The Academic
International Journal of Multidisciplinary Research

An Online Peer Reviewed / Refereed Journal
Volume 4 | Issue 3 | March 2026
ISSN: 2583-973X (Online), SJIF IF: 5.6
Website: www.theacademic.in

Revisiting the Mental Healthcare Act, 2017: A Critical Socio-Legal Appraisal of Rights, Implementation, and Structural Gaps in India

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DOI : https://doi.org/10.5281/zenodo.19541176

ARTICLE DETAILS

Research Paper
Accepted: 23-03-2026
Published: 10-04-2026

Keywords:
Mental healthcare services, international obligations, shortcomings

ABSTRACT

India has shifted from a custodial to a rights-based approach towards mental health law with the enactment of the Mental Healthcare Act, 2017, which prioritizes dignity and autonomy in the right to receive treatment, in line with international human rights obligations. The Act comes into effect as India committed to the UN Convention on the Rights of Persons with Disabilities, which sought to eliminate stigma and discrimination and to increase access to mental healthcare services. However, within that stated progressive intent, the law exposes a series of conceptual and practical shortcomings. Through a critical analysis of the Act's provisions, a comparison with the earlier Mental Health Act of 1987, and an exploration of India's socio-cultural and institutional realities, this paper critically evaluates the Act's effectiveness. We pay special attention to barriers to implementation, family involvement, advance directives, resource constraints, and inconsistencies with international standards. The Article suggests that the Act represents a step forward in norm and approach, but that to work in practice, it will need broader systemic change, financial commitment, and contextualization.

1. Introduction

India's historical approach to mental health legislation shows an ambivalence between the welfare and custodial control models. The Mental Health Act (MHA) 1987, while more progressive than its colonial-era predecessors, still retained an institutional character and continued to alienate a significant number of people living with mental illness. Criticism followed that it was too narrow on rights, unclear in ways and too silent on stigma or reintegration. Such inadequacies prompted the introduction of the Mental Healthcare Act, 2017. It attempted to recast mental health care in a rights-based framework that prioritized agency, informed consent, and access. Beyond this critical recognition, the Act also sought to harmonize domestic law with international obligations, particularly those arising from the Convention on the Rights of Persons with Disabilities. In theory, the Act is groundbreaking. What are the main aspects of this law? It treats mental healthcare as a right, provides for advance directives, and establishes regulatory authorities for mental health institutions. However, the gap between legislative ambition and practice on the ground remains inconsistent at best. However, questions remain about how implementation is feasible, particularly in low-resource and rural regions. What this actually means is that there are two levels to the Act. It looks good on paper, right? However, in reality, it faces structural limitations and cultural realities that cause administrative inertia against its implementation. This gap is taken seriously in this paper, which seeks to unpack it with socio-legal detail.

2. Evolution from the Mental Health Act, 1987 to the Mental Healthcare Act, 2017

Perhaps reflecting a broader human rights approach than the arguably clinical focus of the 1987 Act, the shift from the 1987 Act to the 2017 Act is clear. While the previous statute described a mentally ill person by their treatment need, the definitions were vague and failed to adequately define the type and/or extent of mental illness. On the other hand, the 2017 Act has a broader, more expansive definition that describes disturbances of thought, mood, perception, and behaviour, and excludes only intellectual disability. Such clarifications of the definition mitigate fears of sweeping, indiscriminate institutionalization, a possibility repeatedly flagged by judicial observations. It also connects diagnosis to internationally recognized medical standards rather than arbitrary moral or social criteria. A second big advance is in respect for patient choice. The Act presumes that everyone has the capacity to make decisions about their treatment until it can be shown that they do not. This assumption flips ages-old defaults where providers often assume patients are incompetent until proven otherwise. It introduces a participatory model that involves letting people participate in decisions about their own care. Advance directives go a step further in ensuring this control. This allows individuals to outline their desired treatments in the event they are unable to do so themselves in the future. They could also assign a representative to decide things for them. Though this mechanism is said to increase self-determination, how it operates in practice is another question considered later in this paper. The Act has also widened the listing of rights that persons with mental illness can avail themselves of. He described these rights as the right to mental healthcare, the right to live in the community, the right to freedom from inhuman treatment, the right to confidentiality, and the right to legal aid. This is a significant normative shift from the 1987 Act, which gave only a few specific rights.

