



Mental Health – Concern for All : In Context of the Mental Healthcare Act, 2017



**National Human Rights Commission
India**



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Justice Arun Mishra
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Foreword

Sound Mental Health is the *sin-qua-non* for the overall development of a person's personality. Even though sound mental health is of immense importance, 13.7 per cent, which means 150 million of the Indian population, suffers from some form of mental disorder, and the same is emerging as a widespread disease now. The rising toll of suicide cases, Attention Deficit Hyperactivity Disorder (ADHD), gaming addiction, and adolescent depression is increasing exponentially. The stigma attached to mental illness adds to the woes of the patients.

The mental health issue has drawn the attention of both the national and the international community, and they have taken steps to ameliorate the problem. In July 2016, Human Rights Council Resolution recognised the need to fully integrate a human rights perspective into mental health and community services to eliminate violence and discrimination while promoting inclusion and participation; Human Rights Council calls on States to promote a paradigm shift in mental health and to adopt, implement, update, strengthen or monitor, as appropriate, all existing laws, policies and practices.

According to the World Health Organisation (WHO), mental health and well-being are fundamental to quality of life, enabling people to experience life as meaningful and become creative and active citizens.

Mental Health Law in India earlier was provided through Mental Health Act 1987. The Mental Healthcare Act 2017 has been operational, a significant milestone in dealing with the issue. The Government of India has also taken the issue very seriously. It is required to be implemented in the right earnest. Wherever possible, a mentally ill person should live for healing with his own family and participate in community life, protection from exploitation, abuse and degrading treatment.

Reposing its faith in the National Human rights Commission of India, the Supreme Court assigned responsibility to monitor mental health care institutions. Commission (NHRC) is monitoring the functioning of three premier mental health institutions at Agra, Gwalior and Ranchi. NHRC has kept up with the expectations and worked towards improving these Institutions.

Albeit mental healthcare and protection in India have improved a lot, there is still a lot more to be done to ensure the inalienable and indefatigable rights of the person with mental illness.

India's quest to become a world leader has begun, and the Mental Health of India's populace will play a significant role in this pursuit. All the stakeholders need to unite in the fight to achieve the objective of sound mental health for all.

Through this publication, NHRC has made a concerted effort to recognise and acknowledge mental health and be able to talk about the same without any fear of the social stigma attached to mental health problems. This publication will further augment to sensitise all the stakeholders.



(Justice Arun Mishra)
Chairperson

Surya Kant
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31st October, 2022

MESSAGE

The publishing of this book warms my heart greatly. It is a matter of immense importance that we, as a society and as lawyers, have begun to take mental health seriously and now recognize it as being a clinical state requiring sensitivity in understanding and treatment. The Mental Healthcare Act, 2017, has introduced various provisions that are a crystallization of the enormous strides we are taking to become more humane and caring in our approach towards mental illness. I trust that with the release of commentaries such as these, the legal regulation of issues related to mental health will receive more scrutiny and we will permanently consign to history the archaic attitudes that thought of mental health problems as “mental weakness”.

The most important step that has been taken is to effectively nullify Section 309 of the Indian Penal Code and decriminalize ‘suicide’ that had previously been chargeable. This follows the “patient-centric” approach that has been taken under the Act. It was, in fact, a strange situation that had previously prevailed, whereby if an individual survived an attempt at suicide, would then face the burden of criminal proceedings. The act of attempting to take one’s own life is clearly brought on by factors of immense mental stress, and may be caused by clinical conditions such as severe depression as well. Hence, to categorize these individuals, effectively, as criminals under the IPC was clearly a regressive attitude. The Mental Healthcare Act rectifies this gross inequity.

Another area of important progress, is the outlawing of certain potentially damaging treatments. As in the middle of the 20th century, the practice of lobotomy used to be a common and widespread form of treatment. While it still

remains so for the specific disorders such as epilepsy, it was often utilized for conditions where far less risky forms of treatment were available. As time went on, the dangers associated with lobotomy gained greater recognition and it was increasingly abandoned as a viable method of treatment. Similar is the case with “Electroconvulsive Therapy”, or “Shock Therapy” as it is otherwise known. The cases where it may be used have been severely curtailed and, importantly, its application upon minors has been outlawed completely. The ‘science-first’ approach in the Mental Healthcare Act in recognizing the inherent risks with drastic forms of treatment such as Electroconvulsive Therapy, is worth applauding.

The Act attempts to go beyond mere legal solutions and steps. Section 30 lays down an obligation to sensitize government officials as well the general public, regarding the provisions of the Act and mental health in general. This exhibits the outward projection of the ethics behind the Act and the farsightedness of the drafters that mere alterations in the law would be ineffective without changes in societal attitudes towards mental health problems. This is a continuing process that every individual can contribute to in their own way by extending empathetic attitudes toward those suffering from mental illness and setting an example for those around them to do the same.

In sum, the hope is that the corpus of laws regarding mental health expands from this point forth. In a field such as this, our focus must not exclusively be upon the legal aspects of tackling mental health issues but also on the science and societal effects that such afflictions have. We must also appropriately address issues such as trauma and conditions induced by post-traumatic stress. Specifically, crimes

against young children that are already dealt with under POCSO should be tied in with regulations on how to address the mental health problems they experience after suffering from horrific and heinous crimes. We must ascertain each instance where the Mental Healthcare Act can be supplemental to various other statutes due to the specific issues which arise in different scenarios.

One of the grey areas that we must address is the fact situation where people with mental health issues act against their own self-preservation and interests. The agency given to individuals suffering from problems is laudable, however, we must critically analyse the extent to which these rights are actually assisting patients. We must be vigilant regarding the potential for self-harm that exists when patients refuse treatment which would actually help them in addressing their mental health issues. It is in this context, that the sensitivity and empathy of peers and doctors is of utmost importance. Whenever mental illness is involved, a greater degree of patience and care is necessary to ensure the optimum therapies are applied.

I earnestly encourage further work such as this book into the area of mental health and also champion inter-disciplinary approaches that combine law with science, psychology, and sociology. An inter-disciplinary approach will be the only way to ensure that appropriate steps are taken to guarantee the betterment of those suffering with mental health issues and advance our legal and societal discourse in the right direction. The initiative taken by Justice M.M. Kumar, former Chief Justice of the High Court of Jammu & Kashmir and Member, National Human Rights Commission by inculcating numerous measures to galvanise and sensitise the administrative machinery for implementation of the Mental Healthcare Act deserves a special applaud. My gratitude is also due to the National Human Rights Commission in extending its helping hand, and especially to the authors for their indelible contributions in this regard.


[SURYA KANT]

डॉ. मनसुख मांडविया
DR. MANSUKH MANDAVIYA



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आज़ादी का
अमृत महोत्सव

स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक मंत्री
भारत सरकार

Minister for Health & Family Welfare
and Chemicals & Fertilizers
Government of India



MESSAGE

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. Without mental health there can be no true physical health.

Neurological disorders are an emerging challenge to healthcare systems owing to the high burden of disease. The burden of mental disorders continues to grow with significant impacts on health and major social, human rights and economic consequences in all countries of the world.

Nurturing mental health doesn't just improve our daily functioning, but it can also help us control or at least combat some of the physical health problems directly linked to mental health conditions. There is an urgent need to shift our focus to address our own mental health and wellness in order to live better, increase productivity, enhance our self-image, and improve relationships.

It gives me immense pleasure to learn that the National Human Rights Commission has joined hands with leading experts in the mental health to document issues affecting enjoyment of human rights by the persons suffering from mental illness. I am sure the book will help in clearing common myths and misconceptions about mental illness that exist in the minds of a common man. The book will be equally useful for health administrators, academicians, researchers and healthcare experts.

I congratulate and compliment the National Human Rights Commission for their efforts in compiling valuable information on care and treatment of persons with mental illness in a humane and dignified manner.

(Dr. Mansukh Mandaviya)

किरेन रीजीजू
KIREN RIJJU



सत्यमेव जयते



आज़ादी का
अमृत महोत्सव

मंत्री
विधि एवं न्याय
भारत सरकार
MINISTER
LAW AND JUSTICE
GOVERNMENT OF INDIA

MESSAGE

Mental health is the foundation for well-being and effective functioning of an individual. It includes our emotional psychological and social well-being. It affects how we think feel and act. It also helps determine how we handle stress, relate to others and the choices we make. It is important at every stage of life, starting from childhood till one dies. One cannot enjoy the life if he or she does not have a peace of mind.

Mental health issues affect people from all walks of life irrespective of age, sex, and socio-economic conditions Majority of the persons suffering from mental illness however do not recognize that they are suffering from it. Even if they recognize, many of them avoid treatment as mental illness still carries a strong social stigma.

It gives me immense pleasure to learn that the National Human Rights Commission is making sincere efforts for implementation of the Mental Healthcare Act, 2017 containing provisions to make available mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services.

I congratulate and express my sincere appreciation to the National Human Rights Commission for their initiative and efforts in publication of this highly informative and useful book on mental health I am sure the book will deepen understanding of authorities in the Union and State Governments, health professionals. Civil society organizations, academicians and State Human Rights Commissions, about the problems faced by the persons with mental illness.

(Kiren Rijju)

JUSTICE M.M. KUMAR
FORMER CHIEF JUSTICE, J&K HIGH COURT
FOUNDER PRESIDENT, NCLT
FORMER MEMBER, NHRC



MESSAGE

It gives me immense pleasure to learn that the book *'Mental Health – Concern For All'* is being eventually published. This book was conceived and prepared during my tenure as a Member, National Human Rights Commission as I was incharge of the Core Group *"Health & Mental Health"*.

Our world today has attained a reality that equally exists in the virtual plane as it does in the tangential plane. The rapid development in information technology that has connected us in efficient manners, unimaginable a few years back, has also alienated human interaction. With these changes in dynamics, we have become more aware of the self while the resources around us have remained static. Although, we see a necessary shift today in recognising Health and Well Being in a complete physical, mental and social capacity, yet limited resources and prefabricated judgements hinder equitable access to manage mental health illnesses at a community scale. It has, therefore, become imperative to examine and safeguard the rights of persons with mental illnesses. We require comprehensive and proportional resources for individuals and organisations seeking help, and we need to allow them to seek rehabilitation with honesty, compassion, and empathy.

The Mental Healthcare Act, 2017 is a comprehensive and ably drafted place of legislation. It envisages the establishment of a Central Mental Health Authority (Ss. 33 to 44), State Mental Health Authority (Ss. 45 to 56); Mental Health Review Boards, amongst many other institutions. The Central Health Authority has been established and is functional. However, States have either failed to establish or have established such authority on paper have remained static. A statutory obligation has been cast on all State Governments to establish, by issuing notifications, a State Mental Health Authority within a period of nine months which ended in January, 2018. The net result is that there is no operation for the registration of mental health establishments. According to S.65, no person or organisation

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is to establish or run a mental health establishment without registration with the Central or State Authority. Even the Rules and Regulations framed under S. 121 and S. 123 of the 2017 Act have not been notified by many States. How can the norms for registration be followed if the Rules and Regulations incorporating such norms are not notified by the States? For framing such Rules and Regulations, guidance is readily available in the Mental Healthcare (Central Mental Healthcare Authority and Mental Health Review Boards) Rules 2018; The Mental Healthcare (Rights of persons with Mental illness) Rules 2018 and the Mental healthcare (Central Mental Health Authority) Regulations, 2020.

Despite the deficiencies, it is heartening to read that two inmates of Half Way Home of Institute of Mental Health, Chennai, namely Deepa and P. Mahendran, decided to tie the nuptial knot, and the State Government has also incentivised them (Indian Express October 26 and 29, 2022). It is reported that this was the first such event in the history of 228 years of IMH. If Halfway Homes, Sheltered and Supported Accommodation are established as per the mandate of Rule 3 of the Mental Healthcare (Rights of Persons with Mental illness) Rules, 2018, then such positive events would be witnessed in greater numbers. Another positive change came from Section 115 of the 2017 Act, which has decriminalised attempt to commit suicide under Section 309, and many FIRs have been quashed by various High Courts. Even certain procedures are prohibited, which include electro-convulsive therapy without the use of muscle relaxants and anaesthesia; electro-convulsive therapy for minors; sterilisation of men and women; chained in any manner or form whatsoever (sections 95 and 96).

Acknowledgement of Mental Health in the budget 2022 is a prelude to the normalisation of conversation at a community scale in India against socially tabooed mental health disorders and their overarching hold on every sector of our society. The Finance Minister took cognisance of the effect of the Covid-19 pandemic as an understated reason for the worsening mental health conditions in the country. Medical Journal, The Lancet put forth its research on an increase in major depressive and anxiety disorders with an increase of about 35% as a consequence of lack of social contact, strict movement restrictions, economic insecurity, or the fear of falling sick. An empirical study has been conducted by the National Council of Educational Research and Training, which came close to those conclusions. The study is titled as Mental Health and well-being of School students – A survey 2022. Resultantly, the launch of a 'National Tele Mental Health Programme (NTMP)', that shall see the creation of 23 tele-mental health centres is a desired admission of mental health encompassing all its spheres in the form of the cognitive, behavioural and emotional well-being of an individual.

This book also traces various important provisions of the legislation on the subject matter and the ongoing and previous initiatives to destigmatise its association with shame or disgrace. Within the bounds of the group most affected, from children and women to

prison inmates and the LGBTQIA+ Community, amongst many others, this research increasingly draws toward understanding the link between the changing human-nature relationships and external stimulations on people's health. However, to examine whether there is a link, requires research of its breadth and underlying mechanisms from an interdisciplinary perspective that forms the core of our work published here. The concept of "mental health" is then explored based on the consequences it attracts when not catered to efficiently. Combining these concepts paves a path for the requirement of a developing conceptual model using an interdisciplinary perspective that can facilitate a deeper understanding of the complexities involved in attaining optimal mental health.

All contributions to the book have made a diligent effort in putting forth their recommendations with the support of the Commission for the betterment of existing and upcoming health establishments in recognition of Mental Health at an equivalent standing as physical illnesses. The research has been concluded in an integrated manner and presented with the hope that the concerned State and Central Government institutions shall take it into consideration in their policy decisions. I am indeed beholden to each one of the contributors, especially Prof. (Dr.) Rajesh Sagar, Department of Psychiatry, All India Institute of Medical Science, New Delhi and Prof (Dr.) Pratima Murthy, Director, NIMHANS, Bangalore.

I enjoyed working as a Chair of the Core Group on the subject of Mental Health. The endeavour of this core group to ensure the effective functioning of all Mental Health Institutes led to a campaign which became more pronounced when the full Commission visited Ranchi, Agra and Gwalior to acquire first-hand information. I express my gratitude to Chairperson Mr. Justice Arun Kumar Mishra, Hon'ble Members Shri (Dr.) D. M. Mulay and Shri Rajiv Jain for their wholehearted support. The NHRC is a proverbial 'Missionary Mode' to ensure the implementation of the 2017 Act and that its benefits reach everyone. I am sure this book would serve as a guide to all stakeholders.


(Justice M. M. Kumar)

डॉ. ज्ञानेश्वर म. मुले

सदस्य

Dr. Dnyaneshwar M. Mulay

Member



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MESSAGE

Maintaining positive mental health and curing mental health conditions are critical for constructive behaviours, emotions, and thoughts. In addition, focusing on mental health care can boost productivity, improve our self-image, and strengthen our relationships. A healthy mind can control or combat many chronic diseases.

Investment in mental healthcare has not matched the rising global awareness of the scale of this problem. Approximately, one billion people suffer from mental health disorders worldwide, according to the 2022 WHO data. Moreover, as per WHO, anxiety and depression constitute a loss of productivity, costing the global economy around US\$ 1 trillion yearly.

The silent sufferers are prisoners from diverse social and economically underprivileged backgrounds and suffer from suicidal tendencies, PTSD, and depression, among others. One of the main reasons behind this is a lack of acknowledgement and recognition of Mental Health as an illness.

It is, therefore, essential to make sincere efforts for the social inclusion of stigmatised groups, especially the impoverished and the unemployed. Furthermore, investments in increasing the availability and accessibility of mental healthcare at affordable costs and raising awareness of mental healthcare resources may significantly help reduce the economic costs of mental illness.

This publication will allow us to highlight our country's advancements in mental healthcare and the critical gaps that need immediate attention from policymakers. I am sure this publication will be of immense use to Governments, academic institutions, Non-Government Organisations, Civil Society Organizations, mental health professionals and other stakeholders.

(Dr. Dnyaneshwar M. Mulay)

राजीव जैन
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Rajiv Jain
Member



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Message

Mental illness is emerging as a leading cause of non-fatal illness. Many persons are suffering from anxiety, schizophrenia, bipolar disorder and other variants of mental illness. Such persons lose their ability to cope with everyday stresses of life. Ripple effects of mental illness often extend to families and workplace creating uncertainty, stress and tension. Besides affecting Happiness Index, mental illness also affects productivity.

There is casual nexus between one's lifestyle and mental health. Unhealthy eating habits, lack of physical activity, overuse of technology, substance abuse and pressure from family, peers and employers to excel are believed to be significant causes of mental illness. Complex and fast – paced modern life has exacerbated these factors.

There are several silver linings : negative attitudes towards patients of mental illness are receding; there is more consciousness about patients' rights; more patients of mental health are acknowledging the problem and seeking medical help; there have been improvements in treatment protocols; more importantly, the Parliament has enacted the Mental Health Act, 2017, which has qualitatively changed the landscape of management of the issue.

The National Human Rights Commission is undertaking a comprehensive examination of the working of Mental Healthcare Institutions in the country to ensure that persons suffering from mental illness are treated in a dignified manner without infringing upon any of their human rights. The Commission's informative publication on mental healthcare will greatly help to create awareness about actions required to protect the rights of such persons.

(Rajiv Jain)
Member

देवेन्द्र कुमार सिंह, मा.प्र.से.
महासचिव

Devendra Kumar Singh, IAS
Secretary General



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Message

With the ratification of the UN Convention on the Rights of Persons with Disabilities by India, national legislation was harmonized to reflect the changing needs. The Mental Healthcare Act, 2017 seeks to provide mental healthcare and services for persons with mental illness and to promote and uphold the rights of such persons during the delivery of those services. These rights are quite extensive and inclusive.

The aforementioned legislation would be most effective in dealing with the mental health issues if the gaps so identified by the stakeholders are appropriately addressed. As per the Census of India 2011, the number of persons suffering from mental illness is about 7.22 lakhs. This demands adequate mental health resources and awareness about mental illness and society's approach to dealing with the issues. It also requires adequate investment in promoting mental health, prevention, and care. Improved mental health services save lives beside the prospects of people who may feel hopeless and lost.

We trust that this publication of NHRC would broaden and deepen the understanding for an effective plan of action and provide a bridge to the overall development of this critical segment of Health and Wellbeing.


9.12.2022
(Devendra Kumar Singh)

देवेन्द्र कुमार निम
संयुक्त सचिव

Devendra Kumar Nim
Joint Secretary



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Acknowledgement

Mental health is the umbrella term for our overall emotional, psychological, and societal wellbeing. The state of a person's mental health has a significant impact on their capacity to thrive individually, professionally, and in their community. Therefore, it is a vital component of health and wellness that supports our ability to make decisions, establish relationships, and impact the world in which we live.

The National Human Rights Commission has been playing an important role in assuring compliance with the Commission's proposals and promoting awareness on mental health among State/UT Governments. The Commission has also taken the initiative to directly inspect the state of mental health institutions nationally and suggest similar measures in order to investigate the grassroots truth. The Commission has also emphasised and urged the Governments to take action and implement the Mental Healthcare Act, 2017.

The Commission's ongoing efforts to promote awareness and initiate conversation will undoubtedly inspire some action. The passionate interest of the National Human Rights Commission (NHRC) in mental health and a foresight and vision for the wellbeing of those suffering from mental illness evolved into a mission which culminated in the publication of this book, covering a variety of mental health-related areas.

Therefore, the foremost person I would like to thank and place on record my sincere gratitude to is Mr. Justice Arun Mishra, Hon'ble Chairperson, NHRC, for his persistent guidance and support. It would not have been possible to publish this book without his wholehearted involvement and motivation.

I also express my gratitude to Dr. Dnyaneshwar M. Mulay and Mr. Rajiv Jain, Hon'ble Members, NHRC, for their inputs and support. In addition, I place on record my gratitude to Mr. Devendra Kumar Singh, Secretary General, NHRC, for his unwavering support and guidance.

This book examines numerous facets of mental health, particularly in light of the Mental Healthcare Act, 2017. This book would not have been possible without the teamwork and coordinated efforts of the authors, co-authors and subject experts. I express my deepest gratitude to the authors and co-authors, Mr. Justice M.M Kumar, Dr. L.D Mishra, Dr. Pratibha Murthy, Dr. Rajesh Sagar, Dr. Nimesh Desai, Dr. K.V Kishore, Dr. Shekhar Seshadri, Dr. Mathew Varghese, Dr. Prabha S Chandra, Dr. Pratibha Vinod, Dr. Santosh Kumar Sah, Dr. Nalini Saligram, Dr. Snehil Gupta, Dr. Ravindra Rao, Dr. Swapnajeet Sahoo, Dr. Swarnadeep Singh, Ms. Parul Shrivastava, Ms. Neerja Phatak, Dr. Harshini Manohar, Dr. Arathi JS, Dr. Megha

Sehrawat, Dr. PT Sivakumar, Dr. Shruti Chakravarty, Ms. Pooja Nair, Ms. Mimansa Singh Tanwar, Ms. Aakanksha Sharma, Ms. Shilpi Jain, and Ms. Shaivi Pandey for their contribution.

I am thankful to the editorial team consisting of Dr. Nimesh Desai, Senior Consultant and Professor of Psychiatry, and Former Director, Institute of Human Behavior and Allied Sciences (IHBAS), Delhi; Dr. Rajesh Sagar, Professor, Department of Psychiatry, All India Institute of Medical Sciences (AIIMS), Delhi; and Dr. Snehil Gupta, Assistant Professor, Department of Psychiatry, AIIMS, Bhopal, for their endless support, efforts and valuable suggestions during the development of this book.

I would also like to acknowledge and compliment the Internal Team of NHRC consisting of Mr. Sudesh Kumar, Senior Research Officer, Ms. Aakanksha Sharma, Junior Research Consultant, Mr. Sukhdev Singh, PPS, and Mr. U.N. Sarkar, Assistant Director (Publication) for their support and assistance.

I would like to thank everyone who directly and indirectly contributed their time and effort for the publication of this book, which is an overview of the latest developments in India's mental health system and will certainly allow us to review the direction we will traverse in decades to come.



(Devendra Kumar Nim)

Introduction: Human Rights and Mental Health in 21st Century India

The conceptualisation of Human Rights was put forth by the former United Nations Secretary-General, Mr. Boutros Boutros Ghali clearly, stating that “there are three imperatives of human rights, namely universality, guarantee, and democratisation, which need to be properly grasped.” Human rights are considered universal if they are applicable to all human beings without exception, pertinent in all eras and situations, and non-discriminatory in their application and enforcement. For human rights to be guaranteed, efficient legal systems and procedures must be in place to ensure that these rights are protected. Furthermore, punitive provisions must be there to deal with any violations of the rights enshrined under these framework. In States and communities, only democracy can protect human rights. These Rights are, therefore, unalienable. The relevance of Human Rights in mental health has been because of various factors, including several instance of violations of the rights of Persons with Mental Illnesses (PMIs) across the World and across time. Fortunately, many successive legal provisions have looked at preventing such violations of the Human Rights of PMIs, and, indeed, the active promotion of these rights.

Basic Legal Framework and Provisions

Although several international legal provisions and judicial interventions in the country have been central to the issue of human rights and mental health, the United Nations Convention for Rights of Persons with Disability (UNCRPD), which was enacted by the United Nations General Assembly in 2006, and ratified by the Indian Parliament in 2008, becomes the fulcrum around which all considerations must revolve. The most immediate consequential legislative provision for the mental health field, in accordance with the UNCRPD, in India, viz. The Mental Healthcare Act of 2017 has fundamentally changed the basic framework to ensure rights of the persons with mental illness. The basic framework for Human Rights also draws strength from the provisions in the Constitution of India about recognising the rights of all human beings as automatically and equally to everyone, regardless of any other consideration. The Right to Life is the most sacrosanct and primordial of all human entitlements. It is enshrined in Article



21 of the Constitution regardless of class, caste, clan, sect, gender, faith, and belief. This fundamental provision of equality before the Law becomes explicitly applicable to all Persons with Disability, including PMIs, especially those with mental illness-related disabilities.

The Right to Life is the most basic of these entitlements, encompassing the right to a life of dignity and decency, honour and freedom, and doing certain things in a decent and dignified manner without impinging on the rights of others or without causing any injury or harm to them physically, mentally and emotionally. The right to liberty, which becomes relevant in the context of the treatment and care of some PMIs, especially those with impaired capacity to decide for themselves, has been merged with the right to life under Article 21. These rights are inextricably intertwined and include two main implications- the right to liberty would mean the ability to choose or exercise option, discretion, or volition and the freedom to select the best option based on their knowledge and judgment. This principle has been embodied in Section 4 of the Mental Healthcare Act, 2017. In addition, the Mental Healthcare Act of 2017 has also clearly enunciated, in Section 20, the right of a Person with Mental Illness to protection from cruel, inhuman, and degrading treatment.

To understand the context for implementing the latest legislation, it is appropriate to briefly review the early developments in the history of post-independent India. The Honorable Supreme Court has been actively involved in the essential matters of human liberty and dignity, particularly those that pertain to mental health. The National Human Rights Commission (NHRC) and a few other organisations have also taken an active role in advocating for a review of existing mental health services for the PMIs. The Mental Healthcare Act of 2017 is sure to be a turning point in the history of mental health and human rights, so any deliberation must be in the context of this law. At the same time, the mental health concerns in the early 21st Century go far beyond the issues covered by this Act and deserve to be highlighted for immediate relevance and future application. Therefore, this book is broad-based on the background of that situation. This Chapter reviews the legal and societal developments in India, as an introduction to the other chapters on specific themes of concern.

Judicial Interventions for Reform in 'Mental Hospitals'

The Hon'ble Supreme Court of India, as well as many Hon'ble High Courts, have significantly contributed to the implementation of the legal provisions, either in response to Public Interest Litigations (PILs) or occasionally through *Suo Motu* actions. The opportunity for intervention through the Public Interest Litigation mechanism has been increasingly utilised by these Appellate Courts



whenever concerned citizens and/or Rights Groups have raised the issues of violation of human rights. These appeals and interventions have, quite often, been about such violations in the state-run mental healthcare institutions- what used to be the traditional old-style “mental hospitals”. Indeed, it can easily be said that the prevention of violation of the Rights of Persons with Mental Illness (PMIs) in such settings and reforms of these hospitals have been possible mainly due to above mentioned judicial interventions. Additionally, it has also made it possible that the modern-science driven mental healthcare are available to the population. The impetus for the reform of the “mental hospitals” to modern mental healthcare institutions was given by national efforts in form of the intervention by the Hon’ble Supreme Court, in 1990s, and the then newly constituted National Human Rights Commission (NHRC), and subsequently followed through by the state-level judicial interventions.

Judicial Interventions Beyond ‘Mental Hospitals’

Over and above the interventions of the Hon’ble Supreme Court and the NHRC for reform of the “mental hospitals”, there have been some other judicial interventions which have, in the 21st Century, focused on the human rights of Persons with Mental Illness (PMIs) in settings outside the hospital. One such notable initiative was the “Suo Motu” action by the Hon’ble Supreme Court for review and improvement of the mental health services in the country, following the Erwadi Tragedy wherein several PMIs were burnt alive, shackled to thatched huts in an informal residential long-term facility in Tamil Nadu (WP(C) 334/2001). The Apex Court reviewed and monitored the implementation of the National Mental Health Programme (NMHP) and the adherence to the provisions of the Mental Health Act of 1987, in States and Union Territories. The Hon’ble Supreme Court also directed the Police authorities to close down and not permit any residential facilities for PMIs, without appropriate licenses as per the provisions of the MHA, 1987. The directions passed by the Hon’ble Supreme Court in the case, with extensive deliberations and inputs from various stakeholders, aided in improving mental health services in the country and protecting the human rights of PMIs.

The other broad-based PIL on mental health services beyond “mental hospitals” was in the Hon’ble High Court of Delhi on the issue of homeless populations with mental illness and the wide range of issues related to the rights of PMIs (WPC 6698/2007). The Hon’ble High Court of Delhi had constituted a Monitoring Committee which made extensive recommendations leading to specific orders in 2009, for rights-based provision of mental health services, for various situations, including homelessness.



