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The Concept of Personhood in Mental Health Law: A Jurisprudential Study of the Mental Healthcare Act, 2017

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ABSTRACT

The Mental Healthcare Act, 2017 marks a significant transformation in Indian mental health law by shifting the legal image of the person with mental illness from an object of custody, treatment, or social control to a rights-bearing legal subject. This paper examines the concept of personhood under the Act through a jurisprudential lens, focusing on dignity, autonomy, legal capacity, supported decision-making, equality, community living, confidentiality, and protection from degrading treatment. Influenced by the United Nations Convention on the Rights of Persons with Disabilities, the Act presumes capacity, recognizes advance directives, allows nominated representatives, creates a statutory right to mental healthcare, and limits older paternalistic approaches to psychiatric care. However, the Act also contains tensions: supported admission, emergency treatment, resource gaps, weak implementation of Mental Health Review Boards, and dependence on state capacity may dilute its rights-based promise. The central argument is that the Act constructs personhood as relational and supported rather than isolated or purely medical. It recognizes that mental illness may affect decision-making, but it does not erase legal personality. The Act is therefore best understood as an incomplete but important constitutional and human-rights project that seeks to reconcile care, liberty, dignity, and social inclusion.

Introduction

Mental health law has historically carried a deep jurisprudential problem: whether a person experiencing mental illness is to be treated primarily as a patient, a risk, a dependent, or a citizen. Older legal regimes often answered this question through the concepts of custody and incapacity. The law classified the person on the basis of medical diagnosis, assumed diminished agency, and justified confinement or substitute decision-making in the name of welfare, public order, or family protection. The Mental Healthcare Act, 2017 ("MHCA") attempts to alter this legal imagination. Its preamble declares that the Act aims to provide mental healthcare and protect, promote, and fulfil the rights of persons with mental illness, while also aligning Indian law with the Convention on the Rights of Persons with Disabilities ("CRPD") (Mental Healthcare Act, 2017). The jurisprudential importance of the Act lies in its construction of personhood. Personhood in law is not merely biological existence. It is the status of being recognized as a bearer of rights, duties, choices, identity, privacy, dignity, and legal voice. Mental health law tests this idea sharply because psychiatric disability may affect communication, judgment, or risk perception. A rights-based legal order must therefore answer a difficult question: how can law protect a person without converting protection into domination? This paper argues that the MHCA reorients Indian mental health law toward a model of supported personhood. It does not deny vulnerability, crisis, or the need for care. Yet it rejects the older assumption that mental illness automatically cancels autonomy. Through provisions on capacity, advance directives, nominated representatives, equality, access to care, community living, confidentiality, legal aid, and suicide prevention, the Act treats persons with mental illness as legal subjects whose will and preferences matter. At the same time, the Act's promise remains constrained by implementation deficits, continuing coercive powers, and structural shortages in mental healthcare.

Personhood as a Jurisprudential Concept

In jurisprudence, personhood concerns the legal recognition of an entity as someone rather than something. For human beings, this recognition is tied to dignity, moral agency, autonomy, bodily integrity, and participation in social life. In mental health law, personhood has often been fragile because diagnosis has been used as a gateway to exclusion. Once labelled "insane," "lunatic," or "mentally ill," individuals could be deprived of liberty, property control, family decision-making power, and credibility. A modern conception of personhood must separate impairment from legal disappearance. A person may need support, treatment, interpretation, or protection in moments of crisis, but this does not mean the person has ceased to be a rights-holder. The CRPD strongly influenced this shift by emphasizing equal recognition before the law, legal capacity, non-discrimination, liberty, integrity, accessibility, and inclusion (United Nations, 2006). Article 12 of the CRPD is especially important because it challenges regimes that remove legal capacity merely because of disability. It requires states to provide support for exercising legal capacity and safeguards against abuse. The MHCA reflects this international turn. It places capacity, autonomy, and dignity near the heart of mental healthcare. Duffy and Kelly (2019) describe the Act as a major rights-based statute that explicitly seeks CRPD compliance and creates a legally enforceable right to mental healthcare. This is not a minor technical reform. It changes the normative foundation of mental health law: treatment is no longer only a medical intervention authorized by professionals or families; it is also a legal relationship governed by rights.

From Custodial Control to Rights-Based Law

Indian mental health law evolved from colonial and custodial frameworks toward rights-based regulation. The Indian Lunacy Act, 1912 reflected an institutional and control-oriented approach. The Mental Health Act, 1987 softened some terminology and introduced procedural regulation, but it remained focused on admission, management, and supervision of psychiatric institutions. The MHCA, by contrast, places rights in a dedicated chapter and gives them statutory force. The Act's rights-based orientation appears first in its statement of purpose. It was enacted after India ratified the CRPD in 2007 and expressly seeks harmonization with that convention (Mental Healthcare Act, 2017). This matters because the CRPD treats persons with disabilities not as passive welfare recipients but as holders of equal human rights. The Act adopts similar language through rights to access mental healthcare, community living, dignity, equality, information, confidentiality, communication, medical records, legal aid, and complaint mechanisms. This transition also reflects Indian constitutional values. Article 21 of the Constitution, as developed by the Supreme Court, protects life and personal liberty in a broad sense that includes dignity, privacy, decisional autonomy, and bodily integrity. In K.S. Puttaswamy v. Union of India (2017), the Court recognized privacy and autonomy as central to dignity. Although Puttaswamy was not a mental health case, its logic supports a reading of the MHCA that prioritizes self-determination and personal identity. Similarly, the jurisprudence on advance medical directives in Common Cause v. Union of India (2018) affirms that dignity includes meaningful control over medical decisions. The MHCA's advance directive provisions fit within this broader constitutional movement.