Institutional changes accompany these rights. Central and State Mental Health Authorities will provide regulatory oversight, and Mental Health Review Boards will serve as quasi-judicial forums to resolve grievances. These bodies are likely to improve accountability and help ensure institutional compliance with statutory responsibilities. However, this transition has received criticism. Others argue that, rather than enacting a new law, incremental changes to the 1987 Act might have secured many of the same outcomes with less turmoil. Others have pointed out the gaps that prevented the previous law from being effective, especially the lack of funding and infrastructure to ensure its implementation, which remains mostly unchanged. The 2017 Act, given the debate about whether a more just coming together of psychiatric and legal communities was fully achieved before its enactment, may have been introduced with the same hurdles that limited its predecessor. This raises an important question. Has the law outpaced the system that must now implement it?

3. Rights-Based Approach: Promise and Limitations

The rights-based orientation of the 2017 Act is considered its most progressive characteristic. The Act attempts to devolve responsibility onto the State, depicting access to mental healthcare as a legal right. It requires the government to offer affordable, accessible, and high-quality mental health services. However, rights without corresponding capacity are little more than symbolic. India continues to suffer from shortages of mental health professionals, infrastructural gaps, and inequitable provision of services. Especially since rural areas are also underserved, the upholding of these rights becomes questionable. There is, of course, a cultural aspect as well. In India, family involvement in caregiving is highly valued.

On the other hand, the Act upholds the principle of autonomy and centers the idea of a nominated representative (who does not necessarily need to be a family member). This can lead to a gap between law and social practice. Another limitation lies in awareness. Rights can only be claimed if people know about them. India is still suffering from a lack of knowledge about mental health and stigma that prohibits people from accessing help. If awareness and community engagement are not sustained beyond the Act rollout, the Act could be underutilized.

4. Critical Examination of Key Provisions under the Mental Healthcare Act, 2017

Despite progressive mechanisms, among others, introduced by the Mental Healthcare Act, 2017, a close reading reveals that many of its provisions raise interpretative and practical concerns. When specific provisions are examined in detail, in contrast, the gap between legislative intent and operational feasibility becomes more apparent.

4.1 Advance Directives: Autonomy in Theory, Ambiguity in Practice

One of the most remarkable aspects of the Act is the advance directives. They enable a person to specify what their treatment wishes are before a mental health crisis arises. This not only supports autonomy in principle but also maintains the patient's preferences for care, central to the patient during their incapacity. However, the use of advance directives is anything but simple. An obvious worry is the lack of transparent procedural protections. This Act is silent on the procedure by which such directions are to be issued, registered, verified, or amended. This leads to confusion for both practitioners and patients.

An additional problem comes from the ambiguity of interpretation. Mental Health conditions are subject to change and seldom related to logic. What this means is that an advance directive written at one point in time may not address what would be most appropriate or in the patient’s best interests at a later point in time. This invites the risk of adhering to outmoded protocols, which can lead to treatment failure. What of authenticity, as well? But we cannot overlook the potential for misuse in the absence of a reliable verification system. If directives are forged or altered, those changes can lead to treatment decisions that do not genuinely reflect the patient's wishes. Even the material itself mentions this, as well as the need for regulatory clarity. This means that while advance directives can represent a movement toward patient empowerment, their success hinges on protections from institutions that have not yet been fully established.

4.2 Nominated Representatives: Legal Innovation versus Social Reality

Nominated representative- the notion is on the same ground as advance directives. This enables someone to choose a person who can make decisions on their behalf when they become unable to do so. This clause aims to assist decision-making, not to substitute for it. Nonetheless, its implementation may have socio-cultural implications. Family members mostly do caregiving in India. The Act enables patients to appoint non-family members, which has led to tensions where patients and families remain financially and emotionally responsible for the patient.

There are also practical difficulties in finding and contacting the nominated representative and securing their presence, which could be crucial during a police emergency or in police custody. This could delay adequate intervention and treatment, as such representatives are not made readily available. This is especially troublesome, as the source material notes, when the representative is not a family member. Moreover, the Act does not provide guidance on the scenario where no alternative representative has been nominated. Though it can be sourced quickly via appointment by a Mental Health Review Board within a prescribed time limit, a delay for even a couple of hours can be detrimental to those in dire need of treatment. As such, this provision serves as a complete contradiction of the individual vs. community caring structure. The law articulates autonomy while the social world continues to exist on a family-based support system.

