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## FORCED TREATMENT VS PATIENT AUTONOMY: ETHICAL AND LEGAL DILEMMA IN MENTAL HEALTHCARE

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### Abstract

Among today's most controversial issues in mental health is the ethical and legal tension between forcibly treating people for mental health issues and respecting their right to make their own choices about treatments. Many mental health clinicians believe that once a patient becomes mentally ill, he or she has lost some level of capacity to make competent decisions about treatment. In the past, mental health systems tended to be paternalistic, with a strong emphasis on protecting the individual and controlling him/her by virtue of the system's responsibility to do no harm while still providing care. This resulted in widespread violation of patients' rights through coercion, abuse, and neglect.

The last several years have seen a shift from a medical model to one based on human rights. To this end, the International Human Rights Instruments, including the UN Convention on the Rights of Persons with Disabilities (UNCPRD), have played a huge role in redefining Mental Health Laws. Through this change, India has passed the Mental Health Care Act 2017 which incorporates Legal Capacity, Informed Consent, Advance Statements and Supported Decision Making as the foundation of this new model. The Mental Health Care Act continues to allow for Involuntary Hospitalization and Involuntary Treatment under specific circumstances and therefore, reflects a careful consideration between Autonomy and care.

In this article, we will assess the ethical basis for and legal structures around forced treatment of people with mental illness as well as their rights regarding making decisions about themselves. We will discuss how international standards on human rights, laws in India, and the courts have interpreted these laws will also be evaluated for problems enforcing them. This paper will argue

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that while forced treatment can be legally justified in the right situations, people should have the "default" right to make their own choices about receiving treatment by rules instead of being given no choice regarding forced treatment. If someone is being treated involuntarily, then that must be justified within reasonable limits, justified based on necessity as well as proportionality, along with procedural safeguards and respect for human dignity. Finally, I will discuss the importance of developing better community-based treatment facilities and creating better systems of oversight to encourage improved decision-making processes so that involuntary treatment is not necessary anymore in caring for individuals with mental illnesses.

### **Keywords**

Mental Health Law; Patient Autonomy; Forced Treatment; Mental Healthcare Act, 2017; UNCRPD; Informed Consent; Legal Capacity; Human Rights; Psychiatric Ethics.

### **Introduction: The Central Ethical Conflict in Mental Healthcare**

The conflict between mandatory treatment and the rights of patients is one of the most challenging and sensitive issues in the field of law and ethics in the treatment of people with mental illness. The difference between mental health care and other fields of medical care is that, due to the nature of their illness, many patients who are treated for mental illness may have impaired cognitive abilities to understand, evaluate or communicate their treatment choices. As a result, in certain instances, a patient may seem to refuse treatment without reason, which may result in their being perceived as a danger to themselves or others. Therefore, mental health professionals and/or the State may intervene in order to provide care. This raises the ethical question of whether it is ethical and, if so, the extent to which it is ethical to intervene through forced treatment.

Historically, mental health care has been provided in a paternalistic fashion. That is, mental health providers perceived people who suffered from mental illness as lacking the cognitive ability to make informed medical and treatment decisions and, therefore, were considered to be a "vulnerable population" and as such, were subject to involuntary hospitalization, medical and treatment decisions made without their consent, and long-term institutionalization. Although at the time the justifications given by mental health providers for the use of such involuntary measures often included "the patient's best interest," the reality is that such measures were usually accompanied by instances of abuse, neglect of care, and violation of the human rights of individuals with mental illness. Forced medication, the use of physical restraints, and social isolation were often used as part of the treatment of mental illness and were indicative of a system that valued control and order over an individual's dignity and autonomy.

The fundamental changes over the past two or three decades in how courts view mental illness and mental health have been driven predominantly by human rights discussion in national and international frameworks. Courts have shifted their priorities away from custodial settings to

providing residents with community support; from making decisions for others, to providing assistance in making their own decisions; and from coerced treatment to voluntary consent to treatment. Autonomy for people with mental health issues has become a fundamental ethical principle in health care with an emphasis on informed consent, respecting personal choices, and acknowledging the legal rights of individuals regardless of their mental health status.

