Comments on the OHCHR's Comprehensive Report on Mental Health and Human Rights

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Executive Summary
This document is in response to the OHCHR's Call for Contributions for the Comprehensive Report on Mental Health and Human Rights. The comments contained in this document have been submitted by the Centre for Mental Health Law & Policy (hereafter referred to as 'the Centre'), Indian Law Society, Pune, India.

The mission of the Centre is to strengthen and transform mental health services by adopting a rights-based approach to mental health and promoting evidence-based policy reform for mental health and suicide prevention. The Centre has provided technical support to the Ministry of Health & Family Welfare, Government of India, for the drafting of India's Mental Healthcare Act, 2017.

The Centre has provided consultancy services to other low- and middle-income countries in Asia, Africa, South America, and the Caribbean through the World Health Organization (WHO) and Pan American Health Organization (PAHO).

The detailed inputs are in the following sections:

Existing rights-based policy measures at the local, national, and regional level

Mental health law and policy framework in India

India ratified the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2007, reinforcing its commitment to uphold human rights and ensure dignified treatment of persons with disabilities, including those with psychosocial disabilities. Since then, mental health policy and legislation in India have evolved over the years to promote and protect the human rights of people living with mental illnesses.

National Mental Health Program (NMHP): India's mental health programmatic arm, the NMHP has been operational since 1982. This program adopted a decentralized approach with the launch of the District Mental Health Program (DMHP) in 1996. The program's main objectives are to ensure minimum mental healthcare access, promote mental health knowledge in general healthcare and social development, and encourage community participation and self-help in mental health services[1].

National Mental Health Policy (MHP), 2014: With the ratification of the UNCRPD, a rights-based approach to mental health was articulated in the National Mental Health Policy (MHP) in 2014. The policy focuses on inclusion and adopts a person-centered approach to providing mental health care within a human rights framework. It recognizes the disproportionately high burden of mental health issues among vulnerable populations and emphasizes the need to address the underlying conditions that contribute to their vulnerability[2].

Rights for Persons with Disabilities Act, 2016: The Rights of Persons with Disabilities (RPWD) Act was enacted in 2016 to foster an inclusive and non-discriminatory environment, ensuring equal opportunities for persons with disabilities (PwD). This act in essence legislated the

rights and entitlements enlisted in UNCRPD to guarantee the right to equality, non-discrimination, education, employment, and social security to PwDs[3].

Mental Healthcare Act (MHCA), 2017: The Mental Health Care Act (MHCA), 2017 was enacted to protect and promote the rights of individuals to access affordable, equitable, and quality mental health care and services. It mandates central and state governments to improve access to community-based services such as rehabilitation, parity in insurance coverage for mental health conditions, and the decriminalization of suicide. The Act also supports individual autonomy in treatment choices, allowing for advanced directives and nominated representatives in situations where capacity is labored. Moreover, it protects individuals with mental health conditions from forced institutionalization and rights violations through Mental Health Review Boards[4].

More recently, the other promising policy measures are the *National Suicide Prevention Strategy,* 2022 which aims to adopt a multisectoral approach to reducing suicides in the country; and the launch of the *National Tele Mental Health Programme (TELE Manas)* to expand access to mental health services across India through telepsychiatry and counselling[5] [6].

Challenges and good practices in implementing of measures

MHCA and MHP uphold and protect the rights of individuals with mental health conditions. Even after seven years of enactment of MHCA, the fundamental provisions for effective administration and oversight have not been implemented due to multiple programmatic and societal barriers. Mental health is a concurrent subject, which means that both the Union and State governments have obligations to implement mental health laws, policies, and programs.

Programmatic and policy-related barriers
Scarce financial allocations: Mental health receives chronically low funding from the government, reflecting a lack of prioritization by both the centre and states. Direct allocations for mental health account for only 1% of the total budget allocated to health. Of this, 80% is towards psychiatric institutions with insufficient allocations for community-based services[7] [8].

Poor intersectoral coordination: Mental health and well-being are influenced by social determinants such as poverty, discrimination, and gender-based violence. In addition to mental health services, other social services and special protections such as safe and quality housing, income protection schemes, and skill development are important for psychosocial recovery. The lack of intersectoral collaboration between ministries from education, social justice, labour, women development, housing, and minority affairs impedes addressing these concerns. This is attributed to lack of clarity of roles, an absence of mechanisms for accountability, and a myopic framing of mental health as a biomedical problem.