Role of the National Human Rights Commission (NHRC)

The National Human Rights Commission (NHRC), as the apex statutory agency for human rights, has been active on many fronts, and one of the priority areas is mental health. The NHRC does monitoring and reviews of mental health systems, specifically the “mental hospitals”, advocacy efforts and setting benchmarks for implementation. The NHRC led the initiative to review all such government-run “mental hospitals”, leading to a systematic study of all these hospitals by National Institute of Mental Health and Neuro-Sciences (NIMHANS), Bengaluru and the publication of the Report titled “Quality Assurance in Mental Health” in 1999 has been a turning point in the management of these large scale residential mental health facilities in the public sector, which were mostly moribund long stay facilities until then. This was followed by monitoring the reform of three such hospitals at Agra (Institute of Mental Health and Hospital (IMHH)), Gwalior (Gwalior Mansik Arogyashala), and Ranchi (Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS)), which has brought about significant results and continued them. Over time, the NHRC has collaborated with the Ministry of Health & Family Welfare, Govt of India, on the direction of the Hon’ble Supreme Court, for periodic review of all such “Mental Hospitals” and suggesting actions to convert and upgrade these old-style custodial settings to modern therapeutic centres. Some notable examples of such reformed centres include Institute of Human Behaviour & Allied Sciences (IHBAS), Delhi; RINPAS, Ranchi and IMHH, Agra. These are good case studies to be followed for other centres.

As part of the ongoing proceedings in another milestone PIL in mental health (Upendra Baxi v/s State of UP & Ors- WP(CrI) 1900/1981), the Hon’ble Supreme Court, on request from NHRC had initiated a detailed review of the state of mental health services in various States and Union Territories through various orders in 2014 and 2015. The Hon’ble Supreme Court formed a Technical Committee of mental health experts under the NHRC, which finalised and submitted its exhaustive report in 2016.

The NHRC initiatives and their impact are being highlighted in another chapter of this book, and so may not require detailed elaboration here, especially for the mental hospital-based reforms which have occurred in the last few decades.

Enlarged Scope in Policy, Legislation and Programme

There has been increasing recognition of the need for actions to protect the rights of PMIs and the active promotion of these rights, beyond the “mental hospitals” or government mental health institutions, in a range of residential settings, as well as different situations in the society. The fact that the human rights of PMIs get violated in many settings and situations is becoming widely



recognised, so the scope for interventions gets enlarged.

The National Mental Health Policy document for the country released in 2014 has taken this broad-based view of the mental health field and has laid down the larger framework for services and the human rights perspective. The National Mental Health Programme (NMHP), first introduced in 1982, has been revised from time to time and is now in its stage of implementation across all the districts of the country, thus ensuring that the Right to Mental Healthcare is provided for as given in the MHA 2017.

The MHA, 2017 provides for all residential settings, including General Hospital Psychiatry Units (GHPUs) and Halfway or Long Stay Homes for PMIs, to be regulated as Mental Health Establishments (MHEs). The scope for review of all such settings would be in accordance with the law.

Recent Laws in India

As a consequence of the obligation under the UNCRPD, the relevant national legislations have been modified to align with the provisions of the international framework, which has made a paradigm shift in the matter of rights and services for all persons with disabilities. The two most pertinent laws for PMIs and the mental health field are the Rights of Persons with Disability Act (RPwD), 2016 and the Mental Healthcare Act (MHA), 2017. The central provisions of the UNCRPD, viz. Equality before the Law as a Person, Autonomy with the right of choice, Right to Community Living and protection from any kind of inhuman or degrading treatment also form the basis for the provisions in the RPwD, 2016 and the MHA, 2017. It needs to be appreciated that while all mental health services are to be governed by the MHA, 2017, all aspects of mental illness-related disability are to be regulated as per RPwD, 2016.

This larger framework and assertive rights-based approach for mental health in the 21st Century requires an intersectoral approach, for the prevention of any violation and active promotion of mental health, across the workplace, educational settings, and on the streets.

Role of Family and Non-Government Organisations (NGOs) in Multi-Stake Holder Reality

The role of family and caregivers has been a distinctive reality of mental health in India, and despite the changing social structure, it continues to be so. The informal contribution of families in mental health service delivery may seem at a crossroads with the legalised provisions of law, and yet there needs to be a confluence between the two approaches. The family-based caregivers are coming together as semi-formal and formal groups to influence policy and programmes. For caregivers as well as users of mental health services there are



many examples of such advocacy groups across the country. Persons who have recovered or are recovering from and living with mental illnesses have important contributions to make based on their “lived-in” experience. These groups of users and carers are also complemented by a range of mental health advocates, who comprise concerned citizens, human rights activists, lawyers, and other such persons. As such, in addition to the government, the regulatory agencies, the judicial and quasi-judicial authorities, and of course, the psychiatrists and other mental health professionals, these groups of users and carers form an essential part of the multi-stakeholder reality for the mental health of the society. Many of these stakeholders function formally as registered Non-Government Organisations (NGOs), which contribute to facilitating the service delivery in mental health and monitoring in the form of a “Social Audit”. Further, many NGOs in health, women’s rights, child rights, and social development are taking an active interest in the interface of their core areas of work and mental health. The recent COVID-19 pandemic has enhanced their interest in various aspects of mental health, leading to a sharper focus on the delicate issues of balancing the need for mental health services with the protection of the human rights of the affected populations.

Contemporary Mosaic for Mental Health: Scope of this Book

The concern for Human Rights in mental health may have had its origins in the conditions at “Mental Hospitals”, and justifiably so. Still, with the evolution of the frameworks, the contemporary mosaic is a rich tapestry of the need to focus on the protection of the rights of PMIs, in long-term residential settings and “Mental Health Establishments”, through the wide range of mental health issues of the homeless populations and disaster-affected populations, and specific population groups like women, children and the elderly, to newer realities of LGBTQ populations. This wide range of topics has to be addressed to particular features while retaining the basic concern for PMIs.

The range of thematic issues covered in this book’s subsequent chapters is a reminder of what is generally well-recognised now. Some actions and concrete initiatives may come from judicial agencies, with support from governments and professional groups. The book also covers important issues of stigma, faith healing, suicide, and recent developments in mental healthcare.

Conclusion and Future Direction

The book, as mentioned above, thoroughly lists some of the fundamental rights that should be accorded to every person who suffers from mental illness. It also identifies some principles that should be followed with regard to safeguarding the fundamental rights of individuals with mental illness and weaker



and underdeveloped sections of society to give them equal representation and opportunities.

The book highlights significant advancements in mental health and human rights and specific areas that still need much attention. It also provides essential guidelines to manage a person with mental illness at home, school, hospital, and workplace while prioritising the human right perspective. Finally, it serves as a beacon of hope by highlighting some of the injustices experienced by the weaker segments of society and, eventually, how these setbacks affect a person's general health.

The concerns for human rights and mental health, and possible solutions provided in the chapters of this book, indicate the evolution in the field, reflecting the changing face of India as a Nation, as well as the larger vision. As the country celebrates 75 years of its independence, the progress made in the mental health field has to be appreciated, alongside the work done in human rights and mental health. However, the significant gaps also need to be accepted, and direction for future action identified to ensure that India's Global leadership position in the next few years is also reflected in this critical area of mental health. The full-scale realisation of the mental health needs of everyone necessitates the involvement of all sections of society. Therefore, let mental health not remain on the agenda for only some, but let it be cause for action by all, as envisaged in the Theme by the World Federation for Mental Health (WFMH) and the World Health Organization (WHO) for 2022-23 "Make Mental Health and Well Being for all a Global Priority".

A Synoptic View of Judicially Updated Mental Health Legislations in India

Introduction

India is a welfare state. Our Constitution promotes equality of opportunity and participation, and social inclusion. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) was ratified by the Indian Government in 2007. The Convention required that its suggestions be adopted by the laws governing individual nation/states. The current laws desperately needed to be updated to reflect the UNCRPD and the changing circumstances. As a result, the legislature unified the laws across the country. The preamble of Mental Healthcare Act, 2017 intends to offer mental healthcare and services for people with mental illness and promote and uphold their rights while providing those services. The law is forward-thinking, patient-centered and right-based.

Historical Overview

The Mental Healthcare Bill 2013 was the subject of a report submitted by the Standing Committee on Health and Family Welfare, headed by Mr. Brajesh Patha. On the 19th of August, 2013, the Mental Healthcare Bill 2013 was introduced in the Rajya Sabha. The Bill sought to repeal the Mental Health Act of 1987. The bill was introduced by incorporating the principles of UN Convention on the Rights of Persons with disabilities 2007. The existing Act did not sufficiently protect the rights of people with mental illness or encouraged them access to mental healthcare, thus the introduction of a new bill. (Mental Healthcare Bill, 2013; PRS Legislative Research)

Compared to the Act of 1987, the Bill showed a greater understanding of mental illness. This Bill departed from the Act of 1987 by attempting to empower people with mental illness. *“The Act of 1987, however, did not recognize the agency and capacity of a person with a mental illness. The Bill takes a fundamentally different approach, giving people the Authority to decide how their mental health will be cared for or treated”*. This is consistent with the Convention’s goal of preserving the inherent dignity of people with disabilities. Decision-making ability is acknowledged. If people can comprehend their circumstances, the

probable effects of their choice, and how to communicate it, they can make their own decision. (Parliament of India, Lok Sabha, House of the People).

Previously, people with a mental illness were not given the option of selecting the type of treatment state would wish to receive. People were handled this way even though they were mentally ill and would be institutionalized. However, as of right now, this clause in the Bill offers these persons who are afflicted with mental illnesses the freedom to select the type of care and treatment they desire.

The Bill also uses a right-based approach, which is a first for India's mental health laws. This is a notable improvement over the Act of 1987. *"Only general protection against cruel treatment was offered by the Act of 1987. However, Chapter V of the Bill serves as a Charter of Rights for people with mental illness, enshrining and defending their fundamental human rights. According to the Bill, every person has the legal right to get mental healthcare and treatment from mental health services. This right is intended to guarantee that mental health treatments are offered without prejudice and at a reasonable cost while also being of high quality and quantity"*

Another crucial clause in this Bill stated that *Electro-convulsive therapy (ECT) will only be administered in conjunction with anesthesia and a muscle relaxant.*" Some medical facilities in our nation that treat mentally ill patients administer ECT to their patients without first offering them anesthesia. Therefore, the patient must receive ECT while under anesthetic and take a muscle relaxant to prevent harm from his body's muscles contracting during the procedure, which is an excellent step in the right direction.

"A perfect clause in this Bill stated that minors will only receive ECT after receiving permission from their guardians, and the Review Board has determined that the minor patient should receive the treatment." Therefore, the choice to have ECT treatment was again a commendable provision. When receiving ECT treatment, a patient who typically needs a course of medication for two to three months will recover in just one to two weeks. Therefore, the patient's recovery takes less time. It also offers a lot of other significant advantages.

"It allows for the establishment of National and State mental health agencies. This is significant since mental health facilities will be registered and supervised once the institution is registered with this Authority. The registration of mental health establishments is made necessary by establishing strict penalties for violations to develop the quality and service standards of these establishments", ensuring the registration of psychologists, mental health nurses, and psychiatric social workers, educating law enforcement personnel and mental health professionals about how to implement the Act and provide advice to the government on matters relating to mental health. In addition, the



establishment must adhere to the rules set forth by the competent authority to receive registration.

The establishment of the Mental Health Review Board is another crucial provision in this Bill. It allows the Authority to make decisions regarding the many rights and protections the Bill guarantees. Additionally, any order issued by the Authority or the Board may be appealed to the High Court. The Civil Court lacks jurisdiction to hear any litigation about any matter that the Authority or the Board has the authority to consider.

The Bill also specifies the accountability of a few other agencies. For example, patients with mental illnesses are frequently spotted wandering the streets in our country. Unfortunately, there is no one to look after these people. This has been addressed by provisions included in the Bill, which provides that any police officer in charge of a police station must take any person under his protection if found wandering at large. Based on the medical officer's examination results, such a person will either be admitted to a mental health facility or be placed under arrest and taken to his residence or an establishment for homeless persons (Parliament of India, Lok Sabha, House of the People).

A standing committee was tasked with reviewing the new Mental Healthcare Bill when it was first tabled in the Rajya Sabha on the 13th of August, 2013, and it finished its work on the 20th of November, 2013. The Mental Healthcare Act, 2017 resulted from Bill passed in the Lok Sabha and the Rajya Sabha that year.

The Mental Healthcare Act, 2017 (MHA, 2017)

Section 2 (s) of the Act defines Mental Illness as -

“A substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, especially characterized by sub normality of intelligence.”

Chapter II of the Act deals with mental illness and the capacity to make mental healthcare and treatment decisions. Section 3 determines what is to be called mental illness, which must be as per national and international accepted medical standards. While Section 4 talks about the capacity to make mental healthcare and treatment decisions. The Act also mentions the right of every person, not a minor, to make an advance directive in writing w.r.t the treatment whether that person wants to be treated (Section 5, MHA Act 2017). Every Board has to maintain an online register of all advance directives registered with it

(Section 7, MHA Act, 2017).

Chapter IV deals with the nominated representative. Section 15 talks about the nominated representative of the minor. In the case of minors, the legal guardian shall be their nominated representative unless on an application made to the concerned Board, it may appoint, any suitable individual who is willing to Act as such, the nominated representative of the minor with mental illness.

Chapter V deals with the rights of persons with mental illness, including the right to access mental healthcare (Section 18), Right to community living (Section 19), Right to protection from cruel, inhuman and degrading treatment (Section 20), Right to equality and non-discrimination (Section 21), right to information (Section 22), right to confidentiality (Section 23), restriction on the release of data concerning mental illness (Section 24), right to access medical records (Section 25), Right to personal contacts and communication (Section 26) , right to legal aid (Section 27) and the right to make complaints about deficiencies in the provision of services (Section 28).

The High Court of Delhi in *Mehroz Bano v. Director, IHBAS and Anr* (2021) focused on Sections 5 and 23 of the Act, which stated that information about the patient's illness and the nature of the treatment being undertaken by the patient, shall not be shared with any third party and upheld the patient's right to confidentiality.

The issue before the Kerala High Court in *X v. Dr. S and Anr* (2020) was whether a party to litigation can seek production of the medical records of a stranger to the litigation, particularly those relating to a person with alleged mental illness. It was held after referring to Section 23 of the Act, that a person suffering from a mental illness has the right to confidentiality regarding the treatment he receives. If treatment details were disclosed, they must fall within the seven exceptions listed in clauses (a) to (g) of Section 23, and not otherwise. If it is determined that the documents relating to treatment of a mentally ill person have a material bearing on the case, the court must then consider whether non-production will prejudice the person seeking production. Only if both of the aforementioned questions are answered affirmatively will the court be justified in ordering the production of a mentally ill person's treatment records.

The appropriate Government shall have a duty to plan, design and implement programmes for the promotion of mental health and prevention of mental illness in the country under **Chapter VI** as per Section 29. The appropriate government shall also undertake various programs to reduce the stigma associated with mental illness as given in *Section 30*. Section 31 states that the appropriate government is to take measures concerning human resource development and training etc.



Chapter VII mentions the establishment of a Central Mental Health Authority. This chapter further elaborates on the composition, term of office, resignation, filling of vacancies, and the Central Authority's functions. However, the most crucial section of this chapter is Section 44, which says that the Central Authority shall meet at such times (not less than twice a year).

Chapter VIII talks about the establishment of State Mental Health Authority and mentions its functions. In Section 56, the Act says the meetings of state authority, needs to take place no less than four times a year. **Chapter IX** deals with finance, accounts, and audit, wherein it is provided that the central Authority shall prepare the annual report and forward it to the central government to be laid before both houses of parliament as per Section 60. Likewise, in respect of State Authority similar provision has been under Section 64.

Chapter X states that “no person or organization shall establish or run a mental health establishment unless it has been registered with the Authority under the provisions of this Act.” This chapter also mentions the procedure for registration, inspection, and inquiry of mental health establishments as given under Section 66. Section 67 mentions that the “authority shall conduct an audit of all registered mental health establishments every three years, to ensure that such mental health establishments comply with the requirements of minimum standards for registration as a mental health establishment.”

Chapter XI mentions the Constitution of Mental Health Review Boards. It is stated that any person with mental illness or his nominated representative or a representative of a registered non-governmental organization, with the consent of such a person, being aggrieved by the decision of any of the mental health establishments or whose rights under this Act have been violated, may make an application to the Board seeking redressal or appropriate relief. No fee shall be charged for making such an application. In exceptional circumstances, under Section 77(4), the Board may accept an application made orally or over the telephone from a person admitted to a mental health establishment. All proceedings before the Board shall be deemed to be judicial proceedings within the meaning of sections 193, 219, and 228 of the Indian Penal Code as provided under Section 78.

In **chapter XII**, all the admissions in the mental health establishment shall, as far as possible, be independent, except when such admissions exist, making supported admission unavoidable. Here, “independent admission” means a person who can make mental healthcare and treatment decisions or requires minimal support in making decisions as per Section 85. Also, under Section 86(5) an independent patient shall not be given treatment without his informed consent. “Subject to the provisions contained in section 88, an independent patient may get himself discharged from the mental health establishment without the

consent of the medical officer or mental health professional in charge of such establishment” as per Section 86(7). Under section 87, a detailed procedure is to be followed for the admission of a minor. It is mentioned under Section 87(3) that when an application is made to the medical officer or mental health professional in charge of the mental health establishment may admit such a minor only if there is an examination done by “at least two psychiatrists, or one psychiatrist and one mental health professional or one psychiatrist or one medical practitioner.” A minor shall be accommodated separately from adult as per Section 87(4). The nominated representative or an attendant appointed by the nominated representative shall under all circumstances stay with the minor in the mental health establishment for the entire duration of the admission of the minor to the mental health establishment as given under Section 87(5). The concerned Board must visit and interview the minor or review the medical records. As per Section 87(12), the concerned Board shall carry out a mandatory review within a period of seven days of being informed, of all admissions of minors continuing beyond thirty days and every subsequent thirty days.

Section 89 talks about “*the admission and treatment of persons with mental illness, with high support needs, in mental health establishment up to thirty days. Under Section 89(4) after the expiry of 30 days, a person is allowed to remain admitted in accordance with the provisions of Section 90. If the conditions of section 90 are not met, then such a person will be treated as an independent patient and have the right to leave the mental health establishment. A person admitted under this section is discharged and shall not be readmitted under this section within seven days from the date of discharge. But the same can be allowed if the provisions of section 90 are met*”.

Section 90 talks about the “admission and treatment of persons with mental illness, with high support needs, in mental health establishment, beyond thirty days. The medical officer or mental health professional in charge of the mental health establishment shall report all admissions or readmission under this section, within seven days of such admission or readmission, to the concerned Board” under Section 90(3). “The Board shall, within twenty-one days from the date of last admission or readmission of a person with mental illness under this section, permit such admission or readmission or order discharge of such person” as per Section 90(4). “While permitting admission or readmission or ordering discharge of such person under sub-section (4), the Board shall examine-- (a) the need for institutional care to such person; (b) whether such care cannot be provided in less restrictive settings based in the community” as given in Section 90(5). The person referred in sub-section 4 shall not be permitted to stay in the mental health establishment due to the lack of community-based services at the place where such persons ordinarily reside under Section 90(7).



In **Chapter XIII**, the Act mentions the responsibilities of other agencies, wherein it talks about the duties of police officers in respect of persons with mental illness as per Section 100. According to Section 100(2), a police officer shall inform the person who is being taken under protection of his grounds for taking him under such protection. Such person must be taken up to the nearest public health establishment and shall not be detained in prison or police lock-up as directed in Section 100(3) and (4).

“In the case of a person with mental illness who is a homeless or found wandering in the community, a First Information Report (FIR) of a missing person shall be lodged at the concerned police station, and the station house officer shall have a duty to trace the family of such person and inform the family about the whereabouts of the person” as per Section 100 (7).

Under Section 101, every officer in charge of a police station, who has a reason to believe that any person has a mental illness and is being ill-treated, is bound to report it to the Magistrate within its local jurisdiction. Also, any person who has a reason to believe that such person has a mental illness and is being ill-treated can report the same to the nearest officer-in-charge of a police station under Section 101(2). Section 102 talks about the admission of a person with mental illness to a mental health establishment by a Magistrate. Section 103(3) mentions the duty of the medical officer of a prison or jail to send a quarterly report to the concerned Board of State that there are no prisoners with mental illness.

Also, under Section 103(4) the concerned Board may visit the prison or jail to examine why prisoners with mental illness are kept in prison and not transferred to a mental health establishment. According to Section 103(6), “The appropriate Government shall setup mental health establishment in the medical wing of at least one prison in each State and Union territory and prisoners with mental illness may ordinarily be referred to and cared for in the said mental health establishment”. The mental health facility under subsection (5) must register with the Central or State Mental Health Authority per this Act and adhere to applicable standards and procedures prescribed therein as provided in Section 103(7).

The Act under Section 104 also mentions the duty of the person in charge of a state-run custodial institution, which may include beggar homes, orphanages, women’s protection homes, and children’s homes, to take such a resident to a mental health establishment if he has a mental illness. In case some evidence of mental illness is presented during any legal proceeding before any competent court, and the other party challenges it, the Court shall refer the matter to the relevant Board for further review. The Board shall, after examining such a person

either by itself or through a committee of experts, shall submit its opinion to the Court as given under Section 105.

Chapter XIV mentions the restrictions to discharge functions by professionals not covered by the profession. **Chapter XV** provides about the offenses and penalties.

Chapter XVI deals with miscellaneous provisions. According to Section 115(1) anyone who attempts to commit suicide is deemed to be suffering from severe stress unless proven otherwise and is not subject to a trial or punishment under Section 309 of the Indian Penal Code.

(2) The appropriate government has a responsibility to offer care, therapy, and rehabilitation to a person who attempted to commit suicide due to extreme stress in order to lower the likelihood of another attempt.

Section 115 has decriminalized the offence of attempt to commit suicide.

This demonstrates that the provision of the Act has made it possible to provide the sensitive care that must be given to suicide victims who are mentally distressed and unaware of their wellbeing. The Act has made it possible to provide special attention to cases in which the victim attempted suicide due to stress or a mental illness, and it has established provisions through which they can meet the needs of mentally ill or unfit personnel. In a catena of judgments the High Courts have quashed FIRs and set aside criminal proceedings which were pending under Section 309 of IPC. In *Pratibha Sharma v. State of Himachal Pradesh and Anr (2019)*, the High court of Himachal Pradesh while quashing the FIR stated the reason that no doubt, FIR in the case at hand came to be lodged prior to the enactment of the Act, but it is not in dispute that trial, if any, in aforesaid FIR is yet to commence. Even otherwise, trial on the basis of FIR lodged prior to the enactment of the Act, 2017, if allowed/permitted to continue, petitioner herein would be entitled to take benefit of section 115, which definitely raises presumption in her favour.

The Orissa High Court held in *Jhansi Rani Bhuyan v. State of Orissa (2019)*, that if the FIR in question is read as a whole, it is found that the petitioner, who had lodged an FIR much prior to the date of the incident alleging rape and attempted murder and had threatened to sit on fast in front of the office of the Superintendent of Police, could not be said that she was not under severe stress. As a result, the FIR and subsequent proceedings under Section 309 of the Indian Penal Code were quashed.

Also, under Section 126, *The Mental Health Act, 1987 is repealed*. The Punjab and Haryana High court in the case of *Court on its own motion v. State of Punjab and Ors*, the court disposed of the case with the observation that the state would



take all necessary steps to ensure the implementation of the Act, as well as take necessary steps as and when required for mitigating the grievances of mentally disabled people who have no support from their families.

The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018

In exercise of the powers conferred by sub-section (1) and (3) of Section 121 of the Mental Healthcare Act, 2017 (10 of 2017), the Central Government, has framed “The Mental Healthcare (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018.” Chapter 6 talks about the audit, inspection, and inquiry of mental health establishments, wherein, under Section 22, the Central Authority may either *suo motu* or, on a complaint received from any person concerning non-adherence to minimum standards, can order an inspection and hold inquiry for the same.

The Mental Healthcare (State Mental Health Authority) Rules, 2018

Chapter 3 mentions the provisional registration of mental health establishments by State Authority. Section 11 discusses “the procedure for provisional registration of mental health establishments by State Authority.”

The Mental Healthcare (Central Mental Health Authority) Regulations, 2020

The Mental Healthcare (Central Mental Health Authority) Regulations 2020, which the Central Mental Health Authority released on the 18th of December, 2020, set forth the minimum requirements for the registration of mental health facilities and are included in Chapter IV of the regulations. This applies to all mental health facilities under the Central Government’s supervision. The recruitment policies that apply to the specific mental health establishment shall control the minimum qualifications for ministerial and subordinate staff and any other employee who works in a mental health facility for whom the minimum requirements are not specified in the Act. The mental health facilities under the Central Government are required to maintain medical records following Form-B guidelines as given under Chapter IV, SS. 10-12.

Facilities must meet the minimal requirements listed in the Schedule. In addition, the property must meet the following criteria: (a) it must be a pucca structure; (b) it must have working windows and doors with strong, intact vertical grills and wire meshes to prevent suicide or self-harm attempts; (c) it must have a lift with a generator or power backup for areas with more than four floors; (d) it must have enough ventilation and natural light; (e) it must have enough illumination after sunset to read without tiring the eyes, etc. The living conditions

must be comfortable, including individual cots, mattresses, pillows, and blankets (as appropriate for the season) for each patient, which must be placed with enough space between each bed. Additionally, residents must not be forced to sleep on the floor, maintain good hygiene, and have access to sufficient fans.

To maintain hygiene, cleanliness, and sanitation, the following procedures must be followed: (a) daily sweeping, wiping, and dusting of the entire premises; (b) sanitation maintained in all areas, including restrooms and toilets, using disinfectants; (c) the installation of inverters or other forms of power backup for emergency lighting during power outages; (d) routine maintenance of the mental health facility; and (e) the use of heaters and coolers that are subject to the safety and health of residents. Potable water and wholesome, scrumptious meals must be offered in welcoming environments. The following facilities must be available for social, cultural, recreational, and leisure activities: (a) entertainment programs, social events, and outings for inpatients; and (b) a furnished visitors' room for visiting families.

An adequate number of health professionals must be employed to offer appropriate care. Medical and paramedical personnel must be hired in compliance with the required specifications. The facility must provide enough floor space, including (a) separate wards for mentally ill male and female inpatients, (b) enough space between beds, and (c) enough dimensions to permit comfortable movement and a secure evacuation in an emergency. The common area must feature television, newspapers, magazines, and indoor activities when feasible. Physical restraints must only be used to stop patients from injuring themselves or others; other means must be employed to de-escalate crises. Nursing personnel must be trained in de-escalation techniques to prevent patients from killing themselves. Patients' confidentiality, privacy, and dignity must all be protected, as well as their safety and security, especially in the case of female patients. Residents must be given enough fresh underwear and disposable sanitary items. In public mental health facilities, hygienic napkins must be provided. Essential hygiene products, including slippers, towels, and combs, bathing and washing soap every two weeks, and at least two shampoo sachets per week are required. Basic cosmetics like powder, cream, bindis, and kumkum must also be given appropriately for each tenant. It also states that all mental health facilities must adhere to 2016 Right of Persons with Disabilities Act's requirements (49 of 2016).

A mental health facility must submit a Form-C application to the Central Authority for permanent registration with a fee of Rs. 25,000, information demonstrating compliance with the Schedule's minimum standards, and supporting documentation. The Central Government's mental health facilities must maintain medical records per Form-B instructions and the Authority has the



right to request any medical record upon receiving a complaint. The attending psychiatrist may request the Board's approval for the psychosurgery operation by submitting the following documents with the application: a detailed submission by the attending psychiatrist with a clinical summary of the case- explaining and justifying the need, suitability, and safety of the proposed psychosurgery certified copies of such person's medical records and written informed consent for psychosurgery that has been duly signed by the person on whom it is suggested to be performed.

Judicial Intervention

The Supreme Court in an appeal to create suitable mental healthcare facilities in prisons across the nation issued notice. The petition asked the Union and State Governments to direct prison personnel and law enforcement officials to receive training and information concerning the 2017 Mental Healthcare Act. Insufficient mental healthcare services for mentally ill convicts in jails across India prompted this petition. It stresses on the fact that inmates have fundamental human rights, especially the Right to life. Furthermore, it highlighted the need for better mental health facilities in jails by citing several historical decisions and international human rights treaties (*Kush Kalra v. Union of India and Ors*, 2022).

According to a Kerala High Court order, the State must create a mental health facility in at least one jail to benefit inmates with mental illnesses. The decision was made due to a report that the Secretary of the Kerala State Legal Services Authority provided and the pertinent clauses in the CrPC and the Mental Healthcare Act. It is vital to find and persuade the relatives of mentally ill inmates who have been found not guilty and of inmates who are awaiting trial to give them the care and security they require. The State Government must take action for their rehabilitation by moving them to licensed mental health facilities. The Court noted that most of Chapter XXV of the Code still referred to mentally ill defendants as "lunatics." Therefore, with the "aim to bring about revolutionary improvements in the lives and living conditions of persons with mental illness," the Mental Healthcare Act of 2017 was enforced. "Directing the State to construct mental health institutions in at least one jail in the State" (*Suo Motu v. State of Kerala*, 2019).