4.3 Admission and Treatment Procedures: Consent versus Practical Constraints

Voluntary admission and informed consent are core tenets of the Act. People are assumed to be able to make choices about their treatment. Presuming the applicant is moving forward reinforces an ethos that has shifted away from the latter history of making institutional powers foremost to those at the right to choose. The Act also provides for supported or involuntary admission when a person has impaired decision-making capacity and poses a risk to themselves or others. These include the ability to balance autonomy with the need to care and protect. The challenge, however, lies in implementing those standards. Assessment of mental capacity is not always clear-cut. The degree to which mental illness affects cognition and judgment varies, which is why capacity assessments are more complicated and subjective.

A third problem concerns the length of our procedures. In situations such as admission under certain provisions, it can take time to identify a nominated representative, and if none is available, treatment may be delayed. Nowhere in the material does it state that a patient's outcome is affected even within a few days. Also, it lacks clarity about who these professionals are who would evaluate such things. Because there is a shortage of trained mental health professionals in India, this lack of clarity may lead to inconsistent practices within institutions. That is, although it is normatively desirable to focus on consent, in practical terms, it rests on professional capability, training, and institutional preparedness.

4.4 Role of Police and Magistrates: A Shift Toward Medicalization

Perhaps the most significant of these changes relates to the role of law enforcement authorities. Previously, when the law was earlier, mentally ill persons were brought before a magistrate. The Act also directs that these people be brought to a mental health facility for examination. This change is part of an effort to step back from criminality as a response and step toward healthcare responses. Moreover, it specifies that no person with a mental illness shall be placed at a police lock-up or at a prison, seeking to address custodial abuse. However, practical challenges remain. Police officers do not have the training needed to identify certain mental health conditions accurately. This is likely to be situational: in rural or remote areas, there may be a lack of mental health facilities available to meet statutory requirements, causing a few complications.

Magistrates were redefined as well. Changes to procedural safeguards, including the elimination of mandatory inquiries, have been criticized for potentially leading to less judicial scrutiny. Others argue that a former measure allowing the family to assume responsibility for the individual should have remained, but was altered. These types of changes showcase a larger trend. The law aims at decriminalizing mental illness, viewing it as a healthcare issue. However, the institutions charged with making this transition happen may not be well-positioned to do so.

4.5 Prohibition of Certain Practices: Ethical Progress with Practical Limits

The Act bans practices including chaining, sterilization, and indiscriminate use of electroconvulsive therapy. It further imposes a ban on psychosurgery and a requirement of informed consent for psychosurgical procedures. These are in line with the international human rights standards mentioned above to eradicate degrading or harmful treatment practices. These reflect a commitment to the ethics of dignity and bodily integrity. There are exceptions to this - especially in cases of emergency - but generally you cannot do this under the Act. Physical restraints may still be used, but under very specific circumstances. These exceptions are meant to address pragmatic realities, but they open the door to potential abuse. The difficulty is to avoid that becoming an all-too-easy outcome because of the system that defines choices, or simply because there are no better options available.

5. Emerging Structural Concerns

One of the most common themes among these provisions is the disparity between legal ideals and the capacity of institutions to meet them. While the Act introduces some progressive ideas, they are not easily implemented without resources, training, and coordination that are not consistently available. Many such issues, as the materials state, are systemic and predate the prior law and continue to go unaddressed. This continuity indicates that reforming legislation is insufficient to transform mental healthcare unless the structures that underpin and implement the law are also changed in tandem.

6. Structural and Systemic Challenges in the Implementation of the Act

A closer look at the Mental Healthcare Act, 2017, reveals that many of its limitations do not arise solely from the text, but from the broader ecosystem in which it operates. The law assumes the existence of institutional capacity, financial support, and social awareness that remain uneven across India. This section examines these structural concerns in detail. When we look more closely at the Mental Healthcare Act, 2017, we can see that many of the limitations are not direct results of the law itself, but rather outcomes of the ecosystem around its implementation. The law presumes the presence of institutional capability, funding, and, most importantly, social consciousness, all of which remain disparate across India. These are structural issues which this section explores in depth. The obstacle faced is the lack of adequate funding for mental care. In India, public spending on mental health has been very low historically, accounting for a minuscule proportion of the total health budget. Here, the incommensurate demand creates an instantaneous inconsistency between the rights prescribed in the Act and the State's ability to deliver them.

To make things worse, there is also a lack of trained professionals. A shortage of psychiatrists, clinical psychologists, psychiatric social workers and mental health nurses continues to plague India. While several other countries with which we compete have a more plentiful supply of such professionals, the difference in supply of skilled workers across the United States has become much more pronounced. This shortage is felt at every stage of implementation. All of these activities—capacity assessments, treatment planning, and the supervision of institutions, as well as the functioning of review boards—are contingent on qualified personnel. Even if the provisions are properly drafted, they are still difficult to operationalize without adequate human resources.