Notwithstanding the above, the principle of autonomy as it pertains to mental health is not absolutely guaranteed. Factors such as imminent risk of harm to self or others, acute psychotic episodes, or the inability to make appropriate decisions pose practical limits on the ability to achieve absolute autonomy. As with courts around the world, the Indian judicial system has defined the parameters for permitting involuntary treatment while also providing appropriate safeguards against abuse of involuntary treatment.

The aim of the study was to explore the ethical situation and legal challenges stemming from Forced Treatment and Patient Autonomy, specifically with respect to India and the mental health care system in India as governed by the Mental Health Care Act of 2017. The study also explores the various philosophical foundations, the International Human Rights Norms, Legislative Provisions, Judicial Precedents and Practical Difficulties Associated with Forced Treatment vs. Patient Autonomy. The conclusions reached in this Study are that while Patient Autonomy should always be the guiding principle in decision making, there are cases where Forced Treatment is ethically and legally permissible when properly defined and regulated.

### **Understanding Patient Autonomy in Mental Healthcare**

Autonomy is a fundamental principle of medical ethics, emphasizing that every individual has the right to control decisions that affect their body, including how it is medically treated. Autonomy is associated closely with the principles of dignity, bodily integrity, privacy, and self-determination. Autonomy is demonstrated through informed consent in healthcare. Informed consent requires that individuals are provided sufficient information, they understand the risks and benefits of treatments, and they can provide an informed and voluntary decision about whether or not to accept or decline a treatment.

In mental health services, autonomy is often difficult to apply. Some mental health conditions (e.g. schizophrenia, bipolar disorder, severe depression, acute psychosis) can impair insight, judgment, and the ability to interpret reality for a person. The argument against complete autonomy in these situations is that to allow a patient to refuse treatment can be viewed as abandoning the patient rather than showing respect for their decision. However, under current legal interpretations of mental health laws, there is no longer an assumption that a person with a mental illness does not possess autonomy or the ability to make legal decisions.

The Mental Healthcare Act of 2017 (the Act) provides an explicit acknowledgement that individuals suffering from mental illness have the capability to make their own decisions about

their care unless there is some evidence to the contrary. The fourth section of the Act makes a presumption that such capabilities exist until proven otherwise by a medical professional. This reflects a significant change from the previous legislation (the Mental Health Act of 1987), which endorsed paternalistic attitudes toward individuals with mental illnesses.

Another aspect of autonomy in mental health is the right to make advance decisions about one's care. Advance directives permit individuals to outline their preferences regarding care well in advance of experiencing a mental health crisis. Through this process, individuals continue to exercise control over their own care, even during periods when they may be unable to exercise decision-making capacity. The advance directive process acknowledges that respect for autonomy exists over the long term, not just based on an individual's current mental conditions.

Despite its strong reputation, autonomy cannot exist in isolation. Beneficence, non-maleficence, and justice are all additional ethical considerations in conjunction with autonomy. In mental health service delivery, if only autonomy is emphasized, this is at times in direct conflict with the ethical obligation to protect human life and to avoid causing serious harm to people. Thus, ethical questions arise as to when it is appropriate for mental health providers to intervene and what does it mean to intervene without infringing on an individual's autonomy.

Therefore, the issue of patient autonomy in mental health cannot be viewed as a black-and-white issue. It is a multi-faceted principle and must be carefully considered with regard to capacity, context, and consequential effects of decisions made. Though the emergence of a recognition of the notion of autonomy represents a step forward; it still requires a significant degree of care, consideration, and ongoing ethical contemplation in the application of the notion.