Accused X v. State of Maharashtra (2019)

Facts

The Supreme Court was deciding a review petition in a case where the Petitioner was convicted and sentenced to death for the rape and murder of two minor girls. One of the questions for consideration before the Supreme Court

was whether post-conviction mental illness of the accused would qualify as a mitigating factor for commuting the death sentence to life imprisonment.

Findings

The Supreme Court observed that multiple circumstances such as overcrowding, various forms of violence, enforced solitude, lack of privacy, inadequate healthcare facilities, concerns about family etc. can take a toll on the mental health of the prisoners. The courts also observed that due to legal constraints on the recognition of broad spectrum of mental illness within the Criminal Justice System, prisons inevitably become home for greater number of mentally ill prisoners of various degrees. Due to the prevailing lack of awareness about such issues, the prisoners have no recourse and their mental health keeps on degrading day by day. The aspiration behind the Mental Healthcare Act, 2017 was to provide mental healthcare facility for those who are in need including prisoners. Section 20(1) of the Mental Healthcare Act, 2017 explicitly provides that 'every person with mental illness shall have a right to live with dignity'. The State Governments are obliged under Section 103 of the Act to set up a mental health establishment in the medical wing of at least one prison in each State and Union Territory.

The Supreme Court in this case recognized post conviction mental illness as a mitigating factor to convert death penalty to life imprisonment. The Supreme Court noting that there appear to be no set disorders/disabilities for evaluating the 'severe mental illness' laid down 'test of severity' as a guiding factor for recognizing those mental illnesses which qualify for an exemption. The Court noted that these disorders generally include schizophrenia, other serious psychotic disorders, and dissociative disorders with schizophrenia. Therefore, the test envisaged herein predicates that the offender needs to have a severe mental illness or disability, which simply means that a medical professional would objectively consider the illness to be most serious so that he cannot understand or comprehend the nature and purpose behind the imposition of such punishment. The notion of death penalty and the sufferance it brings along causes incapacitation and is idealized to invoke a sense of deterrence. If the accused is not able to understand the impact and purpose of his execution because of his disability, the *raison d'être* for the execution itself collapses.

Shatrughan Chauhan v. UOI (2014)

Facts

The Supreme Court considered a batch of writ petitions that were filed either by or on behalf of 15 death convicts challenging the rejection of their mercy petitions by the Governor and the President. In two of these petitions,



commutation of death sentence to life imprisonment was prayed for on the ground of mental illness. The court framed guidelines for safeguarding the interest of death row prisoners.

Findings

The Supreme Court noted that some death-row prisoners lose their mental balance on account of prolonged anxiety and suffering experienced on death row. There should, therefore, be regular mental health evaluation of all death row convicts and appropriate medical care should be given to those in need. The Prison Superintendent should satisfy himself on the basis of medical reports by Government doctors and psychiatrists that the prisoner is in a fit physical and mental condition to be executed. If the Superintendent is of the opinion that the prisoner is not fit, he should forthwith stop the execution, and produce the prisoner before a Medical Board for a comprehensive evaluation and shall forward the report of the same to the State government for further action.

The Chief Secretary of the Government of Bihar has been ordered by the Patna High Court to take all necessary measures to ensure the creation of the State Mental Health Authority. On 10th of February “the Patna High Court examined the goals and functions of the State Mental Health Body and the 2017 Mental Healthcare Act, and further expressed amazement at the affidavit presented by the State claiming that the said Authority had not yet been established. The Court further emphasized that the legislation’s main goal was to help those in need whose mental health was assessed under Chapter II by providing them with mental healthcare and assistance. The Court also pointed out that the state government’s affidavit did not include information on how long the procedure would take to finish. Therefore, under Sections 45 and 55 of the Mental Healthcare Act of 2017, the plea has pleaded for a directive to the Respondents to create a genuine and effective State Mental Health Authority (Akanksha Maviya v. The Union of India & Ors, 2022).

The Supreme Court also issued directions while hearing a plea about the rehabilitation of thousands of mentally ill patients. The Court noted that states were in the process of addressing discrepancies indicated in data collected by the hospitals and the Task Force. It was submitted that the practice adopted by Maharashtra was against Section 104 of the Mental Healthcare Act. At this juncture, the Court informed the State, that there was no question of transferring the patients to beggar homes (Gaurav Kumar Bansal v. Mr. Dinesh Kumar and ORS , 2018).

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The COVID-19 Pandemic was also a pandemic for mental health issues with people experiencing worry and anxiety. Following COVID-19, more persons are expected to require mental healthcare interventions. The Committee acknowledged the government's efforts in creating websites and offering teleconsultations to address this issue. However, the Committee noted that in the current environment, people need special care because of issues like domestic violence, alcohol abuse, and social isolation, such as unemployment and social exclusion. There is a need to educate and sensitize the public to dispel the myth that mental health issues are a sign of either weakness or humiliation. Recognizing the potential effects COVID-19 may have on people's mental health, the government has launched several programs to offer psychological support throughout COVID-19. These programs comprise:

- Establishing a 24-hour helpline with distinct target populations—children, adults, the elderly, women, and healthcare workers—to provide psychosocial assistance to the entire impacted population.
- They are promoting an atmosphere of support and caring for everyone through advocacy through various media channels in the form of artistic and audio-visual resources on managing stress and anxiety.
- Online training and capacity building for health professionals by National Institute of Mental Health and Neurosciences (NIMHANS) using the (iGOT)-Diksha platform.
- Publication of comprehensive guidelines titled “Mental Health in the Times of COVID-19 Pandemic - Guidance for General Medical and Specialized Mental Healthcare Settings” by the NIMHANS, Bengaluru.
- The publication of recommendations and guidelines on handling mental health problems according to the needs of various societal groups. On the Ministry of Health and Family Welfare website, under “Behavioral Health - Psychosocial Helpline,” all the recommendations, advisories, and advocacy materials are available.

The Rights of Persons with Disabilities Act, 2016

The RPwD Act, 2016 was passed on the 28th December, 2016, and became effective on the 19th April, 2017. The critical elements of the Act are that the appropriate governments are now accountable for taking decisive action to guarantee that people with disabilities are granted the same rights as everyone else.

- People with benchmark disabilities and those with high support requirements will now have access to additional benefits.



- Between the ages of six and eighteen, every child with a baseline disability is entitled to free schooling.
- A 5% seat reserve in public and publicly subsidized higher education institutions for those with qualifying impairments.
- Emphasis has been placed on ensuring accessibility in government and private facilities in a set amount of time.
- There is a 4% reservation in government occupations for the particular group of people who meet a specified standard of handicap.
- The Act stipulates that guardianship may be granted by a District Court or any other Authority chosen by the state government, and that the guardian and the people under their care will jointly make decisions.
- The establishment of large-scale Central and State Advisory Boards on Disability as decision-making bodies.
- The Act calls for the Office of the Chief Commissioner of Persons with Disabilities and State Commissioners of Disabilities to be strengthened. These organizations will serve as regulatory bodies and grievance redressal organizations. They will also monitor the Act's implementation. In addition, an advisory committee composed of specialists in various disabilities will support these Offices.
- The establishment of National and State funds to aid those with impairments financially.
- The Act establishes sanctions for offenses against people with disabilities.
- Special courts are designated to address instances involving violating PwDs' rights.

The National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act, 1999

The “National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act” established the National Trust as a statutory entity under the Ministry of Social Justice and Empowerment of the Government of India (Act 44 of 1999). The National Trust's vision statement is founded on a human rights, or UNCRPD, approach and depicts a significantly altered India for all Indians. The vision statement highlights NT as a pioneer in India's disability industry.

As legislations about people with disabilities change, focused leadership is the need of the hour. The National Trust works to fulfill the rights of people with disabilities and their families, provide opportunities for their capacity development, and facilitate and promote the development of enabling environments and



inclusive society. The National Trust's objective, or primary goal, is to establish an inclusive community by offering possibilities for people with disabilities through comprehensive support systems, which can be accomplished in part through cooperation with other Ministries, etc. The National Trust's specific goals include enabling and empowering people with disabilities to live as independently and fully as they can in and close to their community; facilitating the realization of equal opportunities, the protection of rights, and the full participation of people with disabilities; extending support to its registered organizations to provide need-based services; and developing procedures for guardianship appointments.

The Rehabilitation Council of India Act, 1992

This law was created to control how rehabilitation specialists are trained and to keep a Central Rehabilitation Register to accredit specialists. As a result, the Rehabilitation Council of India has now been elevated to the leading organization for advancing the career development of people working in the field of disability rehabilitation. The term "rehabilitation professionals" is defined in this Act to include: Audiologists, speech therapists, clinical psychologists, hearing aid and ear mold technicians, special educators, employment counselors, and placement officers who work with people with disabilities, multipurpose rehabilitation therapists, and technicians, as well as any other categories of professionals that the Central government deems appropriate after consulting with the Council.

The Indian Lunacy Act, 1912

The Indian Lunacy Act, 1912, has regulations for handling criminal lunatics and their admission to mental hospitals or asylums. In addition, they are establishing asylums and handling the disposal of lunatics' property. This Act has eight chapters; a summary of each is provided below.

- Chapter 1 has sections defining terms related to India, medical professionals, and lunatics, as well as who will judge or care for them after a court order.
- Chapter two (Reception of Lunatics) No insane, criminal lunatic, or foreign lunatic thus determined by inquisition may be held in an asylum, except for a few circumstances expressly stated in ILA sections 8, 16, and 98.
- Chapter 3 contains provisions relating to care for lunatics, treatment, and visitor visits.
- Chapter 4 contains laws on the High Court of Judicature's Authority to dispose of a lunatic's property for specific purposes in Fort William, Madras, and Bombay.



- Chapter 5 contains provisions about Lunacy procedures outside of presidency towns.
- Chapter 6 contains provisions for state governments to establish asylums or to grant licenses to do so. If curative treatment is insufficient, the Authority may revoke the license.
- The costs of maintaining a lunatic are discussed in Chapter 7.
- Chapter 8 discusses the state government's authority to enact laws, the cost of improperly receiving guests, and the custody of lunatics.

Before 1912, there was no comprehensive law protecting mentally ill individuals, also known as lunatics. However, India changed an outdated direction in 1987 by enacting and promulgating a new one.

The Constitution of India

The Indian Constitution's Parts III and IV contain provisions about health and safety. The fundamental right to health is not explicitly recognized in the Indian Constitution. However, the right to life and personal liberty is guaranteed under Article 21 of the Indian Constitution. The scope of Article 21 was expanded following the Maneka Gandhi Case, and it was clarified that the term "life" in the Article refers to a life with human dignity rather than mere survival or animal existence. The right to health is fundamental to living a life of dignity. Article 21 should be read in conjunction with such other Articles as 38, 39, 41 & 42 of the Constitution to fully grasp the State's responsibility to promote the practical realization of this right.

Article 38: According to this clause, the State must "ensure a social order for the advancement of the welfare of the people." It is reasonable to conclude from the texts other provisions that a person's total welfare includes mental health. Therefore, this article imposes a responsibility on the State to implement policies that will aid in people's mental health improvement.

Article 39(e): This provision instructs the State to develop policies based on specific principles to ensure that the mental health and wellbeing of workers, women, and children are not jeopardized due to financial constraints that might otherwise unintentionally have an impact on their wellbeing.

Article 41: According to this Article, the State is obligated to uphold the rights to work, an education, and public assistance, among other things, in the event of a disability. The State must implement policies to help people with mental health issues maintain economic and social stability while battling their illnesses.



Article 42: This article addresses the creation of regulations to guarantee fair and humane working conditions and maternity leave for expectant mothers. Such rules would ensure pregnant women's safety and that they won't experience unneeded stress or mental anguish throughout their pregnancies and aftercare. These Articles have all established the importance of mental health as an individual's right. Hence, despite the lack of an expressed provision, the Constitution has not precluded the need for protection of the mental wellbeing of the people.



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NHRC Initiatives

The National Human Rights Commission (NHRC) India was constituted on 12th October 1993 under the Protection of Human Rights Act of 1993. It is a statutory body which is responsible for the protection and promotion of human rights in the country. Since its existence, the NHRC has persistently taken the view that the right to life with dignity must result in the strengthening of measures to ensure that all people, and especially those from the economically underprivileged segments of the population, have access to better, affordable, accessible and more comprehensive healthcare facilities. As mentioned in the previous chapter. The Mental Healthcare Act of 2017 was introduced as a legislation, with an aim to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services. Individuals with mental health issues are among the vulnerable categories that have long been abused and discriminated against. Further, neglecting mental health could also impact economic development through the loss of production and consumption opportunities at both the individual and societal levels.

Internationally, the Right to Health was originally represented in the 1946 Constitution of the World Health Organization (WHO), whose preamble defines health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”. The preamble further states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” Later, the United Nations General Assembly adopted Article 25 of Universal Declaration of Human Rights (UDHR), 1948, which states that “Everyone has the right to a standard of living adequate for the health and wellbeing of themselves and of their family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in the circumstances beyond his control.” This means that human rights are mutually dependent, indivisible and interconnected, and any violation on the right to health shall also impede the fulfilment of other human rights, such as the

right to food, and vice versa. The International Covenant on Economic, Social, and Cultural Rights, frequently cited as the primary legal tool for defending the right to health, recognizes *“the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”* The Covenant is noteworthy in the way it accords equal worth to both physical and mental health.

According to the World Health Organization (WHO), “Mental health is a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community.” In the case of children and adolescents, mental health refers to “the capacity to achieve and maintain optimal psychological functioning and wellbeing”. Everyone, regardless of age, sex, income, or race, has a chance of developing mental health problems or illnesses. A person’s mental health can be influenced by social and financial conditions, biological influences, and lifestyle choices. The WHO underlines that having a healthy mental state extends beyond simply being free of mental illnesses or impairments. Psychological health is not only about managing active symptoms but also about consistent caring for wellbeing.

In the realm of mental health, widespread human rights abuses continue. NHRC strongly believes that a transition in rights for people with mental health concerns will entail putting aside “substitute decision-making” and delivering support according to the will and preferences of a patient. A rights-based approach can provide a pathway to the future of mental healthcare, achieve social justice, attain the highest standard of health support systems, and strengthen the governance of health and social services.

The WHO on 11th March 2020 declared the novel coronavirus (COVID-19) outbreak as a global pandemic. The effects of the pandemic have gone beyond the state of the public health system and also changed the already complex economic and geopolitical circumstances of nations worldwide. Unquestionably, the COVID-19 pandemic is a public health and humanitarian emergency on a global scale. Evidence suggested that symptoms of anxiety & depression, self reported stress are common psychological reactions during the initial stages of the pandemic (Rajkumar, 2020). During the pandemic, it was witnessed that the front-line health care workers suffer from anxiety, depression and insomnia. (Gupta & Sahoo, 2020). There were also issues with access to justice and healthcare, stigmatization and discrimination of particular racial and religious groups, and the vulnerability of migrant workers and those working in the unorganized sector, among other things. In addition, disseminating false information fueled by stigma and fear complicated the efforts to control and disclose COVID-19 instances. The National Human Rights Commission firmly felt during the pandemic that a human rights focus on interventions would positively impact the crisis response.



A human rights approach in the interventions will make it possible to develop principles that support community building, engagement, protection, security, integrity, justice, and the maintenance of freedom, equality, respect, welfare, and responsibility. It would also make it easier to create and implement a short- and long-term response to the COVID-19 pandemic that is efficient, just, balanced, and sustainable. To promote a human rights-based response to the continuing crisis, the NHRC has launched many initiatives on various themes in consultation with the Special Rapporteurs, Special Monitors, Civil Society, subject matter experts, and others.

Human Rights Advisories

The National Human Rights Commission (NHRC) is mandated by the Protection of Human Rights Act, 1993 to promote and protect the rights. The Commission was deeply concerned about the rights of the vulnerable, marginalized and at-risk sections of society which had been disproportionately impacted by the COVID-19 pandemic and the resultant lockdowns across the nation. Therefore, in July 2020, the NHRC established (twelve) “Committees of Experts on the Impact of COVID-19 Pandemic on Human Rights and Future Response”, which included independent domain experts, representatives of Civil Society Organisations and officials from the concerned ministries/departments of the Government.

As per the ‘Policy Brief on COVID-19 and the need for Action on Mental Health’ issued by the United Nations (UN), COVID-19 has disrupted services worldwide. Many people were distressed due to the immediate health impacts of the virus and the consequences leading to physical isolation, losing family members and death itself. In addition, millions of people were facing economic turmoil, having lost or being at risk of losing their income and livelihoods. The key factors affecting services were: infection and risk of infection in long-stay facilities, including care homes and psychiatric institutions, mentally ill patients being infected with the virus, frequent misinformation and rumours about the virus, and the closing of mental health facilities to convert them into care facilities for people with COVID-19.

After carefully analysing the impact evaluation and suggestions offered by the Committee of Experts, the “Human Rights Advisory on Right to Mental Health in the context of COVID-19” (**Annexure II**) was issued on October 8, 2020. The NHRC also noted with deep concern that the country, in parallel with much of the world, experienced the second major wave of the COVID-19 pandemic during the first half of 2021. Therefore, considering the nation’s situation resulting from the second wave of the COVID-19 pandemic and the ground reports, especially the impact of the pandemic and related situations on

the mental health of people, the Commission once again issued the ‘Human Rights Advisory on Right to Mental Health in view of the second wave of the COVID-19 pandemic (Advisory 2.0)’ (**Annexure III**) on May 31, 2021, to the concerned Union Ministries and Chief Secretaries/Administrators of all the States/Union Territories.

The significance of mental health is not restricted to patients with mental illnesses alone. Since it affects every aspect of our life, mental healthcare is as crucial as physical healthcare. Every action, thought, and statement we make affects our mental health and vice versa. As it is not limited only to the context of mental care institutions, other advisories issued by the Commission have also included recommendations relating to mental health, as mentioned in the table below:

Table 1: Human Rights Advisories issued by the National Human Rights Commission with recommendations relating to mental health

Human Rights Advisory on Children in Context of COVID-19 issued on 29.09.2020	<p>Mental Health Intervention: Create a cadre of para-mental health workers at the district level, trained in giving emotional first aid, and identify severity that can be reported to specialists.</p> <p>Make mental health services available and accessible to all children by exploring the creation of a panel of counselors from NGOs.</p>
Impact of COVID-19 on Human Rights and Future Response: Advisory on the Rights of Prisoners and Police Personnel issued on 05.10.2020	<p>For inmates and correctional staff: Health protocols may recognize that mental illness is real and have arrangements in place to recognize and deal with its various manifestations, which can be mild or extreme, self-harming or violent and overt or obvious. These can include regular sessions on yoga, meditation, group counseling and meetings, the availability of recreational opportunity and professional counseling from trained staff and collaborations with local organisations and institutions.</p> <p>Policing and Mental Health issues:</p> <ol style="list-style-type: none"> 1. To decrease consecutive working days to catch up on sleep and avoid cumulative sleep deprivation that leads to problems of insomnia. 2. Structural issues: shortage of staff, shift length and timings, number of consecutive working days, job role clarity leads to fatigue, increased frustration leading to various forms of aggression (hostile, verbal, physical).



	<p>3. Motivation: material rewards, bonuses, appreciation, micro-level awards/honours, appreciation letters.</p> <p>4. Wellbeing programme- That which could include activities on tasks that promotes psychological and physical wellbeing. Example: mandatory yoga, deep breathing session, nutritional counseling etc.</p> <p>5. Need for in-house team of mental health professionals (psychiatrists and psychologists) in the police department at district levels to work on the following issues with the police personnel during the pandemic;</p> <ol style="list-style-type: none"> a. Managing stress b. Sensitization to tackle the fear of virus. c. Addressing workplace grievances d. Insomnia/other sleep disorders e. Impulsive behaviour f. Substance abuse and dependence g. Depression and anxiety h. Post-Traumatic Stress Disorder (PTSD) i. Unhealthy and Conflicting family relations/social relations j. Issue related to negative portrayal, self-esteem
<p>Human Rights of Informal Workers during COVID - 19 issued on 05.10.2020</p>	<p>Sex Workers: Specific relief measures such as providing the community with free dry ration, financial assistance, transportation facilities for stranded people, masks and sanitisers, access to reproductive-health services, and counseling for mental health issues, be provided for sex workers</p>
<p>Human Rights Advisory on Rights of Women in the Context of COVID - 19 issued on 07.10.2020</p>	<p>Women prisoners with existing health conditions including mental illness and disabilities may be given priority in releasing on bail.</p>
<p>Human Rights Advisory for Protection of the Rights of LGBTQI+ Community in context of the COVID- 19 pandemic issued on 16.10.2020</p>	<p>Ensure uninterrupted availability of antiretroviral treatment (ART), HIV testing, hormone replacement therapy (HRT) and gender-affirming treatments, including mental health treatments/therapies and counseling for the LGBTQI+ community through all districts and local hospitals and medical health centres even during the pandemic.</p>

	<p>A separate 24*7 toll-free helpline number for the LGBTQI+ community: a separate helpline may be set up to provide support in different regional languages for coping with violence, abuse, health and mental health issues.</p>
<p>Human Rights Advisory on Rights of Elderly Persons in Context of COVID -19 issued on 05.11.2020</p>	<p>Counselors handling mental health helplines to help the elderly with gerontological issues should be trained to adequately deal with calls relating to depression, anxiety, etc.</p> <p>Elderly in Prisons: Necessary action should be taken to follow protocol to periodically review general physical and mental health of elderly prisoners, particularly those that have co- morbidities.</p>
<p>Advisory for Protection of the Rights of Children in the context of COVID - 19 issued on 02.06.2021</p>	<p>Mental health professionals/ counselors: As schools have been shut down and children are unable to socialise with their peers, this creates a requirement for psychosocial support for the children during this period. Therefore, train and create a cadre of mental health professionals/ counselors for children & adolescents as recommended in the NHRC Advisory on Mental Health (2.0) issued on 31.05.2021.</p> <p>Establishment of Special Quarantine Centers for Children from Child Care Institutions (CCIs): Recognizing that most CCIs across the country do not have requisite space or facility to ensure adequate arrangement for isolation of children; identify and establish quarantine centers for</p>
	<p>children tested positive for COVID that are equipped with all essential facilities including oximeters, piped oxygen, medicines, and regular visits by trained health workers.</p> <p>Specialised paediatricians and mental health professionals to be consulted as per need and availability.</p>
<p>Advisory on Identification, Treatment, Rehabilitation and Elimination of Discrimination of Persons Affected by Leprosy issued on 14.01.2022</p>	<p>The State Government: should launch a special program to provide counseling to the persons affected from leprosy and their family members, especially children, to help them overcome stigma and mental stress and to integrate them with the society.</p>



<p>Advisory to Protect Human Rights of Truck Drivers issued on 27.06.2022</p>	<p>The Union and State Governments should endeavour to:</p> <p>Create awareness about ill effects of tobacco chewing, smoking, drinking and consumption of drugs and other psychotropic substances, continuous driving for long hours without adequate rest and sleep and irresponsible sexual behaviour by installation of sign boards at toll booths, parking lots and other prominent locations along highways.</p> <p>Counsel truck drivers addicted to tobacco chewing, smoking, drinking, drugs and other psychotropic substances to avail treatment at de-addiction centres.</p> <p>Undertake regular preventive health check-ups and testing of truck drivers and counsel the drivers to avail proper treatment in case preventive health check-ups reveal any physical or mental disease.</p>
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Workshop on Mental Health Awareness

Mental health related issues and disorders like anxiety, depression, and substance abuse often go unnoticed, unlike physical problems, like flu, headache, etc., for the former do not show visible symptoms. But the truth is that psychological and physical health both work in tandem. The NHRC felt that raising awareness about mental health issues would reinforce employees' self-esteem and nurture a workplace setting where workers are free to be who they truly are. The NHRC also believes that stigma, shame, and denial must be left in the past and that it is essential to ensure that individuals who make up the Commission have excellent mental health. Awareness of mental health promotes easier mental illness identification, and an early intervention can also reduce stigma. In fact, by raising appropriate awareness, mental health can be seen as an illness, managed and treated by clinical professionals, just as we treat or manage physical conditions, such as diabetes, blood pressure, or cancer. Awareness can also create new improvements for people with mental illnesses as it has the potential to improve legislation, research, and service (accessibility, availability, and affordability).

The National Human Rights Commission decided to organise special sessions to build workplace awareness about mental health. This is because the Commission has felt that post-COVID-19 pandemic, mental health issues have gained a sharp focus, which can be dealt with better by building awareness and providing timely psychological and psychiatric treatment.

The first in the proposed series of such sessions was inaugurated by Mr. Justice M.M. Kumar, Hon'ble Member, NHRC, in the presence of Dr. Dnyaneshwar M. Mulay & Mr. Rajiv Jain, Hon'ble Members, NHRC, and Mr. D.K. Singh, Secretary General, NHRC, Mr. Santosh Mehra, Director General (I), Mr. Surajit Dey, Registrar (Law), Mrs. Anita Sinha & Mr. H.C Chaudhary, Joint Secretaries, NHRC, in June, 2022. One hundred thirty people participated in the session from the Commission and other offices of the GPO premises, including the Central Vigilance Commission (CVC), Ministry of AYUSH, and the National Consumer Disputes Redressal Commission (NCDRC). The objective of the workshop was to increase awareness of different issues surrounding mental health, sensitise the attendees, and assist them in recognizing and addressing mental health challenges for themselves, their families, friends, or coworkers.

Core Group on Health and Mental Health

Core and Expert Groups consist of eminent persons, subject experts, representatives of Government, technical institutions, NGOs in a given field required by the Commission, be it health, mental health, disability, bonded labour, etc. These Groups render expert advice to the Commission as per their expertise. The present Core Group on Health and Mental Health was initially known as the Expert Group, which was constituted in the year 2001 under the chairpersonship of the then Hon'ble Member of NHRC Justice Ms. Sujata V Manohar, to deal with the concerns surrounding the rehabilitation of long stay mentally ill patients, who were cured and were either destitute or had been abandoned by their families. The Group spelt out an action-plan to undertake the counseling and rehabilitation of cured patients with assistance of civil society organization. The mandate of the Group increased in 2003 and 2004 laying down several measures to facilitate the process of rehabilitation among patients in Mental Healthcare Centres, such as vocational training, appointment of neuro-psychologists and institutionalized care among others. The Group used to meet every two years to review the recommendations sent to the concerned Union Ministries and State Governments for considerations.

In the year 2018, the Expert Group on Mental Health was merged with the Core Group on Health and thus constituting a larger group of experts from the field to advise the Commission on the issues related to both physical and mental health.

Currently, the Core Group on Health and Mental Health is headed by Mr. Justice M.M. Kumar, Member, NHRC. It includes nine members, two representatives from the Union Ministry, and up to five special invitees. The Core Group Meeting on Health and Mental Health was held in December, 2021, with two major agendas namely, Leprosy and leprosy colonies and the impact of



COVID-19 pandemic on mental health. The second session of the meeting was chaired by Mr. Justice M.M. Kumar, Hon'ble Member, NHRC, to discuss the impact of the COVID-19 pandemic on mental health.

Box 1: Important recommendations emanated out of the meeting of the Core Group on Health and Mental Health, on the impact of the COVID-19 pandemic on mental health, held in December 2021, included:

- Deploying telemedicine and teletherapy to bridge gaps in mental health
- Increasing the investment in mental healthcare at taluk, district, and state levels.
- Need for augmenting mental health resources - Psychiatrists, Psychiatric Social Workers, Psychiatric Nurses, Clinical Psychologists, and Psychologists.
- Compulsory annual review of District Mental Health Programme services.
- Creating a State wise directory of services for acute care, telecare, helplines, rehabilitation, and NGOs, which must be updated annually.
- Mandatory training to be provided for community workers about mental health
- Adequate sensitisation of judicial officers/ police, administrators or department of health, social services, and other relevant departments must be done.
- Increasing the participation of professionals as core leaders in the field of mental health.
- Need for collective public health intervention in stigma reduction (e.g., to increase awareness) using local self-government.

Meetings and Conferences

Substance-using populations also experience human rights violations on several occasions. For example, most countries consider it a criminal offence to possess drugs. As a result, harassment during police procedures on arrests and even imprisonment for a drug user can further lead to human rights violations from the criminal justice administration. To deliberate upon issues and concerns related to substance use, a meeting chaired by Dr. Dnyaneshwar M. Mulay, Hon'ble Member, NHRC, was held in August, 2021, for a discussion with the Society for Promotion of Youth & Masses (SPYM) on 'Human Rights of the People Suffering From Drug Addiction'. Dr. Rajesh Kumar, Executive Director, SPYM, joined the meeting with around thirty NGOs from different States/ regions to deliberate on various issues faced by drug users in India.