Capacity and the Presumption of Agency

Section 4 of the MHCA is one of its most important provisions for personhood. It states that every person, including a person with mental illness, is deemed to have capacity to make mental healthcare or treatment decisions if the person can understand relevant information, appreciate reasonably foreseeable consequences, and communicate the decision (Mental Healthcare Act, 2017). The Act also clarifies that a decision perceived by others as wrong or inappropriate does not by itself prove incapacity. This provision is jurisprudentially powerful. It rejects status-based incapacity. A person is not incapable simply because they have a diagnosis, have been hospitalized, disagree with doctors, or make an unconventional choice. Capacity is decision-specific and functional. This approach protects legal personhood by ensuring that incapacity is not presumed from identity. The Act's model is not pure individualism. It allows support in decision-making, which is consistent with the CRPD's movement away from substitute decision-making. The person is not imagined as an isolated rational actor who must always decide alone. Instead, the law recognizes that autonomy is often relational. People make decisions through families, trusted persons, clinicians, social workers, and community networks. The legal challenge is to ensure that support does not become coercion. The MHCA attempts this through nominated representatives, review boards, information rights, and safeguards.

Advance Directives and Future Personhood

The Act's recognition of advance directives is central to its account of personhood over time. Section 5 allows an adult to make an advance directive stating how they wish to be cared for and treated, how they do not wish to be treated, and who should act as nominated representative (Mental Healthcare Act, 2017). This provision recognizes that a person's autonomy may be exercised before a crisis in order to guide care during a crisis. Advance directives are jurisprudentially significant because they protect continuity of self. A person experiencing a later episode of severe mental distress does not become a legal stranger to their earlier values. The Act allows the person's prior expressed will to travel into future clinical settings. This is a sophisticated model of personhood: identity is not reduced to the present moment of incapacity or distress; it includes biography, values, preferences, and anticipated vulnerability. However, advance directives also create practical concerns. Many people may not know the provision exists. Mental health professionals may be uncertain about implementation. Review Boards may be unavailable or overburdened. Families may contest directives. If the infrastructure is weak, the right remains formal rather than lived. Duffy and Kelly (2019) note that the Act's promise depends heavily on resources and institutional structures. Thus, advance directives show both the Act's ambition and its fragility.

Nominated Representatives and Supported Personhood

The nominated representative mechanism further develops the Act's model of supported personhood. The person may appoint a representative who need not be a family member. This is important in a society where family is often central to care but may also be a site of conflict, stigma, abandonment, or coercion.

By allowing choice beyond family, the Act recognizes personal trust as a legal value. The nominated representative is not meant to erase the person's will. Ideally, the representative assists communication, supports decisions, protects interests, and helps navigate institutions. This differs from traditional guardianship, where the guardian's judgment may replace the person's. The Act therefore moves toward a less paternalistic structure, though it does not fully eliminate substitute decision-making. The difficulty lies in practice. Where a person is poor, homeless, isolated, or socially excluded, nomination may be difficult. State-appointed representatives may lack personal knowledge of the person's values. There may also be conflicts between clinical judgment, family pressure, and the person's expressed wishes. The jurisprudential value of the provision therefore depends on whether "support" is interpreted as fidelity to the person's will and preferences rather than administrative convenience.

Dignity, Equality, and Non-Discrimination

The Act's dignity provisions are direct expressions of legal personhood. Section 20 recognizes the right of every person with mental illness to live with dignity and to be protected from cruel, inhuman, and degrading treatment. Section 21 requires equality and non-discrimination in healthcare, including parity between mental and physical illness and non-discrimination on grounds such as gender, sex, sexual orientation, religion, caste, class, disability, and culture (Mental Healthcare Act, 2017). These provisions attack two older assumptions: first, that psychiatric patients may be treated with lower standards of care; second, that mental illness justifies social exclusion. Legal personhood requires more than freedom from confinement. It requires equal moral worth in institutions, insurance, emergency care, living conditions, and access to services. The Act's insurance parity provision is especially important because economic exclusion often converts formal rights into illusions. The right to confidentiality in Section 23 also protects personhood. Mental health information is deeply connected to identity, reputation, employment, family life, and social standing. Unauthorized disclosure can produce stigma and discrimination. By recognizing confidentiality in mental healthcare and physical healthcare, including digital information, the Act connects mental health rights with privacy and dignity.