### **Forced Treatment: Meaning, Justifications, and Ethical Concerns**

The treatment given without a person's consent (forced treatment) is when medical/psychiatric treatments are administered against the wishes of a patient. This is often referred to as "involuntary admission" or "involuntary commitment." These have typically included compulsory medication, electroconvulsive therapy, physical restraints, etc. The reason for administering forced treatment is to protect the patient from themselves and/or other individuals when there is evidence to substantiate a serious risk to themselves or other individuals and/or the potential for irreversible injury as a result of refusal of treatment.

Forced treatment often is justified ethically on the basis of both beneficence and non-maleficence. Beneficence dictates that health care providers should act in the best interests of their patients, and non-maleficence compels providers to refrain from causing harm. In the case of patients who lack insight into their illness, forced treatment is often viewed as a temporary means to restore insight and to save the patient's life.

Despite these justifications for forced treatment, there are also significant ethical issues attached to the use of forced treatment. First and foremost, forced treatment is in direct opposition to a patient's right to autonomy. Secondly, it often results in trauma, loss of trust, and psychological distress to the patient in the future. Patients who are treated using coercive measures frequently report feeling humiliated, fearful, and powerless. Finally, throughout history, forced treatment has been misused against many marginalized groups of individuals and has further perpetuated stigma/discrimination against individuals living with mental illness.

The subjective nature of how best interest is defined presents further ethical dilemmas. Decisions that are made in the best interest of an individual, from a physician's perspective, may not be the same as what aligns with their beliefs, values or lived experiences. When physicians have authority over an individual's decisions regarding treatment and/or care, this is known as medical paternalism. Medical paternalism occurs when professional authority supersedes personal choices without adequately justified reasons.

In recent years, international human rights organizations have begun to question the validity of requiring individuals to undergo treatments against their will. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) recognizes that all persons with disabilities are entitled to equal recognition before the law and prohibits the forced treatment of individuals based upon their disabilities only. The perspective from this convention is that all forced treatments violate an individual's human rights, regardless of the physician's intentions.

Although several legal systems still allow for the forced treatment of individuals under certain circumstances, the ethical acceptability of such practices will depend upon whether or not they meet the following criteria: (i) necessity; (ii) proportionality; (iii) period of time; (iv) procedural safeguards; and (v) the availability of less restrictive alternatives to the referral to forced treatment. If there is to be any allowance for the forced treatment of an individual, it should be considered the exception rather than the norm.

### **International Human Rights Perspective on Forced Treatment**

Forced treatment and patient autonomy have been at the core of the discussion regarding human rights on a global scale. The UN Convention on the Rights of Persons with Disabilities (UNCRPD), ratified by India in 2007, is the foremost international instrument in this area that employs a rights-based approach with an emphasis on dignity, autonomy, and non-discrimination.

According to Article 12 of the UNCRPD, persons with disabilities (including psychopathological disabilities) are entitled to the same legal capacity as everyone else, and the UNCRPD further states that the States are required to assist persons with disabilities in exercising their legal capacity, rather than to substitute it through a system of substituted decision-making. Traditional mental health legislation that permits involuntary mental health treatment based on the basis of a perceived inability to make a decision is therefore being challenged.

The UNCRPD also prohibits arbitrary or unlawful deprivation of liberty in Article 14 and states that disability should *nunca ser una justificación para su detención*. Article 25 of the UNCRPD requires that healthcare services be provided on the basis of informed consent and free will. Ellis(2006) analyses these provisions together as indicating that forced treatment may potentially fall short of meeting or exceed the requirements established in International Human Rights Act.

The UN bodies and special rapporteurs have stated many times that the involuntary use of psychiatric treatment/violence is a type of ill-treatment. UN bodies and special rapporteurs have stated that the rationale for using involuntary treatment is often vague and leads to abusive practices. The use of alternative interventions for treating mental health conditions, such as peer support and collaborative care, should be given priority over the use of involuntary methods of treatment.

However, there are conflicting opinions regarding how the UNCRPD should be applied. There are many states that believe the Convention does not completely prohibit the involuntary use of psychiatric treatment; some feel that it is appropriate in emergency situations, while there are others that believe that the ideal of complete autonomy can never be reached because of the nature of trying to create an idealized model for mental healthcare.