The Commission organised a National Level Review Meeting on Mental Health in August 2019, at India International Centre, New Delhi, with the objective

of reviewing the status of mental healthcare service delivery in India with particular reference to the implementation of the Mental Healthcare Act, 2017 by the States. The meeting was inaugurated by Mr. Justice H.L. Dattu, Hon'ble Chairperson, NHRC, and attended by the senior officials of Union Ministries, State Human Rights Commissions (SHRCs), Medical Council of India (MCI), Indian Nursing Council, Directors of Mental Health Institutions, experts in the field of mental health and representatives of Civil Society Organisations (CSOs) and Non-Governmental Organisations (NGOs) working in the field of mental health.

In January 2009, a meeting was convened under the chairmanship of Mr. Justice G.P. Mathur, Member, NHRC at the National Institute of Mental Health and Neuro-Sciences (NIMHANS), Bengaluru, to discuss the growing consciousness about the right to mental health at the national and global level. In light of the lack of human resources in mental health, the NHRC firmly believes that whatever human resources are otherwise accessible must be effectively utilised, including upscaling their skills, in addressing mental health issues of the public. Since then, NHRC has renewed its efforts to create a better understanding and awareness in the country. It has also addressed this issue with the Ministry of Health & Family Welfare and the Medical Council of India. In the year before (2008), NHRC had organised a meeting of the Health Secretaries and State Mental Health Authorities at NIMHANS in Bengaluru.

The Supreme Court's direction of 1997

The Hon'ble Supreme Court by an Order dated November 11, 1997, in Writ Petition (C) Nos. 339 of 1986, in the matter of Rakesh Chandra Narayan and Others vs. State of Bihar & Ors. inter-alia directed the National Human Rights Commission as below:

"We have today made an order in Upendra Baxi (Dr.) v. State of U.P. requesting the National Human Rights Commission to be involved in the supervision of the functioning of the Agra Protective Home in the manner indicated in the order. We are of the opinion that the same kind of order needs to be made in this matter also relating to Agra, Ranchi and Gwalior asylums. Accordingly, we request the National Human Rights Commission to perform this exercise in the same manner. The general directions given in our order made in Dr. Upendra Baxi would also be equally applicable in the present case. A copy of this order together with a copy of the order in Dr. Upendra Baxi, and other relevant orders and papers of this matter indicated by Mr Muralidhar, be sent by the Registry to the National Human Rights Commission".

Since then the Commission has been conducting field visits all over the country to inquire about the current status and challenges of the mental health establishments, primarily in government hospitals, psychiatric hospitals or institutions, or psychiatric units/wards of general/ multi-speciality hospitals.

For the proper functioning of the mental hospitals, it is necessary that all the physical and clinical requirements for work be met at appropriate time. The visit reports of the Commission shows that almost half of the patients continue to vegetate in a dehumanised manner within the hospital, as relatives often do not want to take patients home. Many long-stay patients are being abandoned by their families in mental hospitals.

In compliance with the Supreme Court's direction, the Commission periodically receives reports from the three psychiatric institutions, viz *Gwalior Mansik Arogyashala (GMA)*; *Institute of Mental Health and Hospital (IMHH), Agra*; and *Ranchi Institute of Neuro-Psychiatry & Allied Science (RINPAS)*, regarding inmate fatalities brought on by natural causes or by unnatural reasons, such as homicide or suicide and also the overall functioning of the institutes. The Commission has also developed a set of guidelines to standardise the three hospitals' processes for reporting fatalities to the NHRC.

Some recent visits to Mental Health Establishments



In 2022, a delegation from NHRC, headed by Mr. Justice Arun Mishra, Hon'ble Chairperson, NHRC, along with Mr. Justice M.M Kumar, Dr. Dnyaneshwar M. Mulay, and Mr. Rajiv Jain, Hon'ble Members, NHRC; Mr. D.K Singh, Secretary General and Mr. H.C. Chaudhary, Joint Secretary, scheduled visits and inspections of various mental health institutions, in order to have first-hand knowledge of the present condition and to formulate a long term plan for the efficient working of the institutes of the three States, Gwalior, Agra, and Ranchi. Subsequently, the Commission scheduled a physical inspection of the *Gwalior Mansik Arogyashala (GMA)*; *Institute of Mental Health and Hospital (IMHH)*, Agra; *Central Institute of Psychiatry (CIP)*, and *Ranchi Institute of Neuro-Psychiatry & Allied Science (RINPAS)* on July 12, 2022, July 27, 2022, and August 17, 2022, respectively. Workshops followed the visits with respective institutes and other stakeholders, including the authorities from the State and Central Ministries, to sensitise the stakeholders about various challenges relating to mental health for its betterment and formulate a long-term plan for efficient working of the hospitals/ institutes.

During the COVID-19 pandemic in 2020, Dr. Vinod Aggarwal, Former Special Rapporteur, NHRC, also visited RINPAS and submitted that it is inadequately staffed due to the non-availability of recruitment rules. Dr. Aggarwal also visited Rajasthan in June 2019 and Maharashtra in July 2019 to review the implementation status of the Mental Healthcare Act, 2017 by the States and to review the functioning of the Mental Health Hospital, Jaipur, Mental Health Hospital, Jodhpur and Regional Mental health Hospital, Yerwada, Pune. Mr. Ambuj Sharma, Former Special Monitor (Health and Mental Health), NHRC, also visited the Central Institute of Psychiatry (CIP), Ranchi in October, 2019, to review the functioning of the Institute.

Mr. Surajit Dey, Registrar (Law), NHRC visited Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS), Jharkhand in June 2019 for an on-the-spot review to evaluate the functioning of the institution. In this regard, the Commission recognized a need for more trained staff to understand the specific problems of some of the inmates. Furthermore, in the case of homeless persons, it has been suggested that the institute should take more affirmative steps regularly, with the help of NGOs and social workers, to trace the inmates' families and send them to their respective homes, those who have recovered from mental illness.

Mrs. Jyotika Kalra, former Member, NHRC visited the Institute of Human Behaviour and Allied Sciences (IHBAS), Delhi, to review the functioning of the institution in April 2019. In this regard, the Commission recommended the State Government of the National Capital Territory of Delhi that IHBAS should take the necessary steps for recruitment & promotional avenues for the staff. It was also suggested that the rehabilitation program should be evolved for patients who are



either falsely victimised or not taken back into their families for other reasons. The former member also visited Uttar Pradesh's State Government Mental Health Hospital in Bareilly in May 2019 for an on-the-spot review to evaluate the institution's functioning.

Prisoners with Mental Illness

The Commission has been informed of various further serious problems with the country's management of prisons. One such issue was the occasional detention of innocent people with mental illnesses in jails, as well as the fact that these inmates received the same treatment as regular inmates with no attempt made to address their specific problems. In this connection, the Commission strongly recommended that Rule 82(1) of the United Nations Standard Minimum Rules for Treatment of Prisoners be followed. This requires that "Persons who are found to be insane shall not be detained in prisons and arrangements shall be made to move them to mental institutions as soon as possible." Further, Rule 82(4) requires that "the medical or psychiatric service of the penal institutions shall provide for the psychiatric treatment of all other prisoners who are in need of such treatment."

In 2015, the National Human Rights Commission was added as member of the drafting committee to propose changes to the Model Prison Manual of 2003. Based on the suggestions proposed by the expert committee, the new Model Prison Manual Of 2016 also stressed upon the need for better rehabilitation and reintegration programmes for prisoners all over the country.

The report submitted by the Mulla Committee on Jail Reforms in 1983 had recommended that if a prisoner became mentally ill while incarcerated, he should be treated at the closest mental hospital or accommodated in the jail hospital's psychiatric ward, if one existed. The Commission highly endorsed these suggestions.

Deeply concerned about the need to preserve the human rights of those being prosecuted, the Commission moved Criminal Writ Petition No. 1278/2004 before the High Court of Delhi and requested the dismissal of Charanjit Singh's trial. Singh had been incarcerated since 1985, and his health worsened despite extensive treatment at several hospitals and institutions. The High Court quashed the trial of the mentally ill prisoner in an order dated 04.03.2005. The High Court also commended the initiative of the Commission and took note of a promise by the Govt. of NCT of Delhi to take care of the medical needs of Charanjit Singh. Guidelines proposed by the NHRC for considering the cases of the such mentally ill-under trial were accepted by the Court, and appropriate direction was issued to the Govt. of Delhi in this regard.

The NHRC has always taken a serious view of the deaths due to suicide by prisoners and has, therefore, in May 2016, issued Guidelines of NHRC on the “Prevention of Suicide in Prison” (*Annexure IV*).

Box 2: Some of the recommendations from the guidelines proposed by the NHRC for considering the cases of the mentally ill-under trial are as follows:

- Psychological or psychiatric counseling should be provided to prisoners for early detection and to prevent mental illness.
- Central and District jails should have facilities for the preliminary treatment of mental disorders. All jails should be formally affiliated to a mental hospital.
- Services of a qualified psychiatrist in every central and district prison who should be assisted by a psychologist and a psychiatric social worker.
- Not a single mentally ill individual who is not accused of committing a crime should be kept in or sent to prison. Such an individual should be taken for observation to the nearest psychiatric centre or Primary Health Centre.
- If an under trial or a convict undergoing sentence becomes mentally ill while in prison, the State must provide adequate medical support.
- When a convict has been admitted to a hospital for psychiatric care, upon completion of the period of his prison sentence, his status in all records of the prison and hospital should be recorded as that of a free person and he should continue to receive treatment as a free person.
- Mentally ill undertrials should be sent to the nearest prison having the services of a psychiatric and attached to a hospital, they should be hospitalised as necessary. Each such undertrial should be attended to by a psychiatrist who will send a periodic report to the Judge/Magistrate through the Superintendent of the prison regarding the condition of the individual and his fitness to stand trial.
- All those in jail with mental illness and under observation of a psychiatrist should be kept in one barrack.
- If a mentally ill person, after standing trial following recovery from the mental illness is declared guilty of the crime, he should undergo his term in the prison. Such prisoners, after recovery, should not be kept in the prison hospital but should remain in the association barracks with the normal inmates.



- The State has a responsibility for the mental and physical health of those it imprisons.
- To prevent people from becoming mentally ill after entering jail, each jail and detention centre should ensure that it provides
 - o a conducive environment with physical and mental activities for prisoners that reduce stress and depression;
 - o a humane staff that is not unduly harsh;
 - o effective grievance redressal mechanisms;
 - o encouragement to receive visitors and maintain correspondence
 - o overseeing bodies should have members from civil society to ensure the absence of corruption and abuse of power in jails.

NHRC's intervention during the 2002 Gujarat incident

Trauma Counseling for the Victims of Violence in Gujarat: In 2002, the Commission gave financial support to the Swanchetan Society for Mental Health, New Delhi, for a proposal to offer trauma therapy to the victims of violence in light of the widespread violence and horrifying events that followed the Godhra tragedy. Nearly 300 youngsters received specialised counseling and PTSD-related treatments from Swanchetan to help them cope with nightmares, flashbacks, and other psychiatric problems following the riots.

Previous Publications by NHRC on Mental Health

Report of the Technical Committee on Mental Health of the NHRC (2015):

The NHRC had filed a petition to the Hon'ble Supreme Court (CRLMP No 8032/2013) in WP (CrI) No 1900 of 1981, in order to apprise them of the shortcomings in the country's mental healthcare system and to request appropriate guidance for the respective State Governments to take appropriate corrective measures. The Apex Court directed the States to submit detailed responses to the questionnaires submitted by the NHRC, pertaining to mental healthcare. A Technical Committee (TC) was formed in 2014-15, constituting three psychiatrists, Dr Pratima Murthy, Dr Sudhir Kumar, Dr Nimesh Desai and Dr Balbir Kaur Teja, Consultant NHRC. The primary responsibility of the Technical Committee was to evaluate the questionnaire responses by the States. The necessity for an accurate evaluation of the scope and patterns of mental disorders, current services, and treatment gaps is emphasised in the TC report's executive summary. The TC provided the State Government and the Central Government with several suggestions to help achieve the goals. The NHRC also offered recommendations, such as extending the mandate to cover additional aspects of mental health treatment, including

those provided at the community, medical school, and district levels, as well as in the public and private sectors.

Care and Treatment in Mental Health Institutions - Some Glimpses in the Recent Period (2012 Edition): This book is a collection of the Special Rapporteurs of the Commission's visit reports to mental healthcare facilities from 2009 to 2011. The compilation provides the opportunity to reflect on the advancements made in the mental healthcare and treatment field in India over these years.

Mental Healthcare and Human Rights (2008 Edition): The publication was authored by Dr. Pratima Murthy and Dr. D. Nagaraja, summarising the changes in mental health treatment in India since the 1999 report. The publication's goal was to establish minimum requirements for mental health services in India to safeguard the rights of those suffering from mental illnesses.

Quality Assurance in Mental Health (1999 Edition): A project of the National Human Rights Commission, carried out by the National Institute of Mental Health and Neurosciences, Bengaluru, was a nationwide assessment and analysis of mental health establishments and mental health services. The report intended to impact policymakers and decision-makers at the Central and state levels.

Conclusion

A number of efforts have been undertaken by the National Human Rights Commission to enhance institutional mental health treatment. People suffering from mental illness risk suffering serious human rights violations and losing their basic sense of dignity. While keeping the human rights component foremost in consideration, NHRC has established a completely transparent and collaborative manner of monitoring the rate and progress of initiatives with regard to mental healthcare policies and services in India. The commission has always made efforts to enhance awareness of the rights of people with mental illnesses and improve conditions in mental health institutions.



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Myths and Facts

Introduction

Mental illnesses have always been shrouded in stigma. Stereotypes, prejudice and discrimination that have been associated with people with mental illness over the years, have perpetuated the stigma and made it a tabooed topic. People are still hesitant to talk and open about their struggles because of fear of discrimination, feeling of shame and discomfort. In fact, stigma is an important factor of why people do not seek treatment globally (Guttikonda, Shajan et. al., 2019).

According to the National Mental Health Survey 2016, 10.6% of Adults in India have “any mental condition” with a treatment gap of more than 75%. Another national survey conducted in 2019 by The American Psychiatric Association (APA) revealed that mental health stigma is still a significant issue in the workplace. Recent report by UNICEF in 2021 stated that although people are becoming more aware of the effects of mental health issues, stigma still has a significant impact. Stigma prevents children and young people from getting help and restricts their ability to develop, learn, and flourish.

Impact of Stigma

Stigma has a huge impact on the individual living with mental illness. At an individual level, it can affect their self-esteem, induce feelings of self-blame and shame further leading to worsening of symptoms. This is as a result of internalisation of various negative beliefs that arise out of the stereotypes that have been existing within the society towards people living with mental illness. Self-stigma can lead to isolation, helplessness, hopelessness, distress and loneliness that are commonly experienced by the individual and limits their life opportunities. It can negatively affect even their treatment and recovery process (Jahn, Leith et. al., 2019).

The impact is not only at a personal level but even affects their relationships with family and loved ones. The lack of understanding about mental illnesses and its effect can often negatively influence their behaviour towards the one



struggling with it. It may lead to more tenseness within the family structures changing the relationship dynamics. The person living with mental illness may experience lack of empathy and negatively expressed emotions from the family members which may further reinforce self-stigma and affect their coping mechanisms. At the level of community and society, they may struggle with employment, social acceptance and even housing facilities often leading to feelings of being outcasted from social groups (Guttikonda, Shajan et. al., 2019).

Stigma can also significantly affect family caregivers who often refrain or feel uncomfortable in disclosing the mental health condition of their family member. The process of stigmatization even impacts their life and adds to the caregiver burden where they live under the fear of others finding out, subjecting them to negative reactions and discriminating them from the community (Koschorke, Padmavati et. al., 2017). Studies have shown that families of people with mental illness may experience being judged as uncaring, blamed for as the significant cause for mental illness and are given differential treatment as compared to other families (Guttikonda, Shajan et. al., 2019).

Social stigma has been a powerful influence that has often led to discrimination in the community, workplace and even within families, creating a significant and life altering impact both on people living with mental illness and their families. With the help of interventions and strategies, the individual may alleviate their symptoms related to the illness, but the inherent stigma associated with mental illnesses has a life-long impact in the form of societal rejection, compromising their dignity and rights as an individual. It makes it imperative for each individual and stakeholder to take the steps to break this stigma and stereotype that are debilitating, and create a culture which is supportive and encourages people living with mental illness to seek help.

Addressing the Stigma

There are many factors that have contributed to stigma. Lack of awareness and understanding has certainly been the key factor that continues to perpetuate it. Our perception of mental illness has been strongly influenced by how decades ago people with mental illness were stigmatised and treated across the globe. Given the limited scientific understanding about mental illness then, etiology of mental illnesses varied from being thought of as a result of black magic or bad karma. Even media portrayal of mental illness played a critical role in shaping societal perception in the context of mental illnesses. Portrayals have largely been regressive, dangerous or insensitive in the manner they are depicted in

the movies or entertainment forms which needs to change for reshaping the narrative.

Science has come a long way in being able to build a better understanding and develop effective treatments for mental illnesses. Yet it is critical to your role and responsibility as an individual, to break the stereotypes and stigma surrounding the mental health related illnesses by dispelling the myths and understanding the facts as the first step.

Myths and Facts

Myth 1: All people with mental illness are crazy or psycho

Fact: Language plays a significant role in perpetuating the stigma. Colloquial like 'crazy', 'psycho', 'whacko' or 'mentally retarded' promotes insensitivity and stereotypes, for eg., people using the term 'psychopath' for persons suffering from 'schizophrenia'. Not only do the words you use shape an individual's perception about self and the others, it also communicates respect and dignity. Language matters and it is crucial to be mindful of the words you use while describing people with mental illness which are sensitive to their experiences, non-judgmental and respectful of their boundaries.

Myth 2: People with mental illness have weak personalities or a character flaw.

Fact: Mental illness is not a matter of a choice, sign of weakness or character flaw. Like any other physical illness, mental illness is caused due to the complex interplay of biological, genetic, social or environmental and psychological factors (Babalola, Noel & White, 2017). The brain regions play a functional role in determining our thoughts, emotions, decisions and responses. The neurotransmitter imbalances lead to symptoms of mental illness. Genetics or family history of mental illness can also cause greater susceptibility in family members to develop any form of mental illness. Other social and environmental factors like adverse childhood experiences, trauma, abuse, dysfunctional family structures and unhealthy coping mechanisms like substance abuse also contribute to developing mental health conditions. With support and treatment, people with mental illness recover and lead a quality life.

Myth 3: People with mental illness are dangerous

Fact: This is a common misconception about people with mental illness being dangerous. In fact, most people with mental illness are not dangerous. In contrast to being the perpetrators of violence, people with mental illness are considerably more frequently the victims of it and are exposed to a range of human rights violations (WHO). There isn't much evidence to support the idea



that people with mental illness are more likely to be violent than the general population (Lancet, 2020).

Myth 4: Mental illnesses are same as Mental Retardation

Fact: Evolution of language even in the context of mental health has been conscious and critical to bring about the change in the attitudes and experiences of people living with mental illness. The term 'mental retardation' was considered to be socially harmful and scientifically worthless (Nash, Hawkins et. al., 2012). The term 'Mental Retardation' was replaced by 'Intellectual Disability' in the draft revisions of Diagnostic and Statistical Manual to refer to children and individuals with deficits in their intellectual functioning and in various skills needed for daily living. However, not all mental illnesses can be characterised by intellectual deficits. In most mental illnesses or mental health problems, it is the functional impairment that an individual experiences on account of problems in their thinking, moods and behaviours in day-to-day life.

Myth 5: Mental illnesses are rare

Fact: According to the World Health Organisation (WHO), 970 million individuals worldwide, or 1 in every 8 people, suffer from a mental illness, with anxiety and depressive disorders being the most prevalent (Global Health Data Exchange & WHO). Due to the COVID-19 pandemic, the number of people who suffer from anxiety and depressive illnesses greatly increased in 2020. Initial projections indicate a 26% and 28% increase in anxiety and major depressive disorders, respectively, in just one year (WHO, 2022). These numbers are not only alarming, but also emphasises the need for prevention, treatment and accessibility so that more people are helped with early identification and timely intervention.

Myth 6: Mental health problems are permanent. Once someone develops mental illness, they are ill for life.

Fact: Undiagnosed and untreated mental health conditions can have a huge impact on the individual's life affecting their work, relationships, quality of life and self-esteem. With regular pharmacological, psychological therapies and right support, people with mental illness recover, work, participate fully in interpersonal, social and community aspects and lead fulfilling lives.

Myth 7: Only certain type of people develop a mental illness

Fact: Mental health conditions do not discriminate based on age, gender, background, or socio-economic status. As a society we discriminate against people with mental illness. Anyone can experience mental health problems whether they are a celebrity, athlete, politician or anyone. We must make collective efforts to end the stigma and build acceptance.

Myth 8: Children do not experience mental health problems

Fact: Mental health condition affects one in seven 10 to 19-year-olds worldwide, which accounts for 13% of the disease burden in this age range. Main causes of illness and disability among adolescents are anxiety disorders, depression and behavioural disorders. Among those aged 15 to 19 years, suicide ranks as the fourth leading cause of death. Failure to address adolescent mental health issues can have long-term consequences on an adult's life (WHO). It is imperative to strengthen support systems for adolescents that ensure skills to navigate with life challenges, build resilience and promote healthy coping mechanisms. Bringing mental health literacy within school systems by embedding them into the existing curriculum is the need of the hour (Parikh, Singh & Chhiber, 2020).

Myth 9: Psychiatric medications cause dependency and have serious side effects

Fact: There are various types of psychiatric medications. To say that all medications are addictive and can create dependency is factually incorrect. In fact, this myth dissuades people living with mental illness from starting medical intervention and creates a barrier in effective treatment. Most psychiatric medications don't cause dependency. Potential dependency on some psychiatric medications is no more than commonly used medications like painkillers and should only be used under the care and supervision of psychiatrist or primary healthcare physicians.

Myth 10: Anyone can do therapy- parents, friends or colleagues

Fact: Parents, friends, colleagues or teachers form a very essential part of the support systems. It is important to encourage people living with mental illness to talk, share, seek help and support from their families, friends or peers. However, they cannot do therapy or counseling as it is done by mental health professionals who are trained in providing scientifically-based therapy treatment. Counseling is a professional relationship between the therapist/psychologist and the patient which maintains a non-judgemental and empathetic approach. It provides a safe and secure space for patients to express their emotions, identify stressors, develop strategies to mitigate the symptoms and build healthy coping mechanisms. It is conducted in a proper setting and clear-cut boundaries are established between the two as a part of the process.

Myth 11: I can't do anything for someone with mental health needs.

Fact: Everyone has a role to play in extending support to people with mental health problems. As loved ones, friends, peers or colleagues, your efforts



in creating a conducive, safe and sensitive environment for people with mental illness will ensure them that they can lean on in times of need and vulnerabilities. Encourage people to open about their struggles related to mental illness and seek help. At the same time, refrain from using any language that may cause labelling or reduce their identity to being 'mentally ill'. Showing respect while referring to their condition, like instead of saying 'suffering with or victim of mental illness' you use 'living with mental illness, living with anxiety or depression'. It is important that you maintain dignity and individual identity as separate from the illness. Show your empathy, compassion and care through your active, non-judgemental listening and simply ask them how you can best support them in times of need. Your role is valuable in providing psychological first aid which is defined as 'humane, supportive, practical, social and psychological support to anyone who is undergoing distress', will make the person feel safe, connected, calm and hopeful (WHO, 2011). Your presence, by just being there and providing encouragement to seek help, can go a long way in making a positive difference in their lives. Lastly, be a mental health advocate by spreading the right information to generate sensitisation amongst people about mental health through dialogues, more conversations, and advocacy on social media.

As individuals and stakeholders, it is our collective responsibility to put consistent energy in breaking the stereotypes and ending the stigma by addressing the myths that have ever been associated with mental illness and making the genuine effort to understand the facts and right information about mental health.

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Faith Healing and Human Rights

Faith healer is a person who cures sick people by using the power of prayer and belief.

Traditional healer -A traditional healer is defined as a person who does not have any formal medical training but is considered (by the local community) as being competent to provide healthcare using animal, plant and mineral substances and certain other techniques based on social, cultural and religious background.

Magico-Religious healing - The term Magico-Religious is commonly used to describe beliefs prevalent in a particular culture concerning various supernatural influences.

Introduction

Faith and traditional healers are a very common first source of help in our country. They are accessible, economical and the explanation provided by them is consistent with the belief system in the general population. Therefore, use of such services becomes frequent for two important reasons:

- One, They are available closer to where people live, and
- Two, Explanation provided by them is consistent with the belief system of attributing reason for ill health due to a supernatural force or cause beyond the individual.

Traditional and faith healers are categorised into many subgroups, which also includes magico-religious healing practices. The need to work in collaboration with traditional and faith healers receives attention in Technical Report Series 564 (WHO, 1975). Generally, the healing practices are harmless but sometimes they can be very harmful and even end up in fatalities. While one cannot eradicate this group of practitioners from the community, it is important to recognise that by sensitising them and training them about the range of mental health problems in the community, we can increase their sensitivity to recognise serious life-threatening problems so that they can be referred to as early as possible.



For example: a traditional healer or faith healer may be approached by the affected family member of a person presenting with acute behavioural disturbances which could be due to an acute organic brain syndrome, or it may be related to post ictal confusion state, both conditions require urgent medical evaluation, investigations and treatment. Efforts to work with this population through the primary healthcare system have been successful in reducing harmful practices, increasing liaison with medical facilities in and around the neighbourhood. The traditional and faith healing practices in African nations have been institutionalised and there are professional organisations which regulate their practice. They hold annual conferences where they exchange knowledge and keep updating the safety measures consistently in their practice domain. The author in this chapter uses the phrase 'healer' interchangeably.

Case studies from the field

The following are some of the situations encountered by the author during the implementation of mental healthcare programs in primary care settings.

Case 1: A 25-year-old married lady was brought to the faith healer on the background of the following behaviour disturbances, like sleeplessness, excitability, demanding for varieties of non-vegetarian food and even liquor for the last 10 days. She was admitted in the faith healer's residential facility and prescribed the following intervention that includes making the person starve and depriving her of water in addition. The faith healer thought that the person was possessed by a promiscuous evil spirit, and the best way to drive her away was to make the person starve. Unfortunately, the said person was found dead after 6 days in the isolated room. Evaluation suggested that she did not commit suicide but died due to severe dehydration and hunger. Discussions were held with the healer and the undesired outcome in the above case was attributed to the prescription of a dangerous procedure like starvation to drive the apparent evil spirit away which contributed to the death. This case study was published in the World Psychiatric Association Series in the year 2000.

Case 2: A 30-year-old man was brought to a temple with a history of exhibiting repeated self-injurious behaviour which lasted for several minutes. The individual did not have recollection of the episode and often lapsed into sleep after exhibiting the above-described repetitive behaviour problems. The priest thought that he was possessed by a blood thirsty evil spirit and therefore suggested treatment with whiplashes and tying the hair to the tamarind tree nearby. Despite the harsh treatment meted out to this young man, there was no change in the symptom pattern. One fine day, he was found unconscious, and he was rushed to the nearby hospital, where further evaluation suggested the presence of status epilepticus (continuous epileptic attacks), and, therefore,

referred to a medical college hospital. He was initiated on anticonvulsant medication, seizures were controlled. He was discharged back home after 10 days. The primary care team gave the faith healer feedback about the nature of the problem and the healer was willing to learn from his experience. This example illustrates the example of checks and balances in his practice of faith healing, which resulted in saving his life.

Case 3: A 17-year-old boy, only child of a single mother was found to be spending money indiscreetly for the last 2 months. He lived with his mother and grandmother in a village because the father had deserted the mother and the child for reasons unknown. The mother took this as a challenge and started caring for the child to prove to the people that she could manage things without the support of the father and perhaps do a good job nurturing her son on her own. She was proud of the fact that her son had physically grown and that he was a very popular boy in the school. Unfortunately, she realised that the part of the money that was kept in the iron safe was missing, and she often wondered who was taking the money away without her permission. After several rounds of discussion with her mother, she concluded that her son was the culprit. He was taking money to entertain his classmates to gain popularity. She was also given information that he was providing snacks, fruits and chocolates to his friends. One day, she confronted her son about the expenses he was involved in and appealed to him that there could be nobody who could have stolen money other than him. During this process, he started exhibiting odd behaviour as though he was possessed by God and during such possession, he started saying “Srinivas never stole money, that he was an honest, hardworking boy and allegations made against him were indeed wrong”. His mother was shocked to see this behaviour. She offered camphor, coconut etc. presuming that he was possessed by God – The family goddess Durgha had entered his body. Mother stopped confronting him, but the disappearance of money persisted. Whenever she confronted him about the stolen money, he immediately lapsed into the above-described episodes. The healer who was consulted recognised that this boy, Srinivas, was possessed by an evil spirit and therefore subjected the boy to beating with whiplashes. The boy could not tolerate the harsh punishment and ran away from home to the nearby city. He was rescued by the Child Welfare Committee and admitted in a protection centre when the entire story unravelled.