Community Living and Social Personhood

Section 19 recognizes the right to community living. A person with mental illness has the right to live in, be part of, and not be segregated from society. The Act also states that a person should not remain in a mental health establishment merely because of homelessness, family rejection, or lack of community facilities (Mental Healthcare Act, 2017). This is one of the Act's most profound provisions. It understands personhood as social membership. The harm of institutionalization is not only loss of liberty;

it is also loss of relationships, work, community, sexuality, family life, political voice, and everyday citizenship. Community living therefore turns mental health law outward. The state must not only regulate hospitals; it must create conditions for inclusion. Yet this is where the implementation gap is most visible. Community-based services, halfway homes, rehabilitation facilities, trained professionals, and local support systems remain uneven. A right to community living cannot be realized by statutory wording alone. It requires budgets, housing policy, social welfare, anti-stigma work, and integration with public health systems. Without these, people may remain institutionalized not because treatment requires it but because society has nowhere for them to go.

Suicide, Criminal Law, and Compassionate Personhood

Section 115 of the MHCA is a major symbolic and practical reform. It provides that a person who attempts suicide is presumed, unless proved otherwise, to be under severe stress and shall not be tried and punished under Section 309 of the Indian Penal Code. It also places a duty on the appropriate government to provide care, treatment, and rehabilitation to reduce recurrence (Mental Healthcare Act, 2017). This provision changes the legal meaning of suicide attempt. The older criminal model treated the person as an offender. The MHCA treats the person as someone in distress who requires care. Jurisprudentially, this is a shift from culpability to compassion, from punishment to support. It recognizes that criminalization deepens stigma and may deter help-seeking. At the same time, the provision's wording has been debated because it presumes "severe stress" rather than fully repealing criminal liability in all conceptual terms. Still, its practical effect is decriminalizing most suicide attempts and requiring a health-based response. This supports a personhood model in which even the most extreme moment of self-harm does not erase dignity or convert suffering into crime.

Coercion, Supported Admission, and the Limits of Autonomy

The MHCA is not purely anti-coercive. It permits supported admission and emergency treatment in defined circumstances. This is the central tension in the Act. On one hand, it affirms capacity, advance directives, dignity, and legal rights. On the other, it allows admission and treatment without ordinary consent when statutory conditions are met.

From a jurisprudential perspective, this tension reflects the hardest problem in mental health law: how to protect liberty while responding to serious risk, incapacity, neglect, or crisis. A strict autonomy model may fail people who urgently need care but cannot seek it. A paternalistic model may violate rights and reproduce institutional abuse. The Act attempts a middle path through procedural safeguards, time limits, review mechanisms, and Mental Health Review Boards. The success of this compromise depends on safeguards. Review Boards must be accessible, independent, timely, and sensitive to the person's voice.

Information must be communicated in understandable forms. Legal aid must be real. Supported admission must not become routine involuntary admission under a new name. Duffy and Kelly (2017) found that the Act aligns substantially with international mental health law standards but also leaves areas of lower concordance and practical concern. This mixed assessment captures the Act's character: transformative in principle, uneven in operational design.

Implementation and the Gap Between Formal and Lived Personhood

Legal personhood is not secured merely because a statute names rights. It requires institutions capable of honoring them. The MHCA depends on Mental Health Review Boards, Central and State Mental Health Authorities, registered establishments, trained professionals, legal aid systems, public mental healthcare funding, and community services. Where these are absent or weak, the person remains vulnerable despite formal recognition. Implementation difficulties have been widely noted. Duffy and Kelly (2019) identify resource constraints, legal complexity, and possible barriers to care as key challenges. Ghosh, Gupta, and Singh (2022) discuss the gap between the Act's paper framework and clinical practice, including the nonavailability or limited functioning of Review Boards and community-based services. These concerns matter directly to personhood. A person may have the right to challenge admission, but without a functioning forum the right is hollow. A person may have the right to community living, but without housing and support the institution becomes the default. There is also a professional and cultural challenge. Rights-based care requires a change in attitude among psychiatrists, nurses, families, police, magistrates, and administrators. The person with mental illness must be heard, not merely managed. Consent must be treated as meaningful, not ceremonial. Risk must be assessed carefully, not used as a blanket justification for control.

Conclusion

The Mental Healthcare Act, 2017 represents a major jurisprudential shift in Indian mental health law. It reconstructs the person with mental illness as a rights-bearing subject with dignity, capacity, privacy, equality, and a claim to care. Its provisions on capacity, advance directives, nominated representatives, community living, confidentiality, legal aid, and suicide prevention challenge the older custodial model and align Indian law with constitutional and international human-rights principles. The Act's deepest contribution is its model of supported personhood. It recognizes vulnerability without equating vulnerability with legal nonexistence. It allows support without ideally substituting another person's will. It treats mental healthcare as a site where dignity and autonomy must be actively protected. Yet the Act remains incomplete. Coercive admission, emergency treatment, institutional shortages, weak review mechanisms, and inadequate community services continue to threaten its promise. The jurisprudential success of the MHCA will depend on whether courts, governments, professionals, and families interpret it as a living rights instrument rather than a procedural statute. Personhood in mental health law is ultimately not secured by diagnosis or paperwork. It is secured when the law sees the person in full: vulnerable, capable, relational, dignified, and entitled to live as a member of the community.

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