Nevertheless, the International standards still hold some degree of moral authority and allow for states to slowly reduce the use of coercion, create safeguards against coercion and move toward a model of Supported Decision Making. The Indian Mental Healthcare Act, 2017 reflects some of the moral authority and therefore influence of the International standards; however, it does not eliminate the involuntary use of psychiatric treatment.

### **Indian Legal Framework: Mental Healthcare Act, 2017**

The Mental Healthcare Act in India is the most significant reformation of mental health legislation in the country to date (in terms of the Domestic Mental Health Act, 2017). The Act aligns domestic mental health legislation with the UN Convention on the Rights of Persons with Disabilities (UNCRPD), and places the autonomy of the individual back at the centre of the mental health system. The Act establishes that mental health is a right, and as such, acknowledges that all individuals should receive the same respect, dignity, and treatment within the mental health system.

Through Sections 4-13 of the Mental Healthcare Act, an individual cannot be presumed to have lost their ability to make treatment decisions; unless there is an inability or incompetency to provide informed consent, they have the right to decide on their own treatment options. Sections 5-13 introduce advance directives and the establishment of nominated representatives, allowing people to make decisions about future treatments.

At the same time, the Mental Healthcare Act also provides a framework to allow for the involuntary admissions and treatment of individuals who require urgent medical attention but are unable to make informed decisions. Sections 89 and 90 of the Mental Health Act outline procedures to allow for the involuntary admissions of an individual who lacks the capacity to consent, so long as the individual poses a danger to themselves or others. The Act stipulates strict procedures and parameters around supported involuntary admissions, including regular reviews by Mental Health Review Boards and time limits for review.

The Mental Health Care Act, 2017, aims to create a balance between respecting patient autonomy, while also ensuring that the person receives care in the least restrictive way possible. This means that coercive treatment should not be the first option used; rather when considering an involuntary admission, it is necessary to also consider the will and preference of the patient.

While the intentions of the Act are positive, there are still many difficulties that exist within its implementation. Not having enough understanding about the Act, lack of facilities to provide appropriate services, and not having trained professionals will continue the reliance on coercive methods of treatment. In addition, the way in which each State implements the Review Board process will vary and thus result in some discrepancies in the overall functioning of the system.

Therefore, while the Mental Health Care Act, 2017 represents a significant move forward in terms of supporting and respecting patient autonomy, the ethical dilemma of forced treatment versus patient preference continues to exist within the current laws.

### **Judicial Approach to Forced Treatment and Autonomy in India**

Judicial review of mental health rights has been developed significantly by the courts in India. Over time, judges have become increasingly aware of the importance of the respect for personal autonomy and dignity of people suffering from mental illness in light of their rights under Article 21 of the Constitution (Right to Life and Personal Liberty). The Supreme Court of India specifically recognized the right to refuse medical treatment for the first time in the case of *Common Cause v. Union of India*. While the court did not make any ruling related specifically to mental health, it affirmed that the right to make an advance directive is essential to exercising your autonomy as guaranteed under Article 21. Additionally, the courts have consistently stressed the importance of treating people with mental health issues humanely, denouncing inappropriate institutional or custodial treatment (i.e., abuse and neglect) and accepting the State's obligation to protect individuals who cannot protect themselves.

Judicial judgement is an attempt to balance different values, not to embrace one value over the others. Courts do not lightly endorse the use of forcible treatment, nor do they regard the right to self-determination as an absolute. Involuntary treatment will be upheld by the courts if all procedural safeguards have been complied with and there is a clear and present threat of injury.

Currently, there is only a limited body of options (jurisprudence) detailing how to utilize forced treatment under the MHCA 2017 in court proceedings. As cases of forced psychiatric treatment increase, courts will have a major impact in determining the extent and limits of autonomy in providing mental health services.