Discussion

The above three examples indicate the harmful practice by the traditional healers which amounts to violation of rights of people with mental health problems in the community. The occurrence of such incidents is a clear indication of lack of mental health services at the local primary health centers, and at the same time reflects dangerous practices which can be harmful to the person. In



the first instance, the prescription of the healer resulted in death of the individual, which is clearly undesirable. In the second instance, sudden occurrence of unconsciousness resulted in referral which saved the life of the boy since he was suffering from a very fatal condition called status epilepticus, and in the third instance, the boy ran away to the nearby city. Fortunately, he was identified and rescued by the field staff of the local NGO leading to admission for care and support. Subsequently, appearance before the child welfare committee resulted in reintegration with the family. Timely action by the NGO field worker saved the boy from so many unimaginable problems. In the first case study, the intervention for psychotic disorder resulted in a fatal outcome which indicates that the psychotic disorders like schizophrenia, bipolar disorder and acute organic brain syndrome cannot be managed by traditional or faith healers.

Further, the systematic review by Gareth Nortje et al (2016) clearly points out that psychosocial interventions for common mental disorders are effective. In the second case, the traditional healer could not distinguish possession from complex partial seizures. However, he was shifted to the hospital soon after he developed unconsciousness which saved his life. In the third case, the healers could not distinguish between behaviour for gain and malingering to escape punishment. Unable to bear the pain he decides to run away from home which could have resulted in many undesirable consequences. Fortunately, he was rescued at the right time to facilitate reintegration with the family. The case studies demonstrate different interventions based on the understanding of the healer; fatality could have been saved if only the patient was referred in time to the psychiatric facility.

To summarise, the collaborative approach and partnerships with faith and traditional healers is very crucial to improve mental health service utilisation in the country. Approximately, 1 out of every 500 population in rural and urban India, may have traditional or faith healers and such people become the source of support for individuals experiencing distress. In cities and towns, traditional healer and population ratio could be much higher since there are many resources for healthcare. It is also recognised that some healing practices can be harmful or even dangerous. Such practices can be changed by incorporating harmless processes in care and training.

Conclusion

In conclusion, protecting the rights of citizens from harsh and harmful practices of the traditional and faith healer is not easy at the present time. Age old practices have continued to exist in our community due to lack of adequate and proactive healthcare services in rural areas. India has 6,50,000 villages at the present time, if one calculates the population of traditional and faith healers in

rural areas it runs into lakhs. To regulate the practice of these healers is a great challenge because of the attitude. Therefore, a systematic effort to train them in mental health, offering support through the existing primary care in the country is a great way forward. The training could focus on orientation to both common and severe mental disorders, understanding the levels and limits of care in the context of traditional and faith healing, initiation of the concept of safe practice with respect to healing and lastly, periodic review of the prevailing situation in the country.

It is important to register every healer and healer facility so that they can be monitored regularly. Not paying attention to this group can result in catastrophic consequences, while an approach to involve them as a collaborator in healthcare can go a long way in mitigating some distress. It is impossible to ban traditional and faith healing practices in the country but nurturing them to be a partner in mental healthcare delivery in the community is potentially possible which should be undertaken by the primary care team. This task can be extremely challenging because the primary care team can be very reluctant to work with them. Attitudinal change at the level of every primary care team member is essential to build the partnership between traditional/faith healers to improve access to care. It is well established that families consult these healers first before they consult primary care physicians or mental health professionals (Manisha Chethan Khemani et al, 2020, DB Sharma, 2020 & Chandrakanth Lahariya, 2010). Faith healing is popular in Hanumanthapuram temple (Kennedy M, (2010), Balaji Temple in Mehindipur in Rajasthan, Webster G, (2011), and the Muslim clerics use Islamic text and traditions to heal across all Dargahs in the country, and the Pentecostal Christian pastors use holy oils, holy water and other aids to perform healing. These healers typically work within communities where they are known to their patients (Knopi and Swatz, (2019). Healers use a combination of approaches, and it becomes difficult to categorise them as one or the other type. Preventing any harm to the user, violation of users' rights, and lastly, increasing the safety standards to prevent mortality is of utmost importance. Imparting training to orient them about mental health problems and guidelines for referral can go a long way in increasing safety of healing practices in the country.



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Stigma and Mental Health

Introduction

The dictionary meaning of stigma entails negative feelings towards another person or a group based on their particular circumstances or characteristics (e.g., having a mental illness or HIV infection). It can also be defined as a deeply discrediting attribute or characteristic (i.e., a mark of shame or disgrace) that reduces the individual from a whole and usual person to a tainted and discounted one. The three main components of stigma are stereotype (a widely held, oversimplified, often negative belief about a person belonging to a stigmatized group), prejudice (negative emotional response or reaction towards a person based on their membership in a stigmatized group), and discrimination (acting on or behaving negatively towards a person belonging to a stigmatized group based on one's stereotypes and/ or prejudices) (Andersen et al., 2022).

In this chapter, we will describe the different types of stigma or the way it generally manifests, followed by the rest of the discussion focusing specifically on mental health-related stigma. Next, we will elaborate upon some of the important causes and consequences of mental health-related stigma. Finally, we will discuss the different ways of addressing mental health-related stigma.

Types of Stigma

There are three broad types of stigma (see Table 1):

- **Public Stigma:** Refers to the set of generalized negative beliefs or attitudes the general public at large holds against people with mental illness or any other stigmatizing condition, which often leads to avoidance, discrimination, and social exclusion of these people by the general public.
- **Self Stigma:** Refers to the process in which a person with mental illness or any other stigmatising condition cognitively and/ or emotionally absorbs the generalised negative messages or stereotypes about people with their condition and comes to believe and self-apply them to themselves. This is

also known as internalised stigma, as people with mental illness internalise the stigma existing in the general population or society towards mental health disorders or treatment.

- **Structural or Institutional Stigma:** Refers to a more broad and systemic form of discrimination in the form of laws, rules, policies, and/ or practices at the level of government or an organization that results in unfair treatment of people with mental illness or any other stigmatizing condition.

Apart from the three types of stigma described above, several other forms of stigma are described in the available literature - such as perceived stigma and enacted stigma, among others. These are not described here for brevity, and interested readers may refer to other excellent resources describing the construct of stigma in detail (Gaebel et al., 2016). Lastly, there is an additive and cumulative impact observed with stigma experienced by a person by virtue of being a member of one or several stigmatized groups (e.g., racial or ethnic minority, mental illness, homosexual orientation, etc.) over some time. This is also known as layered or compounded stigma.

Table 1: Examples of Different Types of Stigma Related to Mental Health

Public Stigma	Self Stigma or Internalised stigma	Structural or Institutional Stigma
<p>The general population’s negative beliefs are that people with mental illness are violent, unpredictable, not trustworthy or responsible, etc.</p> <p>Thus, the public generally avoids employing them for work or renting them a house, etc.</p>	<p>People with mental illness hold negative beliefs about themselves, such as being incompetent, having weak willpower, good for nothing, etc. This leads to feeling self-pity and hopelessness among them. For example, <i>“why should I even try? I am bound to be a failure.”</i></p>	<p>Negative beliefs and attitudes are reflected in the existing laws and policies in public and private institutions/ organisations. For example, underfunding mental health services or research activities, health insurance excluding mental illness cover, etc.</p>

Mental Health Stigma

Stigma experienced by a person by virtue of him or her receiving a mental health diagnosis or label or getting mental health treatment for the same (e.g., medications, psychotherapy, etc.) can be understood as a mental health-related stigma. Mental health stigma usually encompasses stereotyping (e.g., people



with mental illness are dangerous), holding prejudices (e.g., I am scared of people with mental illness as they are violent or unpredictable, and I do not want to be near them), and indulgent in discriminatory behaviors (e.g., I would not employ or rent to a person with mental illness). Often, it is not restricted to the person concerned but also affects other close contacts of that person, such as family members or close friends, by their association with the stigmatised person. This is known as courtesy stigma and is experienced by people in close relationships with a stigmatised individual (e.g., parent, spouse, child, close friend, etc.).

Simply put, mental health stigma comprises problems with knowledge (ignorance and misinformation), attitudes (prejudice), and behaviours (discrimination) towards people with mental health-related problems. It is highly prevalent worldwide, including in India (Venkatesh et al., 2015). For example, a survey of about 3550 people from eight cities in India reported that about 71% of them used or endorsed terms associated with stigma e.g., crazy, mad, retard, irresponsible, careless, etc. to describe people with mental illness (5 charts that reveal how India sees mental health). Similarly, more than half of the surveyed people believed that people with mental illnesses should not be given any work or responsibility and that they should stay in their groups because of the fear of their problems or illnesses spreading to other healthy people in the same company. Furthermore, the available research suggests that mental health-related stigma is even more significant among the youth and adolescent age group than among adults (Gaiha et al., 2021).

Causes of Mental Health Stigma

Stigma is a multi-dimensional concept, and it is difficult to pinpoint all the causes of the stigma associated with a particular condition, such as mental illness. However, stigma is a universal phenomenon found to exist in varying degrees and forms across different cultures worldwide throughout the known history of mankind (Rössler, 2016). Here, we would like to discuss a few significant drivers of mental health-related stigma that might serve as important targets for interventions to reduce stigma in society.

There are often misconceptions about the causes of mental illness in the general population. For example, supernatural or magico-religious causation of mental illness (e.g., misdeeds of ancestors; misdeeds of parents; misdeeds of the people with mental illness themselves, supernatural forces such as demons/spirits, or punishment from god, etc.), resulting from weak willpower or character flaw in the personality of the person, among others. Similarly, several false negative beliefs regarding the nature of people with mental illnesses are widely



prevalent among the general population. For example, people with mental illness are unable to contribute positively at work, are unpredictable or violent, cannot have normal relationships, are sexually inactive, contagious, or bring bad luck (“*amangalam*,” “*ashubh*”), among others. These faulty beliefs are likely to contribute to the development and/ or strengthening of generalised negative beliefs and attitudes towards people with mental illness among the public (Shrivastava et al., 2012).

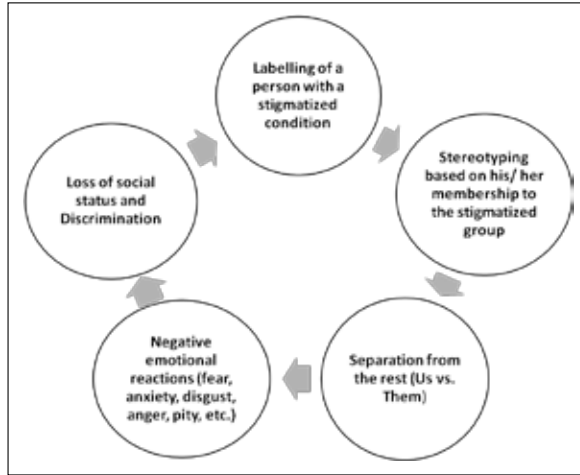
Media plays an essential role in shaping public views and attitudes towards several critical issues in society, including the stigmatising attitudes and behaviours of the population. For example, the sensational or often dramatised portrayal of people with mental illness indulging in violent crimes or behaving unpredictably in both fictional (e.g., news, social media, etc.) and non-fictional (e.g., movies, TV serials, etc.) media tends to reinforce several of the above-mentioned faulty beliefs associated with mental illness (McGinty et al., 2015). In line with this, mental health treatment or admission in the psychiatry ward has often been shown as a way of punishing or coercing the person with mental illness into subjugation, with several safe and effective treatments like modified electroconvulsive therapy being depicted as a way of torturing or altering the personality of the person with mental illness. These inaccurate depictions, coupled with a lack of formal inclusion of mental health education in the school curriculum and the reluctance of society, in general, to discuss their mental health problems openly, could further accentuate several of the existing negative stereotypes and prejudices associated with mental illness and treatment.

Harmful Consequences of Mental Health Stigma

There are several negative consequences of different types of stigma described above on the people with mental illness, as well as their close contacts (e.g., family members, close friends) and even mental healthcare professionals (e.g., psychiatrists) involved in providing care to these people.

Public stigma against people with mental illness promotes discriminatory behaviour and practices against them. This manifests a difficulty in getting jobs or employment opportunities or accessing education or residential accommodation of their choice despite having requisite capabilities or resources (e.g., educational qualification, skills, money, etc.) that would suffice for an average person in the given settings. Figure 1 describes the basic steps involved in this process of stigma-driven discrimination.

Figure 1: Vicious Cycle of Stigma and Discrimination



Similarly, close contacts of people with mental illness also experience negative consequences of public stigma due to their association with a stigmatised group. For example, they could have difficulty securing a residence while living with the person with mental illness or difficulty participating in social gatherings.

- There is also an increased risk for worsening symptoms of mental illness due to public stigma, which is experienced by persons with mental illness that hampers their recovery process due to social exclusion and feelings of hostility directed towards them by society.
- Mental health-related stigmas are also a significant contributor in the delayed seeking of mental health treatment and premature dropout from treatment leading to poorer outcomes in people with mental illness.
- Public stigma related to negative stereotypes such, as persons with mental illness being dangerous or unpredictable, or untrustworthy can drive faulty institutional changes or practices, including the formulation of laws, rules, or policies by the government that can result in failure to prevent undue restrictions on the fundamental rights of people with mental illness (Pescosolido et al., 1999). In addition, this form of structural or institutional stigma could hamper funding of mental health-related research or upscaling mental healthcare services.

As a result of experiencing widespread public and structural stigma, a person with mental illness might also start to accept and self-apply the negative stereotypes the public holds for them as a group. This results in a feeling of decreased self-efficacy and self-esteem in these individuals. Furthermore, this



form of internalised or self-stigma leads to the “Why try?” phenomenon or effect, in which the individuals start believing that “I am not worthy; I am not capable, and so on.” This, in turn, leads to an increased risk of developing hopelessness, depression, and indulgence in other harmful behaviours (e.g., alcohol or drug use disorders, self-harm, etc.) among them (Corrigan et al., 2009).

Lastly, mental health professionals also experience a certain degree of stigma in healthcare settings. For example, the advice of neurologists or neurosurgeon is often given more weightage than that of a psychiatrist, while managing a person with behavioural and mental health problems is often ignored or neglected by other healthcare professionals and is regarded not as crucial as other physical problems, etc.

Tackling Mental Health Stigma

There is a need for different strategies to tackle the problem of stigma at different levels in society or the community (Gaebel et al., 2016).

Interventions at an Intrapersonal Level (Individual/ Close contacts):

- Maintain an open, non-judgmental, and empathic attitude towards persons with mental illness or other stigmatising conditions.
- Understand that mental illness or another stigmatising condition does not define the individual but is only a part of their overall personality or identity.
- Words matter: We should be watchful towards our negative stereotypes or prejudices while discussing or talking to people with mental illness or other stigmatising conditions. We should also try to use the appropriate person’s first language (See Table 2).

Table 2: Pointers on using appropriate language to stop the stigma

Good Examples: To Say During Conversation	Bad Examples: To Avoid During Conversation
<ul style="list-style-type: none">• “He/She is a person with psychiatric illness.”• “Thanks for sharing your problem with me.”• “I am here to help you. Let me know when you are comfortable.”• “I realise it is tough, but I am proud of you for not giving up trying.”	<ul style="list-style-type: none">• “You are a psycho.”• “It is nothing serious. You just need to push yourself harder.”• “Just deal with it quickly and get your Act together.”• “All of us have been through bad times. You need to snap out of it.”• “It is all in your mind. You just have to try and keep thinking about happier stuff.”

Interventions at an Interpersonal Level (Society/ Community):

The anti-stigma strategies working at this level are broadly divided into three broad types based on their basic underlying process or approach towards stigma reduction: Education, Protest, and Contact.

Education-based anti-stigma strategies are based on providing accurate information about the symptoms of mental illness and available mental health treatment options to the general public, including those with mental health problems. These strategies aim to improve mental health literacy levels and challenge negative public stereotypes or attitudes against people with mental illness by providing facts and dispelling myths related to mental illness. For example, to counter the generalised negative beliefs that people with mental illnesses are violent and dangerous, a public information campaign providing the scientific rate of violent crimes committed by people with mental illness is comparable to that observed in the general population can be conducted. However, the available research suggests that not all negative stereotypes and discriminatory practices are amenable to change with simple education-based strategies. For example, it has been noticed that public awareness campaigns over the years improved the overall mental health literacy about the neurobiological causation of several mental health disorders and corrected the myth of them being a result of a character flaw or weak willpower. However, the levels of public stigma towards people with mental illnesses remained high in the population. It has been suggested that providing correct information improves the knowledge component but is not very effective in modifying people's negative attitudes and behaviours in the long run (Pescosolido, 2013).

Protest-based anti-stigma strategies involve calling out social prejudices or morally unfair discriminatory practices towards people with mental illness at various societal levels. It includes advocacy efforts to mobilize public support for bringing about change in society by forming public support groups or self-help groups to highlight the plight of people with mental illness facing discrimination and emphasizing the need to show empathy and compassion towards them. It is also helpful in bringing about positive policy changes by the government and adopting promising practices at the level of public or private organisations promoting equitable access to jobs, housing, and access to other services for people with mental illness. It also includes opposing inaccurate or negative portrayal of people with mental illness in the media with efforts directed towards improving the depiction of mental illness sensitively and responsibly that does not reinforce faulty beliefs or prejudices against them in society. However, excessive use of protest-based strategies in isolation might prove detrimental. Research suggests that simply telling people to ignore or suppress their negative views or emotions towards people with mental illness might paradoxically increase



stigma rather than decrease it (Penn & Couture, 2002). Further, it is unlikely to promote more positive attitudes towards people with mental illness.

Contact-based anti-stigma strategies involve social contact or interpersonal interactions between a person with mental illness or having a lived experience of mental illness with people from the general population. This strategy aims to promote positive interactions between a person with a stigmatising condition and a person from the non-stigmatized general population group.

Of the three strategies, contact-based interventions have shown to be the most effective in reducing stigma (Hartog et al., 2020). Further, a combination of contact and education-based interventions are likely to be more effective than either in long-term stigma reduction. The contact can be directed face-to-face or through a digital medium such as live video-conferencing or a lecture (pre-recorded) by a person with a mental illness or lived experience of dealing with mental illness. Research suggests repeated, one-on-one direct contact between people of comparable statuses has been associated with better stigma reduction outcomes (Corrigan et al., 2012; Cook et al., 2014). Sharing personal stories of experiences with mental health problems and successfully dealing with them by adopting healthy habits and seeking appropriate help from successful people or celebrities have also been shown to be effective in shattering negative stereotypes by reducing stigma and promoting mental health treatment seeking in the population. For example, in recent times, several popular public figures ranging from comedians, and movie actors, to sportspersons have shared their personal stories of struggling with mental health issues and getting better. The widespread media coverage of such stories gives a message of hope along with correct factual information about the causes, symptoms, and treatment of different mental health problems that is also likely to help address the mental health-related stigma among the general public.

Education-based interventions are reported to have had mixed efficacy. In contrast, contact-based interventions have shown the most promise in stigma reduction, primarily if they are implemented from an early age. In addition, research has shown that regular social contact with people with mental illness or lived experiences had the strongest and longest-lasting effect on reducing stigma. Therefore, it might be most beneficial to combine contact-based approaches with education. Thus, anti-stigma campaigns involving education (aiming to challenge inaccurate stereotypes by providing factual information) and contact (encouraging positive interactions between the public and persons with mental illness) based strategies are likely to yield the best results.



Interventions in Government Policies or at a Structural Level:

These include interventions by adopting legislations or laws to tackle mental health-related stigma and discrimination, facilitating the reporting of abuses against stigmatized groups, and making strict provisions to penalize those engaging in such discriminatory activities. Additionally, providing institutional support and funding to organisations working in the field for stigma reduction directly or indirectly. These are a few examples of government-level policies or structural changes aimed at reducing mental health-related stigma in the Indian context:

The Government of India enacted the Rights of Persons with Disabilities Act, 2016 (RPwD, 2016), which recognized mental illness as one of the listed disabilities in the Act. It provided several measures safeguarding the fundamental human rights of people with mental illnesses (The Rights of Persons with Disabilities Act, 2016, n.d.). Also, the RPwD, 2016 provides reservations in government jobs and seats in higher education courses to promote their representation in the employment sector. It also makes provisions for preferential allotment of land and/ or government houses to people with benchmark disabilities, including those with mental illness. These provisions together will help social inclusion of people with mental illnesses and reduce mental health-related stigma and discrimination.

Similarly, the Government of India passed the Mental Healthcare Act in 2017 (MHA, 2017), which guarantees the rights of people with mental illnesses and entrusts the government with the task of providing adequate and affordable mental healthcare services to people in need in the least restrictive settings possible (The Mental Healthcare Act, 2017, n.d.). Also, it places the responsibility of creating mental health-related awareness in the general public on the concerned government agencies. Among several other things, it attempts to treat people with mental illness on par with those having any other physical illness. For example, section 21(4) of the MHA, 2017 explicitly states that “*every insurer shall make provision for medical insurance for treatment of mental illness on the same basis as is available for the treatment of physical illness.*” Further, the Government of India, through its various agencies, such as the National Human Rights Commission (NHRC), conducts periodic inspections of the conditions of mental health institutions in the country to ensure that adequate standards of care and treatment are maintained (NHRC Press Release, n.d.). The NHRC also takes cognizance of any severe human rights violations and promptly issues directions to appropriate authorities to punish the perpetrators. Thus, all these measures will likely help reduce mental health-related structural stigma.



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Suicide

Introduction

Suicide is a public health concern globally. Every year, suicide claims more than 800,000 lives worldwide, and more than 60% of these deaths occur in Asia (WHO, 2014). Over the past five decades, the number of suicide deaths has steadily increased in India (National Crime Records Bureau, Accidental Deaths and Suicides in India, 2018), wherein an estimated suicide-related death rate is 21/100,000, which is more than double the global average (11.4/100,000), and accounts for more than 230,000 annual fatalities (WHO, 2014). These alarming numbers reflect suicide as a reality of our society and affect all sections of the population across age, gender and economic strata, with the most vulnerable being the 15–29-year old, the geriatrics and persons with special needs (WHO, 2014). A multifaceted approach is required to tackle such a rapidly emerging and growing issue. There is no single best way, but a multi-prolonged systematic preventive strategy is synthesised into an actionable plan.

Suicides are preventable. To achieve this, we need to first and foremost de-stigmatise conversations around suicide by acknowledging the lives being lost every 40 seconds (WHO, 2014), further creating a massive personal, familial, community, economic and social loss to a problem which can be prevented through collective efforts of various stakeholders. The UN Sustainable Development Goals (SDGs) emphasise the importance of global attention that suicide prevention needs to reduce premature mortality from non-communicable diseases by one-third by 2030, as stated in Target 3.4 (reduce premature mortality attributed to non-communicable diseases), which includes suicide rates as one of its two indicators. As a country, India needs National Suicide Prevention Policy with a public health approach addressing the psychosocial, systemic, inter-sectoral and community-based issues which all stakeholders accept.

Suicide as a Public Health Issue

The high rate of suicides constitutes a worldwide public health concern



that requires widespread attention. Each suicide is complicated and significantly affects the people in the surrounding. It must be highlighted that not all suicidal deaths can be attributed to mental illness. Suicidal deaths may result from various factors like poverty, unemployment, family/ marital issues/ relationship issues, failure in life, lack of access to healthcare, etc. (Mariwala Health Initiative, 2022). According to WHO, around the world, an estimated more than 700,000 people die by suicide each year. Every year, 108 million people are deeply impacted by suicidal behaviour, with approximately 135 people experiencing intense grief for every suicide or being negatively affected in some other way. Twenty-five people attempt suicide for every suicide that occurs, and many more have thoughts of taking their own lives. Suicidal deaths in India have steadily increased in the past five decades. A total of 1,64,033 suicides were reported in the country in 2021, showing an increase of 7.2% compared to 2020, and the rate of suicides has increased by 6.2% during 2021 over 2020 (NCRB, 2021). Also, suicide attempts are three times higher in females compared to males, while the figure is reversed in terms of suicide completers. In addition, there has been an increase in reports of persons seeking help and having suicidal thoughts online. Despite all this, discussions regarding suicide remain primarily missing from public conversations or are framed as a personal rather than a community problem.

De-stigmatizing and De-mystifying Suicides

The stigma around suicides has always been prevalent. Many myths continue to exist due to a lack of awareness and sensitisation of the problem that people still hesitate to talk about. Conversations around suicide are perceived with fear and anxiety that they are often dismissed. For every death by suicide, there are more than 20 attempts (WHO) which means that the stigma associated with it creates a barrier for people to open up about it and seek help. It is imperative to break the taboo in societies about suicide, which begins by addressing the questions, breaking the myths and understanding the factors associated with suicides. Although Section 309 of the Indian Penal code now decriminalises attempted suicide, and there is the provision of mental healthcare under the Mental Healthcare Act 2017 (115(1)) for individuals attempting suicide, still there is substantial stigma concerning it. Additionally, it is still seen from the lens of a medico-legal perspective. A collective effort from each individual and stakeholder must come together to strengthen the preventive approach.

Understanding Suicides

According to the Center for Disease Control and Prevention (CDC), suicide is defined as a death caused by self-directed injurious behaviour with the intent to die as a result of the behaviour (Crosby, Ortega & Melanson, 2011). A Suicide attempt is described as any non-fatal suicidal Act with the aim to inflict hurt or



harm on oneself, which may or may not have a life-threatening intent or end (Harmer, Lee et. al., 2021). One of the first questions that come to mind when you hear about suicides is what would have pushed an individual to take such an extreme step. To find the answer to this, it is essential first to understand that suicide is a complex interplay of vulnerabilities, risk factors and triggers (bio-psychosocial determinants) in an individual's life. It is rarely caused by a singular event or circumstance and is often influenced by multiple factors of economic, social and individual experiences.

Risk factors associated with suicide

A risk factor is anything that increases the vulnerability to having suicidal thoughts and/or Act on them. Most of the time, several circumstances interact to cause a suicide attempt. Having said that, it's crucial to understand that the sheer existence of risk factors does not compel a person to attempt suicide. For instance, not everyone who has lost their job or relationship has suicidal thoughts. Distal and proximal factors are at play; proximal factors are related to recent developments, while distal factors refer to long-term issues. National Crime Record Bureau (NCRB) report on suicides provides data on risk factors based on psychological autopsies, qualitative research and case reports that recognise globally reported risk factors (Cramer & Kapusta, 2017). The WHO report divides these into five categories that often interact and influence others, while none is mutually exclusive.

1. Individual factors: Biological causes or an individual's history such as mental illness like depression and substance use. Other factors include financial loss and academic failure.
2. Interpersonal factors: Nature of interpersonal relationships such as lack of social support, social isolation, abuse, trauma, relationship conflicts, loneliness, grief and loss.
3. Community factors: Schools, workplaces, neighbourhood experiences such as discrimination, community violence, the stress of acculturation, gender and caste.
4. Societal factors: measures that support the preservation of social and economic inequalities like access to lethal means such as pesticides, the stigma associated with mental illness and help-seeking, unsafe media portrayal of suicides.
5. System factors: Multiple barriers to accessing the healthcare system puts people at risk of suicide.

Impact of Language

Language plays a huge role in perpetuating the stigma around mental



illness and suicide. Recognising how we talk about suicides reflects our attitude and perception towards it is imperative. Phrases like 'committed suicide' that are used frequently in everyday conversations and even media reporting shift the blame on the individual and create a negative association with acts of crime. Our language about suicide matters because it shapes our perceptions and attitudes and those of others. Being mindful of using language that is empathetic, non-judgmental and sensitive will aid in reducing the stigma associated with suicide.

Debunking Myths around suicide

Myth: Most suicides happen as an Act of impulse without any warning

Fact: The Majority of suicides are preceded by warning signs that could be verbal or behavioural. Some suicides may be sudden, but it is essential to be aware of the warning signs to look out for. These signs may be difficult to recognise and understand. They may be expressed directly (e.g. when a person talks about ending their life or has been thinking about it), or they may be expressed indirectly (e.g. when they talk about general futility towards life and feeling of hopelessness).

