights-based protections of the MHCA 2017 apply retroactively to cases registered before the Act officially took effect?

* **The Context:** A woman was being criminally prosecuted under Section 309 of the Indian Penal Code for attempting suicide prior to the implementation of the MHCA.

* **The Judgment:** Section 115 of the MHCA creates a powerful statutory presumption that anyone who attempts suicide is operating under severe stress and must not be tried or punished. The Kerala High Court held that because the MHCA 2017 is a beneficial piece of legislation, its protective umbrella can be applied retrospectively to throw out past cases. The High Court openly chastised the state for continuing to prosecute a vulnerable citizen instead of offering care and rehabilitation.

* **Significance:** This ruling firmly established that the spirit of the MHCA (empathy over criminalization) takes precedence over rigid timelines of past legal offenses.

Implementation Challenges

While the text of the legislation is highly progressive, its execution faces steep structural hurdles across India.

* **Infrastructural Deficits:** India faces a critical shortage of mental health infrastructure. There is an estimated shortage of over 70-80% in the required psychiatric workforce (psychiatrists, clinical psychologists, and psychiatric social workers). Setting up functional Mental Health Review Boards in every district remains physically and financially unfulfilled in many states.

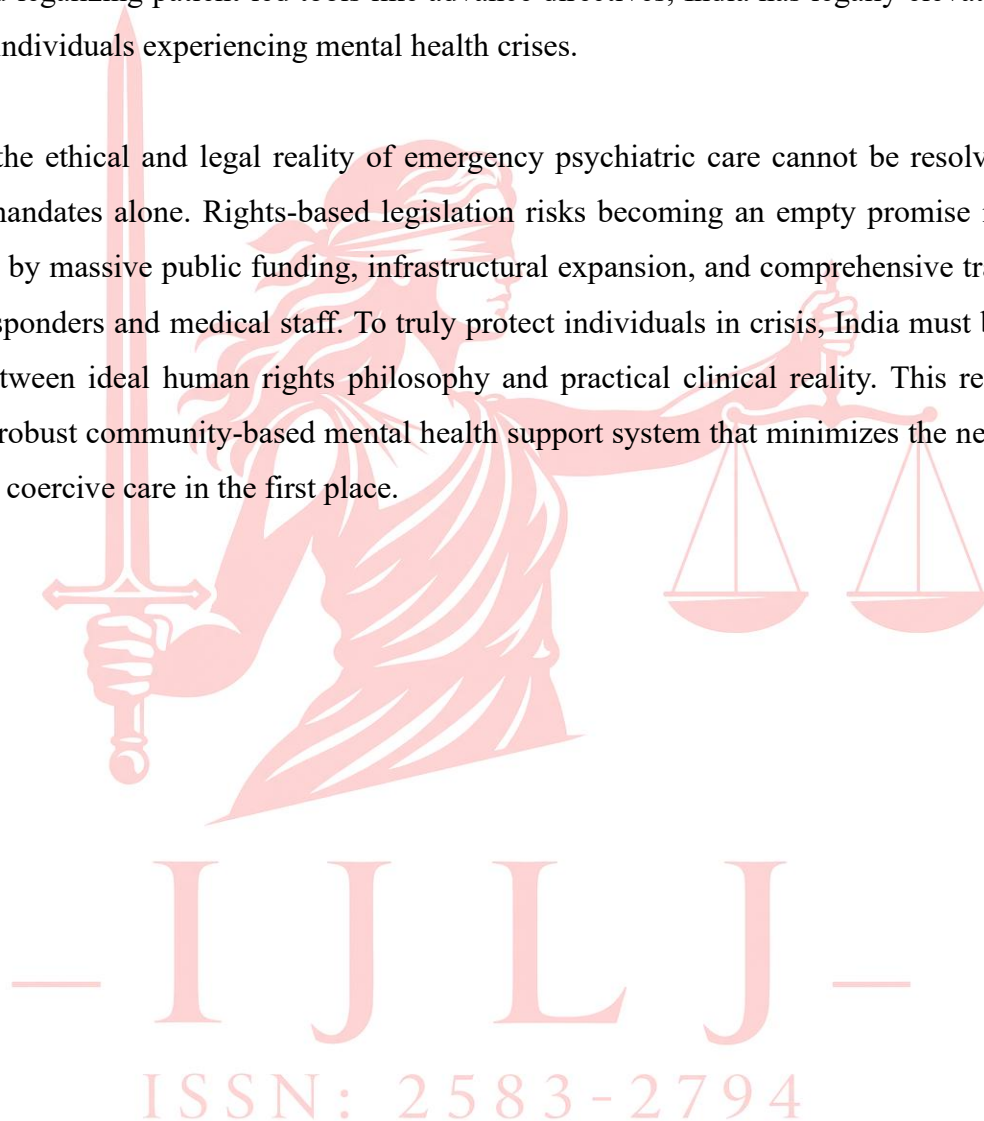
* **Awareness and Legal Literacy:** A large majority of the population, including general practitioners, police officers (who are often the first responders in psychiatric emergencies under Section 100), and even family members, remain entirely unaware of the provisions of the MHCA 2017.

* **The Dilemma of Homelessness:** For wandering individuals with severe mental illness who lack a family or an NR, emergency admission protocols become highly bureaucratic and difficult to execute, often leaving them trapped in the criminal justice system rather than receiving psychiatric care.

Conclusion

The transition from the paternalistic frameworks of the past to the rights-based approach of the Mental Healthcare Act, 2017, represents a historic victory for human rights in Indian psychiatry. By restricting involuntary commitment, establishing independent oversight review boards, and legalizing patient-led tools like advance directives, India has legally elevated the dignity of individuals experiencing mental health crises.

However, the ethical and legal reality of emergency psychiatric care cannot be resolved by statutory mandates alone. Rights-based legislation risks becoming an empty promise if it is not backed by massive public funding, infrastructural expansion, and comprehensive training for first responders and medical staff. To truly protect individuals in crisis, India must bridge the gap between ideal human rights philosophy and practical clinical reality. This requires building a robust community-based mental health support system that minimizes the need for emergency coercive care in the first place.



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