### **Practical Challenges and Ground Realities**

India has many progressive mental health legislation; however, the reality is very different. There are still systemic barriers preventing everyone who needs mental health care from getting it because of stigma associated with mental illness, lack of adequate resources (specifically, lack of access to community-based services) and cost of treatment. As a result, both families and physicians often have to resort to involuntary treatment options.

Often families are the primary caregivers for persons with mental illness because of fear, fatigue or the need to comply with family pressures. Additionally, persons with mental illness who come from lower socio-economic backgrounds may not know about their rights as outlined in the Mental Health Care Act, 2017.

Mental Health Review Boards are designed to be a check against the abuse of the system; yet, they are typically understaffed or do not function at all. Therefore, the lack of resources and support will result in increased risk of violation of rights of persons with mental illness, as well as decreased accountability and oversight.

The disparity between what the law states and actual practice emphasizes the need for comprehensive training and implementation of option for recovery and social reintegration. With proper resources and implementation of services, the concept of autonomous individuals (i.e., those with mental illness) will remain unattainable because it will be only a concept rather than reality

### **Ethical Principles Governing the Balance Between Forced Treatment and Autonomy**

The ethical dilemma regarding forced treatment versus the patient's right to autonomy in mental health treatment can best be understood by analysing it through the four principles from bioethics: Autonomy, Beneficence, Non-Maleficence and Justice. Autonomy has become the most dominant principle of healthcare ethics today; this principle focuses on an individual's freedom to choose, have dignity, and have self-determination. In the case of mental health, the idea of autonomy is challenged because of concerns surrounding impaired decision-making capacity, which creates an ethical tension that posits that respecting a patient's autonomy may violate the moral obligation to protect them from harm and promote their well-being.

According to Beneficence, a health care provider should act in the patients best interest by making decisions related to treatment aimed at restoring health and relieving suffering. In the case of severe

mental illness, many health care workers justify forced treatment as beneficence for the patient because of the consequences of not treating a person with a serious mental illness (such as the risk of suicide or death due to violence, or irreversible deterioration of the patient's condition). The argument for using temporary coercion to forcibly treat patients is based on the premise that the patient will regain the ability to make autonomous decisions after their condition has been stabilised. However, viewing beneficence strictly from the medical perspective ignores the subjective experience of the patient and their values and preferences.

The principle of non-maleficence is closely related to beneficence; Accordingly, it requires that the Healthcare Provider not cause harm to the patient. Although there may be good intentions behind the use of Force to Treat, the use of Force could cause psychological trauma, affect the patient's sense of powerlessness, and damage the patient's trust in the Healthcare System. The use of Coercive Practices (e.g., physical restraint or involuntary medication) can create Long-Term Emotional Consequences. In this respect, Harm Caused may exceed Therapeutic Benefit. Therefore, when making Ethical Decisions, Healthcare Providers should consider both Immediate Harm and Long-Term Harm.

Additionally, the principle of Justice complicates the issue further; Justice Requires Fair and Equal Treatment, as well as the elimination of Discrimination, in all aspects of Providing Healthcare Services. Historically, Persons with Mental Illness have been Subjected to Greater Restrictions on Liberty and Autonomy than those with Physical Illness. In this context, Ethical Consistency requires an exploration of why Patients' Refusal of Treatment in the Physical Healthcare context is typically Respected, whereas Patients' Refusal of Treatment in the Mental Healthcare context is often Overridden. This disparity creates a risk of perpetuating the stigma of Mental Illness and upholds the idea that Persons with Mental Illness are Inherently Incapable and/or Dangerous.

Ethical models are developing toward Supported Decision-Making rather than Substitute Decision-Making. Rather than replace a patient's choice with that of a doctor or guardian, Supported Decision-Making seeks to help patients understand their situation, weigh their options, and express preferences about their decision-making process; hence, it is more consistent with Ethical Principles for Human Rights. In addition to being consistent with human rights and reducing the use of coercion, using Supported Decision-Making allows for a more ethical balance between autonomy and forced treatment by moving away from paternalism and toward a patient-focused, participatory, and least restrictive approach.