Myth: A person talking about suicide is looking for attention

Fact: Talks about suicide must be taken seriously. These need to be looked at as a sign of help-seeking and support from others. Even if the problem they expressed may not be of such magnitude that would culminate into ending one's life, we need to be mindful that their experience and its emotional impact on them may differ from yours.

Myth: Ending one's life is an Act of weakness or courage

Fact: Labelling or glamorising suicides does not help in reducing the stigma. A person thinking of suicide is often experiencing overwhelming emotional distress and is experiencing intense negative feelings of hopelessness and helplessness to bring about any change to the situation or the environment that often drives such behaviour. What they need is non-judgmental support.

Myth: Asking someone if they are suicidal can incept the idea of doing so

Fact: On the contrary, if you recognise someone showing warning signs of contemplating suicide, the only way to know is to ask directly, even though it may be hard to do. Asking about suicide does not increase the likelihood of suicidal behaviour; instead, giving them a safe and compassionate space to open up about it would provide a sense of relief, often as a protective factor.



Myth: Once a person has intent on suicide, they are determined to do so

Fact: Suicide is preventable. Suicide helplines can certainly help when the urge is impulsive. When someone opens up to you about their suicidal tendencies, providing them immediate practical help by empathetic listening, being there with them and encouraging them to talk can deflect the intention. Suicide counters can be used like religion; talking about the consequential impact their death would have on their loved ones, changing their perception about their life, and showing them responsibility and a brighter side of why they live can certainly delay their intention and prevent suicides.

Myth: All people who are at risk of suicide have depression or other mental illness

Fact: In high-income nations, 90% of suicides had a concurrent mental health diagnosis, such as depression (Vijayakumar, 2004), whereas, in South Asia, just 60% of suicides (Lancet, 2014) have found this indicative of other psychosocial and intersectoral aspects contributing to it. This is particularly commoner among youth.

Comprehensive Approach to Suicide Prevention

Awareness, Accessibility, and Actionable measures at multi-sectorial levels are the key to developing suicide prevention strategies that involve the health sector and all other sectors such as education, agriculture, labour, business, social welfare, law, defence, justice, finance, politics and the media. It needs to be a comprehensive, collaborative and coordinated system that works with a wide range of partners, organisations like governmental, private, and non-profit organisations, including people who have been affected by suicide which is designed to reach the entire population with the aim to achieve ‘zero suicides’ as a goal. A landmark development ensuring dignity and a humane perspective to the issue by the Government of India has decriminalised suicides and assuring adequate medical relief to those attempting it in the Mental Healthcare Act, 2017.

Table 1: Comprehensive approach to suicide prevention

Strategy	Approach
Education-based strategies	<ul style="list-style-type: none">• School-based Awareness programs that focus on life skills training, teacher training on Mental Health Curriculum and parent awareness programs.• Universities and colleges to include mental health awareness programs

Strategy	Approach
Healthcare systems and health policy	<ul style="list-style-type: none"> • Tele-mental health services • Primary Healthcare providers and staff training in sensitization and identification of mental health conditions. • Screening for at-risk individuals and strengthening the referrals for counseling services and support • Stress and crisis intervention Helplines • Healthcare policies to include mental health insurance
Community-based strategies	<ul style="list-style-type: none"> • Awareness programs in Resident Welfare Associations • Psychological First Aid training • Gatekeepers Training (e.g, QPR model: question, persuade, & refer) • Strengthening social support including minority, gender
Workplace mental health strategies	<ul style="list-style-type: none"> • Mental health and wellness programs • Policies and culture that support individuals with mental health problems
Targeted approach to reduce suicide behaviour	<ul style="list-style-type: none"> • Treating people with alcohol or substance abuse problems • Support to people with chronic illness or disability
	<ul style="list-style-type: none"> • Programs for people who have previously attempted suicides • Reduce access to lethal means like pesticides, OTC drugs • Programs addressing socio-economic factors like poverty, inequality, unemployment
Media Reporting of Suicides	<ul style="list-style-type: none"> • Safe Media Reporting Practices

Education-Based Prevention Programs in Schools and Universities

An increasing number of suicide deaths among young people is becoming a growing concern. The pandemic has only made suicide risk among some adolescent populations worse. According to the National Crime Record Bureau (NCRB) report 2021, more than 13000 students lost their lives in India, and there



has been a 27% rise in student suicides in the last five years from 2016-2021. Schools offer a crucial opportunity for early identification, risk assessment and youth suicide prevention. Youth spend a lot of time in schools, which makes suicide prevention initiatives more accessible and logistically possible. Additionally, research demonstrates that parents and other caregivers are frequently unaware that their children are engaging in suicidal thoughts or actions, emphasising school-based interventions' significance.

Schools play a crucial role in sensitising and building skills in students, giving them consistent and direct contact that teachers, school counselors and administrators have with children. Their engagement in creating a safe and secure environment for students to thrive is critical to their mental wellbeing. Given the various factors that impact a student's life –family problems and changing structures, peer pressure, bullying, the role of technology, and academic and competitive pressures, it is imperative to impart life skills to students to navigate these challenges. Lack of addressing mental health problems during school years can have long-term consequences during their adult years, leading to poor interpersonal relationships, low self-esteem and overall poor quality of life. In addition, undiagnosed and untreated emotional and behavioural problems in students can result in maladaptive coping mechanisms like drug use, risk-taking behaviours and school dropouts that may also lead to the development of mental illnesses like anxiety, mood disorders etc. (Colizzi, Lasalvia & Ruggeri, 2020). According to the NCRB report on suicide deaths in 2021, family problems, relationships, failure in examinations and illness were some of the top reasons for death by suicide in students below 18 years, while between 2019-2020, failure in examinations was one of the key contributing factors.

Life Skills Programs that are designed with a broad focus on equipping skills that will aid students to navigate day-to-day challenges would help strengthen the preventive mental health in students. Inculcating problem-solving, emotion management, critical thinking, decision making and social skills through everyday interaction and engagement builds resilience & self-efficacy among students necessary for healthy self-development and overall wellbeing.

Teacher training in Mental Health Curriculum must be integrated into the existing education system in schools. Taking an educational approach towards mental health will aid in building suicide-related awareness based on facts and the correct information. Concurrently, normalising it as a part of day-to-day conversations in the school will reduce the stigma and encourage help-seeking (Parikh, Singh & Chhibber, 2020). Teachers play a significant role in a student's life, and an encouraging positive approach to discussing mental health in the classroom will enhance the culture of wellbeing within schools.



Parents are often unaware of what children are undergoing in the form of emotional and mental health issues that manifests in their behaviours. This exists due to the lack of knowledge among the parents and general population about children's emotional, behavioural and psychological issues. Therefore, awareness programs that sensitise parents about the signs and symptoms of mental health problems (and suicide) and even how best to support their children are critical in the prevention and intervention process.

There are numerous and reliable statistics from all over the world indicating that college students have greater rates of depression, anxiety, and drug use (Auerbach, Alonso et. al., 2016 & Jaisoorya, Gowda et. al., 2018). Yet colleges in most parts of the world and India do not have the infrastructure required to address mental health concerns (Jaisoorya, 2021 & Sunitha & Gururaj, 2014). There is a need for robust mental health support systems that build awareness through the correct information and equip students to identify common signs and symptoms of mental health issues (and suicide), address the stigma and promote help-seeking behaviour. In addition, peer-to-peer support and accessible counseling services should be made accessible to all students for timely intervention (The WIRE, 2019).

Healthcare Systems and Policy

Treatment for mental illness is scarce or inaccessible due to a lack of specialists and health resources. The availability of the mental health workforce, including psychiatrists, clinical psychologists, psychiatric nurses, and psychiatric social workers, is one per 100,000 persons, or around one qualified psychiatrist for every 250,000 people (Gururaj, Varghese et.al., 2016). In addition, the distribution of mental health professionals and facilities is skewed toward major cities. Primary physician practitioners are the initial point of healthcare in India, even for significant mental health disorders (Lahariya, Singhal et. al., 2010), and two-thirds of people living with mental illness never seek treatment. The gaps in treatment and accessibility continue to persist, given the magnitude of the problem and require robust health-supported systems to make mental health services accessible and affordable.

Tele-Mental Health Services: Due to the COVID-19 pandemic, there has been a significant disruption in the current traditional modes of providing mental health services, bringing forth the need for alternate service delivery models. Tele-mental health during such times came as a boon for making mental health services accessible. Recognising its dire need, the Government of India, in its recent union budget (2022-23), announced the National Tele-Mental Health Program (NTMHP) launch. This is a welcome step and needs to be adopted by more service providers.



Primary Healthcare Providers (PHC): Training of primary healthcare providers at hospitals, government, private and clinics, including doctors, nurses, and staff at all levels, is necessary to identify the at-risk individuals, given they are first responders to people struggling with physical and co-morbid mental health issues. Screening tools can be used to identify mental health concerns and suicidality and refer such individuals to specialist care.

Helpline Services: Crisis intervention or stress helplines to support people in crisis or needing help can aid a great deal in preventing suicides—helplines in vernaculars to cover the range of the population. Several organisations are committed to the cause of mental health and run a 24X7 helpline providing counseling support. (Numbers for a few mentioned towards the end of the chapter).

Mental Health Insurance: National Health Policy (NHP), 2017 of India introduced Universal health coverage to accelerate the policy attention and intervention, which highlights that “all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship while paying for these services”. Yet there is an urgent need to Act on this goal by increasing the financial allocation and developing mechanisms that aid people in maintaining continued support for the services without feeling the ‘out of pocket’ pressure (Lahariya, 2018). Mental health coverage in insurance policies certainly needs to step up to address the critical challenge in mental health services.

Community-Based Strategies

Community plays a significant role in maintaining and contributing to an individual’s wellbeing. Lack of support, acceptance, discrimination, stigma, out-casting a group or general disconnectedness in our society and within communities can create feelings of shame, guilt, loneliness, anger and helplessness, thereby impacting individuals with mental illness, their families and even influencing the general attitude and perception of the people living within those communities. NCRB data on suicide deaths in 2021 has reported an increase of 8.5 % in suicide deaths in 53 mega-cities of the country, with family problems being the top concern, followed by illnesses, alcohol addiction and marriage-related issues. This highlights the need for building sensitisation on how changing societal structures, increasing stress levels and growing disconnected affect the mental health of individuals at large.

Psychological First Aid (PFA): The most humane, supportive and practical form of support an individual can provide to anyone in distress is Psychological First Aid (PFA) (WHO, 2011). With the rapid changes in relationships, family structures, lifestyles and increasing pressures across age groups, the odds of

someone experiencing emotional distress are higher. There is a need for safe spaces to talk, share and express, which can only be provided by people around through their patience, empathetic listening and a compassionate approach which acts as a cathartic experience for the person in distress. It involves both taking care of oneself and extending care towards others. Every individual must make a genuine effort to provide PFA, whether a teacher, parent, employer, work peer, neighbour or friend. According to the WHO, the three action principles are Look, Listen and Link, which individuals can understand, learn and apply the do's and don'ts to extend their support towards those who need it. This is also a step towards building more robust support systems which are much needed within society.

Gatekeepers Training (GKT): Creating a network of “gatekeepers” is another effective strategy to prevent the rising incidence rates of suicides worldwide. Gatekeepers are people who actively work towards preventing suicides in the community by investing their time and energy through training on the information and abilities to identify and help people with suicidal ideations promptly. Research suggests that GKT improves people’s knowledge, skills, and confidence in helping individuals who experience suicidal ideation (Burnette, Ramchand & Ayer, 2015). Gatekeepers can be anyone teachers, parents, counselors, police personnel or front-line workers who may be the first responders to people with suicidal thoughts. The gatekeepers training programs focus heavily on training service members in knowledge about suicide, beliefs and attitudes about suicide prevention, addressing the stigma and reluctance to intervene and enhancing their comfort and competency to identify, extend care and facilitate referral for at-risk individuals. Some commonly used models with proven effectiveness include QPR (question, persuade, and refer) & ACT-model (ask, care, and tell to a responsible person).

Promoting Workplace Mental Health

Over the years, the working environment has gone through massive change, which has undoubtedly brought opportunities for self-growth and innovation. However, this rapid change has also precipitated an increasing stress level, especially if the work environment does not promote a culture of mental wellbeing. Research has shown that a poor work environment leads to physical and mental health problems, absenteeism, a decline in productivity, and harmful use of substances or alcohol. It is estimated that depression and anxiety, two of the most prevalent mental diseases, cost the global economy US\$ 1 trillion annually in lost productivity (WHO). As per the NCRB report on suicides in 2021, death by suicide amongst professional and salaried persons has been 9.7%. This highlights the need for Workplace Mental Health Programs to address the employees’ growing stress and mental health needs. A focus on



creating a positive mental health culture in the organisation that aims to build a healthy work environment and ensures support for people with mental illnesses is required.

- Building mental health awareness to address the stigma and create an environment where mental health conversations are supported.
- Assessing the needs of the employees and developing policies that provide better accessibility and affordability for mental healthcare needs.
- Encourage leaders to play an empathetic and supportive role by empowering the employees and involving their participation in decision-making.
- Consistent communication on support being available whenever they need it.
- Strengthening peer-to-peer support and promoting an inclusive environment.
- Screening of stress audits and identifying at-risk employees who may show signs of anxiety or depression or alcohol or substance use.
- Providing referrals and encouraging them to seek help from mental health professionals.

Targeted Approach to Treating At- Risk Individuals

The link between mental disorders and suicides has been established for long. While high-income countries show a stronger association between mental illnesses like depression and suicide (National Mental Health Survey, 2015-16), in low and middle-income countries, other socio-economic factors have more role to play. Pesticide self-poisoning is the cause of 20% of suicides worldwide, most of which occur in rural agricultural areas of low- and middle-income nations. The use of guns and hanging are additional methods used for suicide (National Mental Health Survey, 2015-16). NCRB report of suicide deaths in 2021 showed 25.6% suicides amongst wage earners, 8.4% among unemployed persons and 14.1 % among homemakers highlighting poverty, unemployment and inequality as major socio-economic factors that require targeted attention.

Illness and Suicides: Psychiatric disorders are linked to suicides, with depression and substance abuse being the most common prevalence (Brådvik, 2018). Substance abuse increases the chance of overdoses, including fatal and non-fatal ones, suicide attempts, and suicide death. Individuals with alcohol dependence and drug users had a 10–14 times higher risk of dying by suicide than the general population, respectively, and about 22% of suicide deaths have involved alcohol intoxication (Wilcox, Conner et. al., 2004 & Esang & Ahmed,

2018). Patients with a history of psychiatric illness should be screened for risk of suicide, and prevention strategies should be put in place with first-line responders can be family members or nursing staff. Even patients with chronic physical illness or terminal illness like multiple sclerosis, brain or spinal cord injury, HIV/AIDS, cancer etc, should also be screened for suicide risks (Navin, Kuppili et. al., 2019). Restricted access to lethal means like removing sharp objects, cables, and cords, ensuring grilled windows, 24-hour supervision of the patient, limiting to linens in the room, providing medications under supervised care and starting psychological therapies for developing adaptive ways of coping are some of the key prevention measures that should be immediately implemented (Herrmann, Mittman et. al., 2003).

Programs Targeting Socio-Economic Factors: It is crucial to understand the role of social and economic determinants in suicide prevention. For example, unemployment, financial stress, inequality, and unfair work practices are some major contributing factors to suicide, as also represented in the NCRB report. Therefore, specific prevention and intervention programs focused on providing financial aid, restricting access to pesticides and addressing literacy and unemployment while ensuring access, surveillance, and monitoring can be effective strategies for suicide prevention.

In Sri Lanka, suicide mortality dropped by 21% through restrictions on pesticides, a common method for suicide deaths by agricultural pesticides, even in India (Knipe, Chang et. al., 2017). Similar models of suicide prevention integrated programs are required where farmers can be educated on the benefits of storage and give free-of-charge lockers to store pesticides, as studied in the Mehsana district of Gujarat (Pathare, Shields-Zeeman et. al., 2020) through a community intervention program SPIRIT. Cash transfer programs in Indonesia to the poorest reduced yearly suicide by 18% (Christian, Hensel et. al., 2019). It is imperative to focus on education and economic sectors to derive more considerable gains at lower costs by developing programs that cater to the social determinants.

Role of Media

One of the common concerns that contribute to stigma related to death by suicide is the fear that talking about suicide is going to encourage people or increase the likelihood of ending one's life. To address this, it is vital to understand the phenomenon of 'copycat suicides' and media reporting around suicide deaths so that rather than preserving either a dismissive or sensationalised approach towards death by suicide, we can build a more sensitive narrative around it. Research into the causes and prevention of death by suicides has identified a copycat phenomenon called the 'The Werther Effect' (Phillips, 1974) where



media reportage of suicides leads to an increase in suicide deaths in the general population. This term historically comes from the novel 'The Sorrows of Young Werther', who takes his own life at the end of the novel (Wellbery, Ryan et. al., 2004). There was a spike in emulation suicides after a widely publicised suicide during the period. According to research, suicide coverage in the Indian news is brief, explicit, repetitive and potentially detrimental (Armstrong, Vijayakumar et. al., 2019). In addition, many English-language publications regularly reveal the name of the deceased and their suicide technique while making minimal mention of resources for preventing suicide (Armstrong, Vijayakumar et. al., 2018).

Instead, the media should play a role in creating the 'Papageno Effect', which is the opposite of the 'Werther Syndrome', named after the character Papageno from Mozart's opera the 'Magic Flute' (Sisask & Varnik, 2012). Media need to play a responsible role, stop sensationalising suicides and focus on the negative consequences of such incidents. Reporting of suicide fatalities among those with greater social rank and members of populations who are more closely associated with their primary audience (Ganesh, Singh et. al., 2020) and coverage of specific suicide methods, stigmatisation of mental illness, and audiovisual content that puts vulnerable audience members in danger is the result of the media's selection bias and encourages false beliefs about the risks and methods of suicide (Vijayakumar, Chandra et. al., 2021). Through the coverage of non-suicidal alternatives, the press can create a Papageno effect. For positive and responsible reporting of suicides, the WHO has suggested guidelines which would increase awareness, encourage help-seeking, stories of individuals who have overcome suicidal thoughts and promote effective coping mechanisms that aim to reduce suicide and related behaviours and can Act as a protective factor.

Conclusion

Suicide Prevention requires a collective, empathetic and genuine response at multiple levels addressing the psychological, social, economic, policy and community factors from all stakeholders involved in the sectors. Along with it, improved surveillance, monitoring, timely data collection and effective strategies are warranted for better implementation, assessment and evaluation of the system and policies. Every life counts with each effort put together in the direction of suicide prevention.



Helpline Numbers:

1. Kiran 24x7 Toll-Free Mental Health Rehabilitation Helpline by Department of Empowerment of Persons with Disabilities (DEPwD), Ministry of Social Justice & Empowerment.
(1800-500-0019)
2. Fortis 24X7 National Helpline available in 14 different vernaculars
+91-8376804102
3. Vandrevala Foundation 24X7 National Helpline
+91- 9999666555
4. Sneha Chennai
+44 2464 0050
5. Aasra 24X7 Helplines
+91-9820466726
6. NIMHANS Helpline
080-4611 0007



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- <https://www.who.int/news-room/fact-sheets/detail/suicide>
- <https://www.who.int/news-room/commentaries/detail/mental-health-in-the-workplace>

Human Relationships and Wellbeing

Relationships are tender threads that hold us strong. They provide a sense of belongingness, make life worthy of joyful experiences and support us to keep our lives in order even amidst adversities. During our life course, we experience several relationships; some we are born into, others we land up into as a part of schooling with our teachers, classmates, within our neighbourhoods, at the workplace with colleagues, and some we have the privilege to choose for ourselves such as friends, marriage partners or partners in our live-in relationship. Beyond the labels, each relationship has a sanctity of its own and has a critical significance in anchoring our life. Many of these relationships have the propensity to shape our purpose in life, whereas, others give us essential ingredients such as love, warmth, affection, excitement, joy, and intimacy. In any relationship, there are expectations of outcomes of what we will do for each other. Relationships are also defined in terms of conduct, illustrating how we will behave with each other and what are the boundaries. However, all relationships are surrounded by the expression and flow of emotions. Healthy relationships energise us and make us feel good about ourselves. One feels respected and valued, and there is space to express one's thoughts, feelings, beliefs and ideologies. However, if interactions in relationships make us feel overwhelmed, intimidated, suffocated, or subjugated or do not give us the space to be ourselves, then it means something has gone wrong somewhere. These may also be marked by breakups, make-ups, false promises, or empty apologies. This could even be true in a parent-child, sibling, or romantic relationships. We are subtly and sometimes overtly groomed into conduct and outcomes in relationships, yet it requires a lot to nurture to maintain relationships. In certain relationships, we are expected to be a giver. In some, we claim the right to receive all the privileges, and in some, we alert ourselves that it's all about give and take and deciding to reciprocate how well others handle us.

Rights and relationships are a contradiction in terms! To be in a relationship means to do the best to one's capacity for those involved in the relationship. However, that is not always true in the real world. There are relationships where one partner is trodden on or hurt or deprived of their dignity, which is why there



is a need to ponder on rights and relationships when a utopian relationship would be one of giving and sacrifice. A right is an entitlement sanctioned by an established authority, the State. A Right has three components – The subject or the right holder, the content or the subject matter of the right and the duty bearers. Rights are enshrined in the constitution, but there is the human element that gives 'life' to the right- these are the duty bearers. A long chain of people in different capacities and statuses whose duty is to ensure that rights are not violated nor denied. Human rights emerge from the need to ensure that every individual can live a life of dignity and a life that is worthy of being. While Human Rights address all human beings, there are some categories of people who require Human Rights plus something. Often, these groups are invisible to society – unseen and unheard. These may include women, persons with special needs, children or any other by their disadvantaged status.

All human beings enter into a relationship either by one's volition, as in matrimony or naturally, as in the case of biological families, or the application of the Best Interest Principle for children, as in adoption or foster care. All human beings are in multiple relationships. These relationships here do not refer to a couple relationship; therefore, we reciprocate in every relationship quite differently.

The Connection Between Rights and Relationships

In the first case of a relationship of one's own volition, it is assumed that the players are adults, either capable of taking their own decisions or have been counseled by well-meaning people around them; sometimes even coerced or bowing to societal norms and have decided to live their lives together. This sometimes is called marriage. How often have we heard of women rights being denied and violated? We must not forget passive violence which is perpetrated on both men and women. Unfortunately, the political, economic, and social environment in the last few decades has concentrated on accumulation, accrual, returns, etc. This thought has spilled over into relationships for 'rightful' claims-physical, emotional and financial. The concept of duty and responsibility seems to have vanished from society. Whether it be parents towards children, children towards parents, siblings towards each other, partners or even peers. The greed to have their own needs fulfilled overrides all considerations.

Children came into this world through parental choice. Parents may often consider them as their property and they may thus make all decisions for them. Parents may want to keep children dependent on them, at least emotionally. Children, however, need to find themselves and their lives. Each child is an individual who has qualities and capabilities which a parent needs to nurture and refine rather than compare them to others. Parents need to refrain from giving



negative statements, or children can start believing in the same. Labels that children live with can be taken as one's identity. The parent-child relationship is loaded with innumerable commands and statements of expectations that children need to live by. Thus, parent-child communication is often a characteristic of what a parent wants to see in them. In some families, these commands are non-negotiable. In some, they are co-created as per the abilities and temperament of the child. Some families feed their children with energies of motivation and possibilities and are mindful of avoiding criticism or comparison flowing in their interactions. The parenting outcomes, particularly regarding the quality of relationships and emotional wellbeing of children, are qualitatively different in two families. Comparison and competition makes a child see himself as others, and may react or coil in to counter the pressures. Whereas, in democratic and sensitive families, children may strive to be their refined version and grow up to be contented and calm people who value themselves and their lives.

In the case of parents and children, biological, adopted or in foster care, one has to ensure the Best Interest Principle of the child. The United Nations Convention on the Rights of Children (UNCRC) gives a broad framework for Governance and policy, but how can it be ensured that children are protected and cared for within the four walls? The answer to all lies in 'education' in the broadest sense. If society learns to respect individuals and others around them, and believing that every living creature has a right to dignity of life. The right to life without dignity is no right and is no life. Thus, all legal provisions need to be backed up with education.

An eight-year-old girl came in with her parents to the Child Guidance Centre. Amongst many developmental concerns that the girl was manifesting, several episodes of bullying by classmates also surfaced. However, the mother did not consider that as a point of concern. Instead, she wanted the counselors to help her daughter with better academic performance. During the clinical work process, parents were made to reflect on their daughter's emotional wellbeing, particularly about an episode of abuse in school, when three four classmates harassed the girl by physically abusing her and cutting her skirt and hair with scissors in the school itself. The child did not seek any support from the teachers or classmates, nor did she ask the mother to handle the situation for her in the school. Eventually, the mother shared that maybe her daughter had gotten habituated to this kind of maltreatment. She shared several anecdotes to bring out her disappointments relating to her marriage at the age of 20, followed by conceiving a daughter in her first year of marriage. She could neither enjoy courtship nor married life as she became a mother at a very young age. All her dreams were clipped by responsibilities that came rushing to her without her choice. She did not know how to negotiate with society, family and her partner. She would thus vent her anger and disappointment by pinching her daughter



whenever she cried or demanded something. She disregarded the emotional needs of affection and proximity of her daughter. The recovery process now required intensive interventions to restore parent-child relationships through parent training in emotional engagement between parent and child, grooming the girl in skills to negotiate with her parents and peers to meeting her emotional needs, giving her tools for emotional expression and many more. The process was prolonged and required frequent follow-ups and consistent interventions.

This situation needs to be seen from multiple perspectives. First, this can be seen as a situation of child abuse. Mother was emotionally neglecting and abusing her own daughter, and she does not have the right to do that even though it was her own child. Schools also need to assume the responsibility of keeping a vigilant eye on what peers are doing to each other in a class. Children in a class need to be groomed into the management of their emotions and the need to grow collaboratively, or else aggression will continue into adulthood. They will then undermine the dignity and wellbeing of fellow beings in families, workplaces and all other relationships without a sense of remorse.

Jhilmil's mother had died in childbirth five years back, and it was up to Jhilmil to take care of her three younger sisters and father, who was a rickshaw puller. The neighbourhood was an unauthorised colony, home to carpenters, rickshaw pullers and the like. It was the year 2020, the year of the coronavirus pandemic. While many had fled as the lockdown was announced, there was still a large population left behind. Neighbours noticed that fourteen-year-old Jhilmil was putting on weight. Look at her stomach, said one of the ladies; another gasped, is she pregnant? But how? Who is the guy? The woman wondered. Finally, one of the older women found an opportune moment to speak to the girl and was shocked at the story that tumbled out in a matter-of-fact tone.

Her father had been abusing her for some years. He always used a condom, but now that the shops are closed, he does not have condoms. So she was now pregnant and did not know what to do!

Aware of the law, the ladies reported the matter to the police, who placed the girl through a Child Welfare Committee in a Child Care Institution (CCI), and the unrepentant father was arrested. The CCI staff convinced the girl to abort the child, and the matter ended there. However, in actuality, the matter does not end here. Jhilmil and her siblings will grow up with these scars of childhood. They will have ambivalent or negative feelings towards fatherhood.

Such situations can be prevented. Young adults have to be prepared before they get into wedlock or choose to be a parent. They must be emotionally and mentally prepared for marriage and have the right parenting skills to create the best outcomes for their child. Policies and laws, such as age at marriage,



cannot be sufficient. We need to have systems that groom youth to have healthy, fulfilling relationships in a marriage. We need to have processes that groom young parents into the science and art of parenting. Merely paternity and maternity leave will not take care of real parenting needs. In the first case, considering that the mother had mental health concerns and was not fit to be a mother, rescuing and sending the child to a Child Care Institution cannot be befitting. There is no guarantee that the little girl will find an emotionally enabling environment in the institution. The emotionally traumatic experience of being away from the family in an institution can further complicate her trauma.

Growing up as healthy individuals, who acquire developmental and emotional milestones, learn healthy social skills, and have tools to cope when there are problems, requires a complete ecosystem. Happy childhood depends on the parents and caregivers who Act as their first support systems. However, parents can also have their mental health challenges. They too may be trying to cope with their fears and worries and find it difficult to understand the needs of their children; are unable to go beyond meeting the instrumental needs of their children and are unable to give happy experiences to their children as a part of its growing up process. Parents and children may also experience shared risks, such as inherited vulnerabilities, living in unsafe environments, and facing discrimination or deprivation.

Numerous legislations, including The Juvenile Justice (JJ Act) (Care and Protection of Children) Act 2021; Protection of Children from Sexual Offences 2012 and its amendments; The protection of Women from Domestic Violence Act 2005, aim to safeguard the best interest of the child and ensure care and protection to children. However, something is missing in our efforts to give children a safe and happy childhood. We have to look beyond legislations and create awareness about legislation in society.