It also showcases this gap by noting the minuscule number of mental health professionals per capita. This indicates an unrealistic expectation of service delivery from the current system, as mandated by the law. A second structural problem is the Act’s minor role for families. Historically, families have been the primary support instead of a mental healthcare system. They offer financial aid, emotional support, and supervision for a few years.

In contrast, the 2017 Act focuses on personal autonomy and institutional mechanisms of decision-making, such as appointed representatives. Though this shift aligns with human rights tenets, it does not reflect the socio-cultural ethos of Indian society. Families cannot be included in treatment decisions unless specified in advance, and do not always have the power to challenge whether an institutional action, e.g., forcing a patient to be admitted to a hospital against their will, occurs. This leads to a schism between the letter of the law and the lived experience.

Even as this is happening, families are shouldering caregiving responsibilities. The Act fails to provide any effective relief for them, neither in terms of direct cash outflows, nor in terms of guidance, nor in terms of institutional mechanisms. As mentioned in the original writing, this absence cripples the law's functional power. The result is a paradox. In practice, care retains a strong family focus while the law marginalizes the family.

For any legislation to work, it must align with the broader context of related laws or policies. In this regard, multiple inconsistencies in the Mental Healthcare Act, 2017, become evident. The first is the Rights of Persons with Disabilities Act, 2016. Though both laws do provide some protection of rights to the mentally ill, there are still important gaps in the two Acts, such as provisions for social inclusion, anti-discrimination and access to welfare schemes. For instance, the National Mental Health Policy, 2014, highlights the need for community-based care and a special approach to vulnerable groups, including children and persons in a custodial setting. These priorities are not fully reflected in the 2017 Act, which fails to provide adequate legal protection for all people in certain categories.

The second place where there was divergence before was between criminal law, mental health law, and suicide. The Mental Healthcare Act presumes that one who attempts suicide is in grave distress and ought not to be punished; under earlier criminal law, however, an attempt to commit suicide was an offence. While more recent legislative developments have resolved this contradiction, this artifact of earlier overlap underscores the need for better policy design coordination. The full extent to which these discrepancies illustrate a bigger problem. Mental health cannot be regulated as an isolated phenomenon. It lives at the intersection of disability law, criminal law, social welfare policies, and public health systems. When reforming sectors such as diaspora relations, education and commerce, fragmentation across these domains dilutes the potency of reform. But no amount of legal reform can crack open the entrenched social psychology that underlies such attitudes. One of the most significant barriers to accessing mental care in India is still the stigma around mental illness. Many people postpone or avoid seeking treatment for fear of discrimination, social exclusion, or loss of status. That is why the Act acknowledges that awareness is important and requires mental health literacy to be promoted. Still, the implementation of such initiatives is uneven. There are sporadic awareness campaigns and even fewer outreach programs, but they are restricted to urban areas only; rural or marginalized communities never get the privilege.

Stigma also affects institutional behavior. Implicit biases are ingrained in healthcare providers, law enforcement agencies, and even families, which may play a role in decision-making. Those attitudes can erode the rights the Act promises, especially regarding consent, confidentiality, and dignity. The material outlines stigma as a social process that arbitrarily devalues individuals based on perceived otherness. This cannot be fully resolved without continuing work outside of the law, through education, community engagement and cultural change. It aims to encourage community living and discourage institutionalization.

Meanwhile, the growth of mental health care in the community has been restricted. In many areas, the majority of treatment is still performed in institutions. Lacking a robust community infrastructure creates a variety of challenges. Dumbed-down (or homely) patients discharged from these institutions might not even be able to secure follow-up care or access to basic rehabilitation and socio support systems. This can lead to an increased chance of relapse and readmission to treatment.

Integrated services that address wider determinants of mental health — housing, employment, education, social security — are also needed. Recovery is never complete without this sort of support.

However, the original draft recommended, among other things, community mental health centers, outreach services and supported living options. These measures can help fill the gap between institutionalization and social reintegration, but they do need continued investment and a coordinated policy environment to succeed. In this context, the Mental Healthcare Act, 2017, was enacted to bring India into line with its international human rights obligations, particularly the Convention on the Rights of Persons with Disabilities. Though the Act encompasses many of these principles, complying in full has proven more elusive. Some provisions, including the use of physical restraints or involuntary treatment in certain circumstances, are at odds with international standards. Likewise, the framework for capacity assessment and substituted decision-making has been viewed as not being complementary to the foundations of the supported decision-making paradigm. That shows that, though Indian law meets many international standards, gaps remain. These gaps are not only technical in nature. That reflects deeper tensions between ideal and actual amounts.