### **Supported Decision-Making as an Alternative to Forced Treatment**

The concept of Supported Decision-Making, which allows for a rights-respecting way to support individuals affected by Mental Health, was created as an alternative to Forced Treatment. Unlike Substituted Decision-Making (i.e., making decisions for individuals) through this concept, Supported Decision-Making empowers individuals with mental illness to use their support systems

to make their own decisions. Further, the concept of Supported Decision-Making reflects and accepts that there is no definite line between having and not having a capability to choose. Therefore, Supported Decision-Making acknowledges there are times when an individual affected by a mental illness has lower decision-making capabilities and higher decision-making capabilities.

The United Nations Convention on the Rights of Persons with Disabilities ("UNCRPD") strongly supports the idea of Supported Decision-Making. The UNCRPD states, among other things, that State Parties (Countries) must recognize an individual that has a disability as having a legal ability to make decisions. Therefore, it is the responsibility of each State Party to establish appropriate methods to ensure that an individual with a mental illness is given appropriate support; that is, allowing the individual to make their own decisions with the assistance of another person. Examples of such assistance may include providing individuals with simple methods of communication, allowing family members or friends to be involved in decision-making, providing individuals with the ability to create "Advanced Directives," as well as providing crisis planning and establishing a timeframe for individuals to make decisions. By allowing individuals with mental illnesses to be supported and assisted in their decision-making, an individual's autonomy is preserved.

The 2017 Mental Healthcare Act in India implements the notion of supported decision making in itself by using advance directives and nominating representatives of individuals to support their decision-making during times of mental health crises. By incorporating these tools, the Act allows for the expression of preferred treatment while providing individuals with the ability to choose a representative who can assist them through their mental health crisis. The Act emphasises the wishes and preferences of the individual above all else, thus reducing the need for the use of involuntary treatment, aligning mental health services with the guiding constitutional tenets of liberty and dignity. However, there are obstacles to the use of these tools in practice and in implementing supported decision-making. The primary obstacle is the limited education/knowledge concerning supported decision-making on the part of patients, families and Healthcare Providers, resulting in low levels of use of these tools. Further, systemic barriers such as the scarcity of mental health professionals, high caseloads and limited community based resources make it very difficult to successfully implement these tools. Practitioners sometimes view supported decision-making as being laborious when working in emergency situations which leads to the use of coercive methods as a first recourse.

However, the concept of "supported decision-making" is a significant solution to the ethical issue between mandatory treatments and personal sovereignty. It redefines the State's relationship to individuals by transforming it from a regulatory agency (controlling) to a facilitator of choice (supporting). Although it may not completely eliminate the requirement for compulsory treatment, it significantly reduces the likelihood of occurrence; when needed, compulsory treatment will only be employed after every reasonable alternative has been exhausted. Fortification of the "supported

decision-making" model (training, infrastructure, and legalization) will likely decrease the ethical quandaries faced by mental health professionals and create a more natural, ethically sound, and rights-compliant system of mental health care.

## **Conclusion and Way Forward**

The ethical and legal dilemma of how to balance an individual's right to autonomy with the need for involuntary treatment of mental health conditions sits at the crossroads of care, rights, and responsibility. Autonomy should be the foundation of mental health services; however applying it requires an understanding of context and the establishment of strong safeguards.

The Indian Mental Healthcare Bill/Act 2017 has attempted to provide an answer to this challenge by outlining competing values associated with the provision of mental health services. However, the Mental Healthcare Act requires additional support to ensure that all stakeholders understand and can comply with the Mental Healthcare Act.

Forced treatment, whenever necessary, should only apply to an individual's needs, and all forced treatment should operate under principles of being Transparent, Proportional to the individual need, and Respect for the Dignity of the individual receiving treatment.

In the future, India must invest in community-based mental health services, develop appropriate Supported Decision-Making mechanisms, and educate individuals about their rights within the context of mental health services before any real and meaningful balance can be reached between autonomy and the provision of care.

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