As a part of growing up, we experience different shades of relationships. A child can feel happy with any child in his immediate vicinity in class and share small, tender but meaningful daily life experiences. Gradually, children develop affinities with some over others and come to be seen in groups and cliques. Around adolescence, the need to have more satisfying, personalised experiences makes us choose friends to whom we feel accepted and understood and attracted sexually. Parallely, what emerges is to possess the relationship so much that we may demand exclusivity of time and attention and would not want this "special" friend to be a friend to anyone else for any interaction. This is also seen to continue even in a marriage where the couple possesses each other and feels jealous if the partner shares joy in other relationships, especially at the cost of their relationships. The relationships turn into power struggles, and each may control the relationship overtly or in passive ways of non-conformity, abuse and



neglect of each other's needs. The individuals may even try to seek emotional support outside this relationship and justify the same by deceit received from the companion.

The situation can be reversed if there is efficient programming and sensitive grooming about relationships, types and purposes of relationships, boundaries, and responsibilities in a relationship. For example, in many schools, as a part of the school mental health programme, the counselor may regularly organise Circle Time Activities, where children sit with each other and listen to each other's experiences, reflect on the situation of their classmates and assume an empathetic position where children come to understand varied emotions and context of people and introspect on ways to be supportive of each other in their journey of life events. An almost similar scenario could be understood in the form of support groups that are created to anchor people in distress, such as Alcohol Anonymous. Support groups, whether in the form of extended family, friends or more purposefully designed groups such as chanting groups or congregations, are the needed safe spaces where people can unload their worries, gain perspectives and find navigation to move ahead in life.

A news item claimed recently that a racket involved in child trafficking was busted. The entire sequence of trafficking was carried through a hospital where young, unwed pregnant girls who came in for abortion were trapped. They were encouraged to continue the pregnancy and to give the child to childless couples. In the process, these children were sold for large sums of money. A twenty-year girl was caught in a sting operation and landed in the hospital to abort her seven-month pregnancy. She was unmarried and was utterly disappointed that her boyfriend left her alone and disowned the relationship. The girl accepted the emotionally loaded proposal of the traffickers and gave birth to a girl child. This case was identified in the sting operation and the baby girl was rescued. The perpetrators were arrested and booked under the Indian Penal Code and JJ Act (01 September 2022 news item). The scenario brings out immaturity in intimate relationships, pre-marital sex, unsafe sex, inability to assume responsibility in relationships, reproductive rights and many more. It not only brings out an issue of trafficking but of the larger fabric of consensual sexual relationships in young adults and how the ecosystem is grooming youth and adolescents into having sexually responsible and mature relationships.

During young adulthood, the youth has to become physically, socially, financially and emotionally independent from the family. However, this does not mean an emotional cut-off from the family. They need to strive to develop their unique identity. They need skills to build intimacy and an ability to create and maintain close relationships that can endure hard times and other challenges. In an intimate relationship, one thrives through commitment, compatibility, and



attachment with someone who is not one's family and learns to share emotions. One has to discover who they are outside of their family and within one's family. One's ability to develop an intimate relationship depends on how successful one is at developing their identity earlier in life. This also demands that the individual come out openly with the family with their thoughts, feelings and orientations. If one is, for example, a lesbian, gay, bisexual, or transgender person (LGBT), this stage may include making the sexual orientation known or "coming out" to family and friends.

Exploring interests and career goals paves the way for developing independence. Living successfully, away from the family and developing financial and emotional autonomy must be prioritised. The individual must begin to be responsible for one's health, nutritional, physical, and medical needs. Healthy habits must be focused on at this time, such as good nutrition, regular exercise, and safer sex practices. Another critical dimension is establishing oneself in work or a career. Core virtues earned through this stage, such as trust, morals, initiative, and work ethic, promote a smooth transition to other stages of life. More advanced educational institutions over the past decade have been affirming the need for Life-Skills education, particularly for adolescents, so that they emerge as thoughtful, sensitive individuals who can make informed choices for their best interests.

Becoming a couple, either by marriage or a committed union is another stage of life. Intimate relationships involve a process of adaptation and relationship building. Marriage or committed union often requires these unique skills. When an adult joins a family through marriage or committed partnership, a new family gets created. The new union must make a delicate mix of one's ideas, expectations, and values shaped by their family of origin and their lived experiences with peers, colleagues and others. In a marriage or a union, the couple has to reshape their goals with that of the partner by understanding different points of view and creating a third, or a better option, essentially the one that is realistic for this stage of life. They find ways of managing finances, relationships with in-laws, their sexuality or sexual compatibility, friendships, recreational activities and overall lifestyle. The ultimate goal at this stage is to achieve interdependence, which occurs when one is fully able to enter into a relationship with another person. Most researches show that a happy marriage is full of passion and sexual intimacy in the early phases. However, these can become less important in later phases of marriage. A satisfying marriage at all stages requires critical analysing and placing others' needs over one's own to nurture mutual interdependence.

The Search for Equality, Respect and Dignity

A couple may think of having a child at some point in marriage or the union. Some couples may decide not to have children as they may find child care demanding, challenging and time-consuming and may fear compromising some of the critical aspects of their life, including personal space and time, career etc. Deciding to go in for having a child brings in more role, dimensions and a higher need for support systems to meet the new demands and continue with what has been satisfying and meaningful in earlier stages of life. Taking on the parenting role and transitioning from being a couple to being a parent brings emotional turmoil. Often, the couple may triangulate the child in their conflicts and offload their concerns as complaints to the child, who does not know what position to assume. He may cease to be a child and is expected to be a mini adult who is to anchor the marital challenges of his parents. During this stage, the couple needs to evolve further into a new dimension of their relationship as individuals. They need to continue expressing their individuality while working together to hold the marriage firm.

Children benefit when their parents have a strong relationship. Caring for young children cuts into the time a parent may have for themselves or each other. However, couples who have successfully negotiated their needs and can look after the family unit's needs and draw meaning and purpose from these relationships, find this stage rewarding and happy despite challenges. Parenting demands that the parent provided a safe, loving, organised and consistent environment where children explore their individuality and grow purposefully. Parenting rests on certain beliefs and a whole range of parenting practices aligned to the child's developmental needs and temperament. Love, care, warmth, and nurturance are the essential ingredients of parenting, but it equally calls for some authority that rests with the parent, as the child may not have all the wisdom to answer all growing issues. However, parents have to balance control with a sense of empathy for the child in alignment with the child's needs, wishes, abilities and rights. When the child feels that the parent values their special uniqueness and has their best interests at all times, the bond deepens, and the child cooperates and reciprocates to structures and responsibilities allocated and strives towards mature behaviours. The interactive space created between the child and parent rests on open communication of feelings and thoughts, mutual problem solving and respecting everyone's individuality. Parents can demand socially mature behaviours for age and qualities of independence and interdependence. These dynamics can be swayed in families where parents either become too demanding of the outcomes and achievements, set unrealistic goals for their children or are too rigid; wherein there is no scope for dialogue and decisions taken by parents have to be honoured in every way. This restricts warm and loving interactions between parent and child, or the child has to work very hard to keep the parent



pleased for some happy experiences. Such children are likely to withdraw socially and feel anxious and unloved most of the time. Living with continuous fear of rejection, children may strive for perfection and overly focus on achievement at the expense of necessary emotional growth. They may turn rebellious, fail to develop good interpersonal relationships, or may not develop the essential individuation required to become fully functioning adults.

Certain parents may take on the role of showering love but fear losing the relationship by demanding or structuring their lives. They do not mind giving in to demands and granting excessive entitlements. These children lose out on emotional maturity and self-regulation accomplishments and may not be valued as desired peers and friends. They do not respect authority and may get into conflict with them frequently. Parenting practices are not written predicaments to be followed, but each couple or family develops it mutually to give each other meaningfully happy experiences while living together. A parent may choose to reverse the processes as they grew up, thinking that did not yield what they wanted from their life. Some may follow what others do, or they may not be with time in the ever-modernising world. Couples become wiser having raised their first child, but the lessons learnt may not fully apply to the second child due to their gender, temperament or other inherent differences. Thus, raising each child is an exclusively attuned process.

However, having or raising children does not mean the loss of one's identity. Indeed, parents must invest some of their time and provide their children with their rights of survival, development, protection and participation in their social and economic context; but it is not an "either-or" situation. All relationships can be maintained within the family with a bit of understanding and patience. The cycle of violence or deprivation should not be repeated. There is no shame in seeking professional help for marriage or parenting. The worst case scenario is when parents are in distress themselves are not financially or emotionally capable of looking after their children or are into anti-social activities, substance abuse etc. Such children grow up often emotionally withdrawn, lacking self-control, more gullible and susceptible to abuse, or at risk of using substances themselves. In such scenarios, State strongly takes over and rescues them and tries to provide restorative and developmentally appropriate experiences as their entitlements in Child Care Institutions.

The sibling relationship is also essential to relationships within a family system. Siblings have the potential to be a ready support system in a family who share similar realities but can end up competing with each other for want of attention, care, love and opportunities from their parents. A family in the process of raising their daughter discovered that she has an underlying developmental disorder. She was diagnosed to have Attention Deficit Hyperactivity Disorder.



This affected the entire family system as it demanded relocating finances for her special education and therapies and grooming her to be socially mature and responsible amidst her impulsive tendencies and overactive behaviours. Both parents were working and had varied working hours. Burdened by additional care and responsibilities, the family opted to take the younger son as a co-parent who was allotted the responsibility of maintaining the vigilance of her elder sister. While it may be a respite to the working parents, the relationship between the siblings was adversely affected. The younger one got into the role of commanding, checking and complaining about her sister's otherwise unintended behaviours. Parents would turn critical towards the elder daughter, and the younger of the two assumed importance and a position in the family decision-making. These dynamics left the girl very sad and distressed, and as she approached her teen years, she was observed to be even more reactive. Follow-up sessions at the Child Guidance Centre targeted restoring her self-worth through Play Therapy sessions. The brother discovered the sister's brighter and more vibrant side during these sessions. The therapist handled all emotional dynamics between the siblings during the therapy. In moments of difficulty, while playing a game, the girl would often guide and protect her brother, and the young boy saw her sister receiving compliments. These interactions gradually reshaped the relationship between the two, and they started to enjoy certain pleasant moments together, which also continued in the home setting. Restoration of the parent-child relationship and bringing cohesion to the family became a critical therapeutic task. Disturbed sibling relationships owing out of jealousies, comparisons or social reasons may not always be reported to clinical settings, nor may they improve with time but can deepen and may result in adult life dynamics related to property disputes or the like. In later years siblings either support or animosity with each other. Not all siblings are blood ties. There are step-siblings and half-siblings. This relationship is respected and can be a great safety net. Yet it flounders when comparing progress and property. Going back to childhood, if parents can provide a strong foundation, this bond will only strengthen.

Marriage is viewed with the highest sanctity, and the larger narrative states that it must be preserved at all costs. Thus, even if the couple wasn't feeling too happy with each other, they had several reasons for being together; it could be financial dependence, maintaining social face, or for the sake of children. However, with the changing face of women's independence, financial stability and career orientation, it is reducing her chances of wanting to continue in a stale or a dead relationship. Couples are seeking more emotional depth and satisfaction in a relationship in the absence of which the relationships are dissolving, and we witness higher divorce rates.



Positive, strong relationships are essential to one's emotional and mental wellbeing. Relationships, whether in friendships, romantic relationships or marriage, are extreme sources of joy and support wherein we share life burdens and feel at ease to unload our concerns. We feel supported and understood, and relationships add to our inner strength. The essential ingredients of any relationship are commitment, trust and care. Care is embedded in responsiveness and consistency. Care that is attuned to the needs and feelings of others makes a person feel hopeful both today and in the future. Another valued dimension of relationships is commitment, loyalty and faithfulness. Not all relationships exude similar intensities. Some relationships, whether marriage or otherwise, can be formal, where the individuals involved think about costs and benefits at all times. Such relationships may be straightforward and precise but are not very mature. Relationships can also be hurtful, conflicted, dominated and self-centered. In relationships, we need people to share the hard and the good times. Sharing of positive emotions, including laughter, is considered to strengthen relationships. In active constructive relationships, people celebrate each other's joys and achievements. However, in hurtful relationships, the partner may think that they have to put in a high cost for others' achievements and bring out themselves as a martyr or the one being exploited. It is hoped that the science and art of relationships are furthered by all social institutions so that we harness the best and achieve mental and emotional agility for collective living. Emotional wellbeing is a right of every individual. However, emotional wellbeing is not a logical corollary to the absence of a mental disorder. All of us are worthy of the quality of life, yet each of us is a part of others' ecology that can ensure the quality of life.



Suggested Readings:

Carter, E. A. McGoldrick (Eds.)(1980). The family life cycle: A framework for family therapy. *New York: Gardner.*

Darling, N., & Steinberg, L. (2017). Parenting style as context: An integrative model. In *Interpersonal development* (pp. 161-170). Routledge.

Steve, B., & Marie, C. (2014)*Positive psychology*. Pearson Education India.

The Statesman, 01 September, 2022, P. 2 , *Child Trafficking racket busted , private hospital owner along with 3 arrested.*

Child Mental Health

Introduction

Children and adolescents form about 40% of the Indian population. According to the recent United Nations International Children's Emergency Fund (UNICEF) report, India has the largest adolescent population in the world, at about 253 million, and every fifth person is between 10 to 19 years of age (*Children in India*, n.d.). The prevalence of psychiatric disorders is high amongst children and adolescents, especially children from vulnerable and disadvantaged backgrounds. The National Mental Health Survey (NMHS) reports a prevalence of about 7.3% among adolescents aged 13-17 years, with about 9.8 million adolescents requiring active mental health interventions (Gautham et al., 2020). The gaps in scaling up child mental health services and child protection mechanisms are amplified by the COVID-19 pandemic (Ramaswamy & Seshadri, 2020).

India has a very long history of progressive policies and legislation. With the near-universal ratification of the United Nations Convention on the Rights of the Child (UNCRC), there has been a transformational conceptualization of child mental health over the last two decades. The convention recognizes the fundamental human rights to which all children are entitled. These rights include their right to survival, the right to development of their physical and mental potential, the right to protection from conditions that are harmful to their development, and the right to participation (*Convention on the Rights of the Child Text*, n.d.). In addition to fundamental rights, the Constitution of India provides affirmative or positive discrimination, especially towards children. Legislations and policies are one of the strongest tools for the empowerment of children. Following the ratification of UNCRC, India has formulated legislations that are child-centric and child-rights based, with some of the pivotal legislative frameworks being the Protection of Children against Sexual Offences (POCSO) Act 2012, Juvenile Justice (Care and Protection of Children) Act 2015, Right to Education Act 2009, Prohibition of Child Marriage Act, 2016, etc.(Table 1)

Table 1: Legislative frameworks, policies, and programs for child rights protection

Legislative frameworks	Policies and Plans related to children	National Programmes
<ul style="list-style-type: none"> •Right of children to free and compulsory education Act, 2009. • Protection of Children from Sexual Offences Act, 2012. •Juvenile Justice (Care and protection of children) Act, 2015. •Prohibition of Child Marriage Act, 2016. •Rights of Persons with Disabilities Act, 2016. 	<ul style="list-style-type: none"> •National Policy on Education, 1986. •National Policy on Child Labour, 1987. •National Nutrition Policy, 1993. •National Health Policy (NHP), 2002. •National Charter for Children, 2003. •National Plan of Action for Children (NPAC), 2005. •National Policy for Persons with Disabilities, 2006. •National Policy for Children, 2013. •Child Rights in Five Year Plans. •National Education Policy, 2020 	<ul style="list-style-type: none"> • Integrated Child Development Scheme. •Integrated Child Protection Scheme. •Rashtriya Bal Swastha Karyakram. •Rashtriya Kishori Swastha Karyakram. • Universal Immunisation Programme. •Janani Shishu Suraksha Karyakram (JSSK). • Mid-day meal programme.

Despite the incremental efforts for a child rights-based approach to legislative frameworks, incidents of deprivation and violation of child rights with a consequent impact on child mental health continue to persist. The focus of this chapter is to highlight the interface of child mental health and the systemic framework to mitigate mental health concerns and optimise child development from a child rights perspective.

Child Mental Health and Child Rights

Children are the assets of our nation. Child Mental Health is not only restricted to the hospital or clinic setting but in nurturance and promotion of child mental health in spaces that are important to children and have a significant impact on their overall development. These spaces include home environment, school, child-friendly public spaces, community, and more extensive mechanisms that ensure the safety and protection of children at the level of policies and legislation. While opportunities to enjoy and exercise their rights can promote mental health, instances of violation and disregard for the rights of a child can have a profound impact on mental health.

Legislations for Children and Adolescents:

- Juvenile Justice (JJ Act) (Care and Protection of Children) Act, 2015

The Juvenile Justice (Care and Protection of Children) Act, 2015 is one of the progressive legislative frameworks of the nation, catering to the needs



of children in conflict with the law and children in need of care and protection (Juvenile Justice Act. n.d.). The spirit of the legislation is one of rehabilitation and restoration of optimal development and functioning of juveniles in conflict with the law. It is against the concept of retributive justice and the transfer of juveniles to adult /criminal justice systems (Ramaswamy et al., 2021). Most importantly, the legislation recognizes the child in conflict with the law as one also in need of care and protection, emphasising the rights of a child to protection.

Juvenile Justice Boards (JJB) are constituted to deal with matters related to children in conflict with the law in a child-friendly manner, with the principle of 'best interest of the child' as the central premise. The key principles of the law include the presumption of innocence (any child is presumed innocent and without criminal intent), equality, dignity, worth, and non-discrimination.

Embedded within the law are provisions to address care and protection needs and a strong recognition of child rights, such as prohibiting the detention of any child in custody and prohibition of capital punishments. In the juvenile justice system proceedings, when found not to be in conflict with the law, the juvenile is to be immediately transferred to the Child Welfare Committee to ensure care and protection. Section 18 of the Act lays down orders to facilitate rehabilitation and social integration of children in conflict with the law, which includes re-integration with the family and community, opportunities for mental health interventions, and skill development for effective community integration. The rehabilitation plans are formulated with due consideration to the child's views, active participation, and family involvement.

In case of a heinous offence alleged to have been committed by a child, Section 15 of the JJ Act mandates a preliminary assessment to be conducted by the Juvenile Justice Board (JJB), with the assistance of experienced mental health professionals (at the Board's discretion). The objectives of the preliminary assessment, which is a psycho-legal assessment, are to ascertain the physical and mental capacity to commit such an offence, along with the ability to understand the consequences of the offence and the circumstances in which the alleged offence was committed. If based on the preliminary assessment, the Board finds it fit for the child to be tried as an adult, the case may be transferred to children's court. The proceedings of the children's court and individual care plan focus on rehabilitation, including provisions such as a place of safety where the child can receive rehabilitative interventions and skill development until he/she reaches age 21.

The spirit of the JJ Act, being one of reformative justice and not retributive justice, does not recommend transferring children to the criminal justice system. However, section 15 is not in keeping with the basic premise of the law as it deems it possible that juveniles aged 16–18 years, alleged to be in conflict with

the law, are capable of “adult-like” decision-making processes. In this context, if the preliminary assessment is conducted purely from a vulnerability lens to understand pathways to offence, it can be utilised to facilitate the rehabilitation of the child in conflict with the law (Ramaswamy et al., 2021).

Although the JJ Act is a child-friendly law, its implementation in the real world has many practical challenges, limiting all the legal, social, educational, and health benefits to juveniles. The Act emphasises addressing the mental healthcare needs of the juveniles. However, it is far from actual-world implementation. The challenges range from poor funding allocation, resulting in inadequate infrastructure and resources in the fit facilities (observation homes, special homes, places of safety, Child Care Institutions (CCIs), and paucity of mental healthcare professionals to provide counseling services. The available professionals are mostly volunteers or are associated with NGOs, and effective implementation of the individual care plan and community integration is challenging (Snehil & Sagar, 2020).

A study by the The National Commission for Protection of Child Rights (NCPCR) in the National Capital Region (NCR) reports that children in childcare institutions face adversities such as bullying, abuse, and lack of access to nutritious food and healthcare services (Sagar R. et al., 2017). It highlights the urgent need for ensuring access to basic needs, safety and protection of children in CCIs and capacity building of key professionals and stakeholders in the judicial and child protection systems.

In armed conflict regions such as Kashmir, children are caught in a cycle of incarceration and despondency due to punitive and arbitrary procedures, alongside the ineffective implementation of the juvenile justice systems and violation of child rights (Bhat & Mander, 2018). In addition, incidents of severe violation of child rights involving sexual abuse of girls in the CCIs of Muzaffarpur, Bihar, and Deoria, Uttar Pradesh, have revealed the status of traumatization and adverse experiences in the CCIs across the country (SC on Shelter Homes Abuse, n.d.). In the light of these incidents, registration of the CCIs under the JJ Act, along with regular social audits and inspections of the CCIs has been mandated. However, strengthening child protection systems alongside existing mechanisms continues to be inadequate in successfully implementing child protection policies.

- Protection of Children against Sexual Offences (POCSO) Act, 2012

The Protection of Children against Sexual Offences (POCSO) Act 2012 was enacted to provide a robust legislative framework for the protection of children against sexual abuse, including penetrative and non-penetrative sexual abuse, sexual assault, sexual harassment, and any form of involvement of children in pornography (*POCSO Act, 2012*). Before POCSO, the legislative frameworks



predominantly applied to adult female victims and did not protect individuals from sexual offenses other than peno-vaginal penetration (IPC sections 375, 376). The POCSO Act is a progressive legislation enacted in accordance with the child protection policies of India, with a basic premise of gender neutrality and with due consideration to the aspects of child development in the adversarial judicial processes.

Section 19 of the Act mandates reporting of any apprehension or knowledge that a sexual offense has been committed against a child to the Special Juvenile Police Unit (SJPU) or the local police, thus vesting the responsibility of child protection with every citizen of the nation. Furthermore, guidelines and rules have been formulated for the effective implementation of the law (*POCSO-ModelGuidelines.Pdf*, n.d.; *The Protection of Children from Sexual Offences Rules, 2020 | Ministry of Women & Child Development*, n.d.), including guidelines for recording the statement of the child, physical examination and sample collection, assisting the child and the family throughout the trial processes, legal aids such as court-appointed support person and child-friendly procedures in the courtroom.

Children as Witness

Proceedings of the criminal justice system, especially the courtroom experience, can be intimidating for children. It is recognized by the Supreme Court of India that children in this context are 'Vulnerable Witnesses.' The definition is expanded to include age and gender-neutral victims of sexual assault and witnesses suffering from mental illness and any other disability such as speech or hearing impairment, among others (Badade - In The Supreme Court Of India Criminal Appellate J.Pdf, n.d.).

The Vulnerable Witness Deposition Centre (VWDC) scheme has been initiated, and the Supreme Court of India has directed the state high courts to adopt and notify centers in each district for vulnerable witnesses, which cater to creating a safe and barrier-free environment for deposition. The above scheme has been recently adopted after a decade-long deliberation. The guidelines and structured protocols for the recording of the evidence of vulnerable witnesses include the identification of stressful factors of the adversarial criminal justice systems, such as multiple depositions, delays, and continuances, a pre-trial visit to the court, meeting the judge, and provision of legal assistance such as allowing the presence of a support person and court-appointed facilitator during the deposition (*Notificationfile_lcwcd2x4.Pdf*, n.d.). The child-friendly court procedures include in-camera trial, not coming face-to-face with the perpetrator, recess during deposition, and comforting objects such as books, toys, etc. All questions to the child, including cross-examination, shall be put only through the court. These measures are in place to avoid and minimise re-traumatization and

secondary victimisation of the child.

Delay in Judicial Process and Trial Outcomes

Despite statutory stipulation for the establishment of 'special courts' to facilitate speedy trials for cases under the POCSO Act, it is far from effective implementation in real-world settings. Judicial processes are significantly delayed, indirectly affecting (altering) the trial outcomes and depriving the child of the right to justice (Juyal et al., 2017).

Consensual Sexuality among Adolescents: Implications under POCSO

According to the POCSO Act, the age for valid consent for sexual intimacy is 18 years. The age limit for consent, alongside mandatory reporting under the Act, has rendered adolescents in India in consensual and non-exploitative romantic and sexual relationships vulnerable to criminal prosecution. According to the National Crime Records Bureau (NCRB) report of 2017, the number of cases under the POCSO Act quadruples in the higher age range (16-18 years), the majority of them representing adolescent relationships (*POCSO criminalising teen sexuality?*, 2019). In the above context, while girls are considered 'victims incapable of agency, maturity, and decision-making,' boys are considered 'perpetrators with criminal intent'; however, as per the interpretation of the gender-neutral statute, both male and female adolescents are victims and offenders vis-à-vis.

Furthermore, in a recent judgement, Madras High Court recognized adolescent relationships as an important developmental marker for adolescents' self-identity, functioning, and capacity for intimacy. In light of the same, adolescents should not be criminalised (*POCSO Act Never Intended to Treat Adolescent Boy as Offender*, 2021). Therefore, there is a need to re-examine the age for consent, particularly in the light and spirit of the legislation, to prevent sexual offenses while at the same time recognizing adolescents' sexuality rights.

- Right of Children to Free and Compulsory Education Act, 2009:

The right to Education is a constitutional right for all children of the country. The Right of Children to Free and Compulsory Education Act, 2009 acts as a legislative framework for Sarva Siksha Abhiyaan, the education policy for children, which initially focused on universal primary school education and school retention and later extended to universal education up to 14 years of age (*Right to Education Act 2009-.Pdf, n.d.*). The basic premise of the legislation is the fundamental right to education. As per the statute, free and compulsory education should be provided for all children less than 14 years of age in the nearest school (including 25% reservation for children from disadvantaged family backgrounds in private schools) and up to 18 years of age for children



with developmental disorders and disabilities, in concordance with the Rights of Persons with Disabilities Act, 2016. Schooling and education provide opportunities for optimal development of children's physical and mental capacity.

Dropping out of school and poor academic achievement can result in exposure to adverse circumstances such as deviant peer association, child labor, and suboptimal adult outcomes, posing mental health-related risks at various developmental stages. As a result, various legislations pertaining to children, specifically RTE and JJ Act, have formulated mechanisms to protect children from any abuse, including physical, emotional, and sexual abuse in school spaces.

Corporal Punishment

Corporal punishment is a punishable offense in keeping with the child's fundamental right to safety and protection. Unfortunately, corporal punishment in schools is still prevalent in our country despite its prohibition by law. A study on Child Abuse in India conducted by the Ministry of Women and Child Development in 2007 found that every two out of three school children reported facing corporal punishment ("Study on Child Abuse 2007, Ministry of Women and Child Development, Government of India," 2007). As per the NCPCR guidelines, corporal punishment could be classified as (a) physical punishment, (b) mental harassment, and (c) discrimination. Physical punishment could be in the form of causing physical harm to children by hitting, kicking, asking children to assume an uncomfortable position, forced ingestion of anything, or detention at any specific place. Mental harassment could be in the form of passing sarcastic remarks, humiliating, intimidating, shaming, or name-calling the child, and discrimination based on caste, gender, or socioeconomic status.

Corporal punishment can cause physical injuries (both temporary and permanent) and can have an enduring impact on the child's mental health and self-esteem. Children experiencing corporal punishment often tend to drop out of school. Guidelines have been provided regarding the management of problem behaviours in the classroom, effective disciplining practices, and strategies to promote a positive and supportive school climate (*NCPCR-Guidelines-for-Elimination-of-Corporal-Punishment.Pdf*, n.d.).

Child Marriage

Child marriage (<18 years) is an internationally recognized child rights violation. Despite the statute of the Prohibition of Child Marriage Act, 2016, child marriages continue to be practiced. India is estimated to have over 24 million child brides. Apparent social vulnerabilities such as gender inequity, poverty, living in rural areas, belonging to a particular community, and lack of financial and social

support are common reasons and determinants of child marriage in India (Lal, 2015; Yadava, 2002). Making a child go through marriage can impact multiple aspects of physical health and development, including dropping out of school or higher education, teen pregnancies, and subsequent sexual and reproductive health issues. Adverse psychosocial environments determining child marriage and teen pregnancies can continue to pose a psychosocial disadvantage to the child born out of child marriage and represent a serious violation of the rights of the two children involved.

Children with Disabilities

The Rights of Persons with Disabilities (RPWD) Act formulates a rights-based approach for individuals with disabilities and specifically recognizes the rights of children with disabilities (*RPWD Act 2016-49_1.Pdf, n.d.*). Promoting the rights of children with disabilities is paramount to facilitate their optimal development. A supportive environment, barrier-free access to child-friendly spaces, universal access to education, equality, and non-discrimination are fundamental rights of children with disabilities. Unfortunately, this vulnerable population frequently encounters non-realization and violation of rights. This can be detrimental and reduce the opportunities for optimal development and utilisation of their potential. From a socio-ecological lens, disability is understood as a 'socially constructed identity.' Therefore, there is a need for collective efforts of the community to facilitate equal participation and integration of children with disabilities.