7. Areas for Reform and Policy Recommendations

While the Mental Healthcare Act, 2017, has provided a progressive framework, systemic and practical barriers continue to restrict the MHC from realizing its full potential. To strengthen the Act, a focused approach to reforms that address both legal uncertainties and structural weaknesses is needed. A common criticism of the Act is how it was drafted with little to no contribution from mental health professionals. Future amendments must take a more collaborative approach, involving psychiatrists, psychologists, social workers, legal experts, caregivers, and persons with lived experience. Such involvement helps to ensure that legislation aligns with ideals on paper and in practice. It also increases legitimacy and makes deployment easier. The existing framework of advance directives is not lacking in procedural axioms. Impose standardized formats, a registration system, and a verification mechanism to avoid abuse and ensure authenticity.

Additionally, periodic review mechanisms might be established to assess whether directives remain relevant over time. Formulation of Guidelines for Interpretation – Mental health professionals face complex circumstances for assessing rights restrictions. To assist them in applying these directives, clear guidelines for interpretation are also needed. Given the central role of families in India, their participation must be recognized and supported by the legal system. The Act needs to accommodate better families' input in treatment planning, discharge decisions, and review processes while maintaining patient autonomy.

But we must also invest in caregiver support systems. This includes, among other things, financial assistance, counselling services, and respite care initiatives. Acknowledging caregivers as stakeholders, rather than just informal members of the community of care, can lead to better overall treatment outcomes. Access to services is crucial for a meaningful exercise of the right to mental healthcare. The State has to radically up its game when it comes to mental health infrastructure, from hospitals to community centers, to rehabilitation units. Video content is growing fast, and so is HR. There is a need to scale up training of mental health professionals and provide monetary incentives to work in underserved areas. If such investment does not come, the rights the Act seeks to guarantee will remain aspirational rather than enforceable.

Careship should become more community-oriented than institution-oriented, with a focus on community-based models that emphasize integration and rehabilitation. Such measures could reduce reliance on institutionalization by establishing community mental health centers, mobile outreach units, and supported living arrangements. These services should be coordinated with broader social welfare programs that address housing, employment, and education. These determinants of mental health are interconnected, and mental health cannot be independently treated or separated from these determinants.

In this context, the source material stresses the importance of these community-based approaches and how they can help increase inclusion and recovery. Public awareness campaigns should be continuous and specific. Mental health literacy should be promoted at the school, workplace, and community levels. Well, it takes more than disseminating information to reduce stigma. But it is all about changing mindsets through conversation, representation and building community. This is where peer support groups and self-help organizations are crucial. Legal entitlements can be asserted only when people believe they can enforce them. That empowerment begins with awareness. How well the Act works will depend on its interdependence with associated legislation and policy. There needs to be greater alignment between the Mental Healthcare Act, the Rights of Persons with Disabilities Act, and national mental health policies. Specific guidelines should be developed to clarify overlaps across social protection, anti-discrimination, and access to welfare schemes. This kind of alignment can eliminate confusion and enhance administrative efficiency. Although the Act aligns with many international principles, further alignment is needed. This includes measures that reinforce supported decision-making, restrict coercive practices and enhance protection of autonomy. Regular examinations can be conducted to ensure compliance with evolving global benchmarks. These reviews can inform subsequent reforms and policy actions.

8. Conclusion

The Mental Healthcare Act, 2017, is a turning point in the history of mental health law in India. It changes the conversation from control and institutionalization to rights, dignity, and autonomy. By doing this, it brings Indian law in line with the broader human rights discussion worldwide and meets the long-standing calls for reform. The Act, however, also illustrates the limits of legal transformation without any corresponding structural change. Despite these categories, resource constraints, institutional weaknesses, social stigma, and policy fragmentation continue to obstruct so-called progress. Yet there is an even deeper tension. The Act values individualistic rights, but the Indian society still revolves around collective identities, especially the family. Closing the divide requires an approach that balances both rights and realities. The analysis in this paper indicates that the Act is both a success and a failure. It functions better as a bridging tool. While this opens the way to a more humane and rights-based system, the world has much further to go, not in what the law says, but in what it does. The Act will be either a dead letter or a game changer, depending on whether people with mental illness can receive care, assert agency, and live with dignity.

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