Lack of community-based models for rehabilitation of PwMI: While the acknowledgment of community-based mental health care in MHCA is a promising step, substantial work remains to effectively implement these community-centric models. To some extent, the integration of mental health services into primary and general healthcare has been done through Ayushman Bharat Health and Wellness Centres[9]. But for people transitioning from long-term psychiatric institutions to community settings, community residential services remain largely inadequate. Moreover, there is a need to generate employment and livelihood opportunities to ensure access to sustainable income.

Absence of governance and administrative oversight: At the national level, the Central Mental Health Authority was established in 2018, however, they are not fully functioning with several

actions yet to be implemented. Among the 36 states and Union Territories, five have not established a State Mental Health Authorities (SMHA). Additionally, in several states these authorities are defunct. Many have not constituted Mental Health Review Boards necessary to uphold the rights of PwM; registrations of mental health establishments and professionals are not maintained; and rules and regulations for the implementation of the MHCA are yet to be notified.

Societal and cultural barriers

Resistance to rights-based approaches: Generally, there has been an inertia among mental health professionals to adopt a rights-based approach to mental health, particularly with concerns around decisional autonomy, capacity determination, and compulsory admissions. This has been repeatedly highlighted in the discourse around the status of psychiatric institutions in the country. Recently, the National Human Rights Commission (NHRC) pointed out the inhumane conditions within institutions and the lack of long-term measures by the government to transition individuals to community care[9].

Stigma and discrimination: The stigma around mental health not only discourages individuals from seeking help but also leads to discrimination against PwMI, exacerbating their marginalization. Structural discrimination that infringes on the rights and opportunities of PwMI is still persistent. In personal legislation, such as the Hindu Marriage Act, 1955 and the Special Marriage Act, 1954, mental illness stands for grounds for divorce or nullifying marriages[10]. Similar discriminatory clauses are present in laws for making contracts and executing wills[11].

Good practices to implement policy measures

Integrating mental health into primary care: Through the DMHP and Ayushman Bharat Health and Wellness Centres, significant efforts are being made to train medical officers and community health workers to deliver mental health care to individuals in rural and remote parts of the country. These services are further augmented by TELE Manas intended to increase access to specialized psychiatric and counselling services. Capacity building is underway, and it is difficult to assess the impact of these programs.

Community models of mental health care: In India, civil society and non-profit organizations have played a significant role in delivering innovative services at scale. Some prominent examples that have gained international recognition include *Atmiyata* run by the Centre and *Home Again* implemented by The Banyan.

Atmiyata is a rural mental health initiative focused on closing the care gap for individuals with common mental health conditions. *Atmiyata* is implemented by a cadre of trained community volunteers trained and mentored to provide psychosocial support, make referrals, facilitate access to social benefits, and build awareness on social determinants of mental health. The program is cost-effective, scalable, and complements the public health system. A recent study suggested that *Atmiyata* had a significant impact on recovery from symptoms of depression and anxiety with sustained effects at an 8-month follow-up[12].

In the western state of Gujarat, *Atmiyata* has reached 2.5 million people. The project is now being scaled across the states of Maharashtra, Chhattisgarh, Uttarakhand, and Himachal Pradesh, covering 101 villages and impacting 100,000 adults[13].

Home Again by The Banyan provides housing support to women with mental illnesses who are transitioning from long-term institutions to the community. Recognized by WHO and the Lancet Commission, this initiative creates community-integrated living spaces that promote

dignity and autonomy, reducing reliance on hospitals[14]. The program targets marginalized women with mental illnesses who are poor and homeless, lacking family and state support. Currently, 585 individuals with histories of homelessness and mental health issues reside in 125 homes across 23 locations, with 90% achieving community integration and 70% of women showing reduced disability[14].

Use of OHCHR's Mental Health Guide

The Centre has referred to OHCHR's Mental Health Guide (Mental health, human rights, and legislation: guidance and practice) to draft mental health legislation for Barbados, St. Vincent and the Grenadines, St. Kitts and Nevis and Antigua through the Pan American Health Organization (PAHO). Apart from capacity and resource constraints that curtail adapting practices highlighted within the guide, we have observed that an abolitionist stance to banning involuntary hospitalization and treatment is challenging, particularly in situations where an individual is at risk to themselves or others. Further, deinstitutionalization processes should be gradual, and considerations need to be made for low-resource settings.

Other policy tools for the implementation of a human rights perspective to mental health

In India, considering the federated governance structure and absence of political leadership we recommend the following policy tools:

Local policy interventions for mental health: The 73rd and 74th amendments of the Indian Constitution bestows powers to local governance councils called *panchayats* within rural and urban settings to decentralize governance for health, education, and social services at a village level. As a part of their mandate, *panchayats* are responsible for promoting health among community members. Panchayats have the funding and governance capabilities to ensure access to mental health services and social protection schemes for PwMI. However, their resources and capacities are yet to be activated as an effective policy mechanism to improve access to mental health care.

Judicial intervention to promote and protect rights of PwMI: The courts in India have been at the forefront of guaranteeing the rights of PwMI. By taking *suo moto* cognizance and through Public Interest Litigations, courts have played a significant part in recognizing rights violations and holding the state accountable in several areas. This has been observed in matters of improving the quality of mental health facilities, parity in insurance coverage for mental illness, and ordering for the reversal of decisions on involuntary admissions of PwMIs. Other quasi-judicial bodies such as the National Human Rights Commission have frequently recognized violations within mental health institutions and have ordered respective government authorities to take necessary action[9] [15].

Coalition building and civil society action: India has a history of mobilising people's movements to demand for better health care that meets the needs of individuals. These movements or coalitions go beyond professional groups and include service users, carers, and civil society organizations. These groups can play a critical role in driving the political agenda for mental health and can be used as a pathway to catalyse change and demand for better implementation of law and policy framework. The *Mitanin* program by the Government of Chhattisgarh is a successful initiative where women health volunteers have evolved into advocates for community rights, going beyond healthcare delivery[14]

Disaggregated data on persons with psychosocial disabilities and mental health services

Prevalence of mental health conditions

The National Mental Health Survey (NMHS) conducted across 12 states of India revealed a 14% lifetime prevalence of mental illnesses in the survey population. A higher prevalence of mental morbidity was reported in males (13.9%) compared to females (7.5%). In the 13–17 year age group, the prevalence was 7.3%, indicating that nearly 9.8 million adolescents require services.

Suicide rates

The National Crime Record Bureau (NCRB) reported 170,924 deaths by suicide in 2022. India's suicide rate is 12.4 per 100,000 population. The suicide rate has increased substantially from 129,887 in 2017 to 170,924 in 2022 indicating a rise of 25%. The data recorded is only death by suicides and no data is available on suicide attempts. Additionally, suicide-related deaths are underreported by the NCRB with 27% per year in males and 50% in females which has been attributed to a lack of community-level reporting and social stigma[16 17]. In 2022, suicide deaths were most prevalent among males (72%) as compared to females (28%)[18]. While data on trans individuals is collected, the reported cases are negligible. Suicide deaths were highest in the age group 18-30 years (35%) followed by 30-45 years (32%)[18].

Mental health services

The NMHS identified an 85% treatment gap for common mental illnesses. According to the National Sample Survey (NSS) 2017-18 (75th Round), the average cost of hospitalisation for psychiatric and neurological ailments was ₹26,843 per year. Public hospitals' cost of care was reported ₹7,235, while for private hospitals cost of care was ₹41,239, respectively [19]. Further, estimates showed 59.5% and 32.4% of households had catastrophic healthcare expenditure on mental illness, exceeding 10% and 20% of monthly household consumption expenditure, respectively[20].

Overall, India has 1.93 mental health workers with merely 0.29 psychiatrists, 0.07 psychologists. 0.80 mental health nurses and 0.06 social workers per 100,000 population[21].

There are 136 psychiatric institutions in the country, of which 46 are government-run[21]. Of all people admitted to MHI, a quarter of people spent more than a year. In 2023, according to the National Human Rights Commission of India, more than 2000 people were reported to be in psychiatric institutions despite having recovered from their mental health conditions[22].

Further, India has reported 389 general hospitals with integrated psychiatric services. Based on the online dashboard *Manoashraya*, launched by the Government of India (GoI) in 2023, there are 330 facilities across 33 states and union territories which include rehabilitation and halfway homes. As per recent data, 115,000 community-based mental health centers have been reported in India[22].

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