Mental Healthcare Act, 2017 (Aspects pertaining to Children and Adolescents)

The Mental Healthcare Act (MHA), 2017 is a recent progressive rights-based legislation and is in concordance with the United Nations Convention on Rights of Persons with Disabilities (*Mental Healthcare Act 2017.Pdf, n.d.*). Aspects pertaining to the rights and treatment of children and adolescents are discussed here. Only the nominated representative (legal guardian/ parent) has the right to make an advance directive and decisions for the mental healthcare of the minor (Sharma & Kommu, 2019). Parents/legal guardians are the nominated representatives in the case of a given child unless it is proved that they are unfit for making decisions or not acting in the child's best interest. This provision acts on the basic premise of a child's right to health and development. It prioritises 'best interest' in case of difference of opinion between parents and the child in treatment-related decisions. However, it is essential to note that the legislation does not recognize adolescents' right to participate in decisions pertaining to their healthcare.



In the case of mothers with mental illness who require inpatient care or prolonged treatment and rehabilitation, the legislation recognizes the critical role of separation of the mothers from their child (<3 years) and its impact on the child's development. Therefore, children (< 3 years) cannot be separated from their mothers while getting treatment in a mental healthcare institution unless there is any risk to the baby from the mother's illness. In that case, the mother will have supervised access to the child.

All admissions, treatment decisions, and discharge of minors with mental healthcare needs consent only from the nominated representative, and there is no recognition of active participation or role of the minor. While the legislation is a rights-based approach with many positive initiatives, it fails to recognize the rights of minors. In many cases, child and adolescent mental healthcare needs may not be recognized by the parents, or there may be discrepancies related to mental healthcare between the parent and the child, especially in cases of high parent-child conflict or adverse circumstances in the home environment. In the above case, the child may be deprived of an essential assessment or treatment due to a lack of parental consent, despite assent from the child. Therefore, there is a need to relook at the provisions of the legislation concerning a child's right to participation.

Monitoring Child Rights

The National Commission for Protection of Child Rights (NCPCR) has been constituted to examine and review the safeguards provided by the legislative frameworks pertaining to child safety and protection and oversee and recommend measures for effective implementation (National Commission for Protection of Child Rights, n.d.). The State Commission for Protection of Child Rights (SCPCR) and District Child Protection Unit (DCPU) have similar functions at a state and district level and operate under the support and guidance of NCPCR. The commission visualises a rights-based perspective flowing into national policies and programs, along with specialised responses at various organisational levels such as the state, district, and block levels, taking care of specific issues and strengths of each region.

Implications and Future Directions

There is a need to focus on sensitising stakeholders and capacity building, not limited to knowledge and awareness of issues pertinent to child rights (violation) in interactions with various systems of care. Strengthening the existing child protection mechanisms and parallelly developing additional mechanisms for effective scrutiny and implementation of legislative frameworks is the need of



the hour. Though efforts have been made to strengthen child protection systems in our country, instances of serious violations continue to persist. It is thus paramount to understand and evaluate children's mental health concerns from a vulnerability lens with due consideration to child rights. Ensuring an active participation of children in matters related to them will help in planning changes that can be meaningful to them. There is an urgent need to undertake and promote research in the field of child rights.



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Geriatric Mental Health

Introduction

A “senior citizen” or “older adult” is defined by the United Nations and the Government of India as a person who is 60 years and older. Senior citizens constitute over 12.3% of the world population. In the next 30 years, the population of older persons is expected to increase to over 22%. Due to longevity, in most countries, there are more persons living upto their 80 and 90 years of age. According to the Census of India 2011, there were about 104 million (8.6% of population) older persons in India. Old age is associated with many health, social, economic and environmental risk factors contributing to increased vulnerability for human rights violations as well as mental health issues. The comorbidity of chronic physical health conditions, sensory impairment and frailty, poses problems. In addition, low levels of literacy, lack of adequate public awareness, limitations in the family and social support along with mental health conditions increases the challenges in ensuring the human rights of older adults. Ensuring human rights with geriatric mental health issues requires multidisciplinary interventions implemented through health and social care systems. These complex issues are more prominent in the developing world causing problems for the older person, their families, as well as societies and nations. Hence it is important to discuss the Rights of Senior Citizens in accessing and receiving quality health services for their physical and mental problems.

The Ageing Population & Human Rights in India

The population of adults aged 60 years and above in India is increasing rapidly (13.8 crores in the year 2021) due to an increase in life expectancy (32 years in 1947 to 69.66 years in 2019). It is estimated to increase by another 5.6 crores by the year 2031. Higher proportion of women, rural background with low levels of literacy and rapid growth without adequate expansion of health and social care services are some of the important challenges related to population ageing. This causes a dual problem as women avail health services lesser than men and accessibility and availability of health services in the rural areas are much less than the urban areas. The right to health for elders, especially for

women and persons from rural areas is a critical issue that warrants discussion and redressal.

The Universal Declaration of Human Rights adopted by the United Nations general assembly highlights the basic and fundamental rights of human beings and affirms their universal character. Despite the absence of a specific convention to protect human rights of older people, higher vulnerability for human rights violations in older people has been recognized and advocated through several global initiatives. Indirect benefits through “The Convention on Rights of Persons with Disabilities (CRPD)” offer protection for older persons. The relevant principles are respect for dignity, non-discrimination, full participation and inclusion in society, equality of opportunity, and accessibility. The “United Nations Convention on the Rights of Older Persons (UNCROP)” has been proposed to ensure a legally binding provision to protect the human rights of older persons. The United Nations Principles for Older Persons (UNPOP) has encouraged all governments to incorporate the rights for Independence, Participation, Care, Self-fulfilment, and Dignity into their national programs wherever possible.

Magnitude of Health Issues in Elderly

Older age brings about several changes in the person and their families, namely changes in role transitions, negative life events, decline in earning capacity and other kinds of losses which increases dependency on other family members and society. In addition to these social changes, older age is associated with two or more chronic medical illnesses, sensory (visual or hearing) impairment, and frailty. Most elders would have chronic Non-Communicable Diseases (NCD's) like diabetes mellitus, hypertension, heart disease, respiratory illnesses, cancers and osteoarthritis. These factors possibly increase their stress levels and make the older adult more vulnerable to mental illnesses. Mental illnesses in older adults can range from mild psychological symptoms (subsyndromal) to common mental illnesses like depression or anxiety disorders. Older adults also have a higher chance of getting a more severe mental illness like dementia or other psychotic illnesses.

Coexisting mental disorders like depression and anxiety would be present in 25 to 50% of this population who have an NCD. Coexisting mental illnesses have a big impact on the physical illnesses, affecting treatment compliance, medical consultations, and worsening the mortality and morbidity due to these NCDs. These physical and mental illnesses in older adults are an important contributor of mortality in addition to morbidity and disability.

Mental Disorders in Older Adults in India

Increase in the older adult population in the last few decades has led to



focus on the mental health issues concerning this population. The National Mental Health Survey of India (NMHS, 2016), carried out in 12 different sites all over India including 5590 older adult participants revealed a life-time prevalence of all mental disorders of 15.1 % and current prevalence of 10.9%. The prevalence rates of lifetime and current depressive disorders was 6.93% and 3.53% respectively, more in women than men. The prevalence of the neurotic, anxiety and stress-related disorders was 3.31% and that of alcohol use disorders was 4.07%, with higher prevalence in men. For severe mental (psychotic) disorders, the life-time prevalence was 2.00%, and current prevalence was 0.68%.

The Longitudinal Ageing Study of India (LASI) with 40335 persons in the age groups of 45 years and above (median age 58 years) reported the prevalence of major depression in older adults as 8.3%. More than 90% of them were not aware of the mental health condition existing in them indicating significant diagnosis and treatment gap. The risk of depression was higher in those residing in rural areas, poorer socioeconomic strata, those who were widowed, and with low education. Depression was also associated with poor health, limitations in the activities of daily living and low life satisfaction. The study showed that depression was undiagnosed, untreated, and closely linked to poorer health and wellbeing outcomes in older adults from India. These survey data reveal that older adults (especially women and those in rural areas) are not getting the benefit and access to quality mental healthcare that they should be receiving.

Cognitive Disorders in Older Adults

Cognitive disorders (namely dementia) are an important group of neuropsychiatric disorders affecting older adults. Dementia usually affects older persons, with most cases starting after the age of 65 years. The number of persons with dementia in India was estimated to be more than 5 million in the year 2020 as per the Dementia India Report (2010). It is estimated to increase to more than 14 million in the year 2050. Many persons with dementia may have impaired mental capacity and are likely to need assistance for their daily activities. The decline in the family support system is contributing to an increase in the need for institutional care for persons with dementia. These factors may contribute to increased vulnerability for human rights related issues in persons with dementia.

Human Rights In Older Persons With Mental Illness

Mental health and wellbeing are an essential part of human life and are as important as physical health and wellbeing. Sound mental health can be considered as the basic right that is essential to make sense of and find meaning in all the other rights a person is expected to enjoy. People with mental illness are

most vulnerable to violation of their basic human rights. Over the years, various guidelines and laws have been created at the national and international level to protect persons with mental illness and ensure their basic human rights. The following section looks at the guidelines that define human rights of persons with mental illness.

Guidelines on the Rights of Persons with Mental Illness

At the international level, the *United Nations Principles for the protection of persons with mental illness and the improvement of mental healthcare* was adopted by the general assembly resolution 46/119 of 17 December 1991. It laid down provisions to promote the rights of mentally disabled persons in healthcare and consists of 25 principles which incorporate the basic standards for the rights of people with mental illness. These resolutions have been formulated for upholding and safeguarding the rights of a person like dignity and autonomy. In addition to this, it also articulates the right of an individual to work in the community and to be cared for in the community.

The World Health Organisation (WHO) *Guidelines for the promotion of human rights of persons with mental disorders* was adopted in 1996 to facilitate better understanding and implementation of the *United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare*. The WHO guidelines describe the rights of persons with mental illness based on the UN principles and give the guidelines for the application of the same, as is given below:

1. *“All persons have the right to the best available mental healthcare, which shall be part of the health and social care system.”*
2. *“All persons with a mental illness or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person”*
3. *“All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment”.*
4. *“There shall be no discrimination on the grounds of mental illness” - Discrimination is “any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights”.*
5. *“Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights [...]” “qualified legal assistance to protect their rights and to have their condition taken fully into account in any legal proceedings”.*



6. “Any decisions that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of this incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law [...]”
7. *“Where a court or other competent tribunal finds that a person with mental illness is unable to manage his/her own affairs, measures shall be taken, so far as is necessary and appropriate to that person’s condition, to ensure the protection of his or her own interests.”*

Another landmark proclamation in the protection of persons with mental illness is the *United Nations Convention on the Rights of Persons with Disabilities* adopted by resolution 61/106 of the UN General Assembly in 2006. ‘Disabilities’ include disability due to mental illness. The following rights are mentioned in the proclamation:

1. “Respect for inherent dignity, individual autonomy including the freedom to make one’s own choices, and independence of persons
2. Non-discrimination
3. Full and effective participation and inclusion in society
4. Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity
5. Equality of opportunity
6. Accessibility
7. Equality between men and women
8. Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.”

Mental health of a person plays a significant role in the enjoyment of his/her human rights and people with mental illness are most vulnerable to violation of their basic human rights. Over the years, various organisations like the UN and WHO have developed guidelines to protect people with mental illness which have been covered in this section. It is based on these guidelines that countries around the world have formulated laws and policies for enforcing the same. It is evident that elderly persons with mental illness require special attention. In the following section, some important programs and laws relating to the mental health of elderly in India are detailed.

Programs And Laws Related To The Mental Health Of Elderly

In India there are specific programs and laws relating to the protection of the rights of the elderly person with mental illness with provision of care to this

vulnerable group of individuals. The important programmes and laws, currently in effect are described below:

1. National Programme for the Healthcare of Elderly, 2011
2. The Rights of Patients with Disability Act, 2016
3. The Maintenance and Welfare of Parents and Senior Citizens Act, 2007
4. Mental Healthcare Act, 2017
5. The Indian Succession Act, 1925 [Section 59-Testamentary capacity]
6. The Indian Evidence Act, 1872 [Fitness to give witness]

National Program for the Healthcare of the Elderly (NPHCE)

The Ministry of Health & Family Welfare had launched the NPHCE during 2011. It is an articulation of the International and national commitments of the Government as envisaged under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), National Policy on Older Persons (NPOP, 1999) and Section 20 of “The Maintenance and Welfare of Parents and Senior Citizens Act, 2007”. Among many things the NPHCE includes the vision “to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an ageing population” and “to promote the concept of active and healthy ageing”. This program is envisioned to be implemented by integration with the National Health Mission through the already existing public health delivery systems at every district. Though this program does not specifically talk about mental healthcare, it would be understood that geriatric mental health would also have to be covered.

The Integrated Program for the Older Person (IPOP) is a scheme under the Ministry of Social Justice and Empowerment. Under the scheme, there are funds available for the establishment of mobile medical care units, day care centres for older adults, respite care homes, old age homes and in setting up elder helplines.

The Rights of Persons with Disabilities Act (2016)

This Act replaced the pre-existing Persons with Disabilities Act, 1995 and is articulated in accordance with the *United Nations Convention on the Rights of Persons with Disabilities*. The Act defines a “person with disability” as “a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others”. In accordance with the definition of disability given above, disability due to mental illness also comes under the purview of this Act. Any person with disability is entitled to certain rights like the right to equality and non-discrimination, right to community life, right to protection from cruelty and



inhuman treatment, right to protection from abuse, violence and exploitation, right to protection and safety, right to a home and family, accessibility to reproductive rights, right to vote, right to justice and legal capacity. They are entitled to have a provision for guardianship and designation of authorities to support.

Maintenance and Welfare of Parents and Senior Citizens (MWPSA) Act (2007)

The *Maintenance and Welfare of Parents and Senior Citizen's Act, 2007* makes it the legal obligation for children/heirs to provide maintenance by monthly allowance to parents/senior citizens. It also presents a simple, speedy and inexpensive mechanism for the protection of life and property of senior citizens. According to this Act, parents/grandparents who are not able to maintain themselves with their own income and childless senior citizens, have the right to demand for maintenance from their children or relatives. The Act also has a chapter on provision of Old Age Homes and Medical Care to senior citizens. It also mentions that there must be provisions made for clinical services, research and facilities to care for the elderly persons. Regarding the protection of life and property, the Act maintains that wide publicity through media (TV, radio, newspapers) should be given to make the public aware about the Act. Sensitisation and awareness training about the Act should be conducted. Senior citizens helpline should be operated in the office of every district collector.

Mental Healthcare Act (MHA) 2017

Mental Healthcare Act (MHA) 2017 is the comprehensive Act which governs the provision of mental healthcare services in India. It has been drafted based on the requirements of United Nations convention on RPWD, 2008 and is the revised version of the Mental Health Act, 1987 which was in effect before.

The Act covers the rights and entitlements of any person with mental illness and mandates the means to provide these services as well as the checks to ensure the same. Elderly with mental illness are no exception and are also protected by this Act. The *MHA 2017*, in fact, has addressed many of the aspects which are particularly important in elderly like the newly introduced provision for an Advance Directive (AD) and Nominated Representative (NR). The rules related to capacity, rules about admission (voluntary and supported) and discharge, and rules related to mental health establishments are of relevance in elderly who are further burdened with other medical comorbidities, auditory and visual impairments and diseases like Dementia. These modifications are an effort to provide standards of care in line with that in the RPWD Act and mentions rights covered under the same.

According to this Act, every person with mental illness is deemed to have Capacity to make healthcare decisions about his/her mental healthcare and treatment if the person has the ability to understand the information relevant to make a decision, if the person has the ability to appreciate any foreseeable consequence of the decision/lack of decision or if the person is able to communicate the decision by means of speech, expression, gesture or any other means.

As mentioned, the Advance Directive is a new addition in MHA, 2017. Every person (who is not a minor) has the right to make an advanced directive mentioning how to be cared for mental illness. The person with mental illness or past history of mental illness can decide about the individual or individuals (in the order of preference) that he or she wants as the nominated representative to make decisions on his/her behalf.

Indian Succession Act (1925)

According to Section 59 of Indian Succession Act (1925), every person of sound mind, not being a minor, has the right to dispose of his or her property by will. Testamentary capacity refers to a civil competence regarding the ability of an individual to make a will, which he/she desires to execute after their death. The law considers that every person has adequate capacity to make a will, until proven otherwise. To consider as having testamentary capacity, the testator should have the knowledge of the nature and extent of his property. The persons who are kindred to him or in whose favour of it would be in position to the knowledge of the nature of the will and the effect of its provisions and the ability to make a rational plan as to the disposition of his property. This section of the Act is especially important in elderly with mental illness and dementia, as these are common grounds on which the will of an elderly gets challenged in court.

Indian Evidence Act (1872)

As per the Indian Evidence Act, the right to participate in the legal proceedings and giving testimony is the right of all individuals. No person should be denied the same for the reason that he/she has mental illness. However, in case of an individual with a psychiatric illness, assessment of the status of his illness, possibility of his testimony being coloured by the illness and his capacity to be an unbiased witness who understands the proceedings of the court should be assessed by a psychiatrist. This is applicable in the same way to elderly individuals.

Special Issues and Challenges in Elders with Mental Illness:

When an older person suffers from a mental illness, it negatively impacts



their rights, freedom, autonomy and quality of life. Of all the entitlements charted out by United Nations Principles for Older Persons and Dignity, these are most relevant when it comes to older people with mental illness namely A) Right to autonomy, B) Right to safety C) Right to care and protection.

Mental health and human rights are not mutually exclusive and intersect at various domains. Mental illness not only affects the individual but impacts society with increased disease burden, thereby leading to poverty and social disruption. At the same time, mental health has not gained the same recognition in international and national laws, policies and programs as physical health. This calls for the need to discuss and make people aware of the human rights issues of the elderly person with mental health problems.

Ageism & Age Discrimination

Discrimination of elderly on the grounds of age is a prevalent practice worldwide, in healthcare. Elders are often seen as incompetent, dependent and diseased. These negative attitudes devalue older people. This may be exacerbated by the adverse effects of discrimination and stigmatization by having a mental illness, the 'double jeopardy' of psychiatric stigma and stigma against old age.

Factors like female gender, socio-economic status, race, ethnicity, religion, language and lack of supportive infrastructure adds to this discrimination. Ageism bias exists in family members, medical and mental health professionals, and the community at large. Many medical and mental illnesses, like early memory problems or depression, present in late life are presumed to be a part of the normal ageing process and hence ignored. Ageism is one of the important factors that reduces utilisation of mental health services and denies the rights of older adults.

Stigma

Stigma is defined as the negative perception, attitude and discrimination held about individuals with mental illness. Stigma levels are higher in rural areas compared to urban areas. In many areas in India, older adults continue as the head of the family even later in life. In case an older adult develops symptoms of a mental illness, and other family members do recognise them, they may not seek any help due to stigma and fear of discrimination of the family by the community. Alternatively, it may be more acceptable for families to seek magico-religious and other alternative healing practices as a first resort. Studies reported an inverse relationship between stigma and treatment seeking patterns among people with mental illnesses.

Poor Awareness and Low (Digital) Literacy

Poor knowledge about mental illness poses a challenge to the mental healthcare delivery system. Health literacy has been described as “ability to access, understand, and use the information to promote and maintain good health”. Mental health literacy is seen as an important measure to create awareness and knowledge to access mental health services. Several means such as print media, digital medium and campaigns have been used to promote mental health education. Though, not so frequently and definitely not on a large public health scale. The literacy level of older adults in rural areas was only 34% in India as per the 2011 census. Although there is an increase in literacy level among older adults compared to the previous decade as seen in the Longitudinal Aging Study in India (LASI) study. This was more evident in urban than rural older adults.

Though, some of these concerns are being addressed by digital media, many older adults have challenges in using digital communication (by mobile phones, tablets, computers) and the applications that are required to run them. This could be due to low literacy levels, lack of exposure and affordability which Act as a barrier in mental healthcare delivery. To ensure the rights of this population, there must be a drive to create awareness and education about the use of digital technology to access health.

Capacity

Capacity implies the ability to understand the available information and to decide autonomously and be able to communicate it. Legal and mental capacity are two different terms and a deficit in the later should not imply a deficit in the former. Issues pertaining to capacity often occur in the context of testamentary capacity, voting rights, capacity to make treatment decisions, gift deeds and organ donation. Lack of capacity may also result in financial and sexual abuse and neglect of elderly with mental illness. The older person should be assessed for presence of capacity before making any decision. Even in persons suffering from moderate dementia capacity it may be retained in certain aspects of decisions and that needs to be respected. In more severe mental illness, independent decision making may not be possible. Instead of completely making decisions for the elderly with mental illness (ie. substituted decision making) supported decision making should be encouraged.

Consent

Informed consent is one of the important practices in medical science, be it for any treatment or research. It forms an integral part of one’s autonomy and the right to make decisions for self. With ageing, some decline may occur in cognitive functioning which in turn may affect decision making capacity. Presence of



mental illness doesn't imply lack of competency to give consent. Though an elder person may not have the capacity to make decisions about their finances, they may still have the capacity to give or refuse consent for treatment. Furthermore, decisions made by elderly may vary from what seems ideal in the background of different cultures, ethnicities and religions. This should not be taken as a sign of inability to give consent. Even in disorders like dementia, a person may still have the capacity to consent in the early stages. As long as they can understand the matter in question, can convey the decision, and the consequences of the decision, consent should be possible. In cases where capacity to give consent may not be fully present, shared decision making should be promoted.

End of Life care

Prolonged life expectancy is often accompanied by multiple medical comorbidities, dependency, frailty and functional impairment. Aggressive medical treatments may mean improved survival but could often worsen quality of life. Elderly suffering from mental illness may not be able to identify their deteriorating health or communicate the same to others. Cognitive deterioration and poor communication may prove to be a major hindrance in the participation of elderly with mental illness and in the decision making process pertaining to end-of-life or palliative care. Decreased pain and suffering, better quality of life, place of death, and dying with dignity remain the important concerns for the elderly. Though MHA, 2017 has provisions for advanced directive and nominated representative to prepare for end-of-life issues, lack of any uniform legislation on rights of elderly with mental illness, euthanasia and "Do Not Resuscitate", remain as a major lacunae.

Elder Abuse

Elder abuse is defined as a "single or repeated Act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. The prevalence of abuse in older adults from a few Indian studies ranges from 14% to 40% and is commonly under reported. It can be in various forms: physical, psychological/emotional, sexual, financial abuse and neglect. Elder abuse constitutes both acts of omission and acts of commission.

Presence of elder abuse in residential settings is a cause of concern. Abuse in older adults is both a risk factor for causing mental illness as well as a barrier in seeking professional mental healthcare. Presence of mental illness increases the incidence of abuse further. And moreover, people with mental illness may not be able to communicate the same or ask for help. They are unaware of their rights thereby putting them at risk of exploitation.

Gaps in the Existing System

As described above, there are legal provisions, policies and programs to ensure the rights of mentally ill older persons. To ensure that these laws and guidelines are effective and beneficial for the target population, it is essential to have a good picture of how it has been implemented in practice and what are the possible gaps in the system. Some studies have shed light on the result of the implementation of these laws and guidelines. The Agewell Study on Human Rights of Older People in India, 2014 was a national survey with a representative sample of 50,000 older people from 300 districts of 25 states & Union Territories of India. The survey found that 56.6% elderly respondents faced harassment/mistreatment due to housing despite many of them owning their house/property. Every third elderly person reported misbehaviour/ mistreatment as the most common form of elder abuse, and every fifth person reported being subjected to restrictions in their social life by their family members or others. Age based discrimination and lack of employment opportunities were found to limit any gainful engagement opportunities in elderly. The study also found that 27% of elderly had no access to proper medicine/ healthcare facilities. Around 48% of elderly acknowledged facing age discrimination.

The LASI wave-1 survey (2017-18) included 31,902 elderly persons aged 60 and above. The study reported that 5.2% of elderly above 60yrs reported facing one or more ill-treatments such as physical, verbal/disrespect, economic exploitation, emotional/psychological or neglect experienced in the past year. Only 29.1% of those above 60yrs received pension as per the National Old Age Pension Scheme. Only 28.4% elderly were aware of any concession given by the government to elderly and only 18.6% reported receiving any concession or benefit. Among the elderly, only 12.3% were aware about the *Maintenance and Welfare of Parents and Senior Citizens Act*. These reports serve as a reality check, and it is seen that a significant percentage of the elderly population still face discrimination of various types. There is a lack of awareness among elderly (and persons with mental illness) about their basic human rights, benefits, concessions, and the laws in place to safeguard them.

The *NPHCE 2011* program has the merit that it recognizes the specific and specialised needs of the geriatric population and seeks to implement it from primary to tertiary care levels. However, its greatest criticism is that it completely neglects the role of home based care of the elderly within the family. In a country like India, with its large population and ever-increasing demands for elderly care, a properly structured and implemented home-based care has a significant role to play.

Mental Healthcare Act 2017 is currently the standard law that seeks to address the mental healthcare of all individuals including elderly in India. Though



there is no special section on the care of elderly with mental illness, the provisions with respect to capacity, making an advanced directive, assigning a nominated representative, registration and checks on mental health establishments, provisions of admission and discharge have tremendous implications in protecting the rights of elderly with mental illness. Though these are the merits, there are still some ambiguities in the Act. There is a lack of clarity with respect to the description of what is the mental capacity of an individual with mental illness. The Act suggests that all three aspects (ie. understanding information, anticipating foreseeable consequences, and communicating decisions) are not necessary for assessing capacity. This lack of clarity would affect decisions about the fitness to decide about matters relating to the will, advanced directives, nominated representative and admission to a mental health establishment.

Though the Advance Directive helps persons with mental illness to express their wishes related to how to be treated for mental illness, the Act does not specifically clarify on the palliative and end of life choices of an individual or the provision to refuse treatment in case of a progressive illness like dementia. With regard to choosing a Nominated Representative, there are some differences between MHA 2017 and MWPSA Act 2007. MHA gives an elderly with mental illness the provision to choose a nominated representative, irrespective of whether that person is a family member or not. The MWPSA Act makes it mandatory by law for the children to give maintenance and support to parents. This is of significance in the elderly considering how common family conflicts and disputes over property are in the community.

MHA 2017 has elaborated on the duties of the government for the provision of an accessible, affordable and quality mental healthcare. The Act also states that if the government fails to provide the same, compensation should be given to the individual. Even though all these mandates seem encouraging, it seems they are not translated to reality. The quality and quantity of the care facilities that are currently available not meet the increasing care needs. There are lesser number of trained professionals in geriatric mental healthcare. In addition to this, most of the mental healthcare, hospitals and services are restricted to urban areas and metros.

According to the definition given in the Act, old age homes may also be considered as mental health establishments if they house mentally ill persons. There is no clarity regarding the rules and minimum standards of care in these settings. Considering the vulnerability of elderly to all forms of abuse, this deficit fails to address the right of an elderly to both quality care and the right to be protected against any sort of abuse. In the case of elder with dementia, there is a risk of old age facilities being misused for abandonment of

the elderly.

A key issue is the long time taken to get these provisions implemented. Implementation of the Act for admission and discharge, guidelines for care at mental health establishments, proper functioning of the review boards to supervise facilitation of care, are yet to be notified in most States even after five years of the Act. While the demand for care keeps rising in an alarming way, the healthcare provisions are only warming up to the demands.

The Way Ahead to Improve Rights of Mentally Ill Elderly:

Public Awareness and Education

Increasing awareness in the community and in older adults about health and human rights issues should be conducted as national awareness campaigns. This could be possible by using print and audio-visual media like the newspapers, TV, radio, internet and social media with culturally appropriate educational campaigns. This will make all stakeholders aware of the Rights of Older persons with mental health problems. Public education programs should also be held on Healthy Ageing. This will go a long way in primary prevention of many of the geriatric health issues including mental disorders. The “Vayo Manasa Sanjeevani” program of NIMHANS is one such initiative to provide comprehensive information for the promotion of mental health and wellbeing of older adults to achieve the WHO/UN campaign for “Decade of Healthy Ageing 2021-2030”. Readily available information on availability of geriatric services and how to access them would be a requisite to improve the rights and quality of life of patients as well as caregivers.

Provision and Training of Caregivers

Older persons with or without mental disorders have a right to have the provision of caregivers, either formal or informal. For effective caregiving roles, it is important for the state and other agencies to create the provisions to recruit, train and create the availability of trained caregivers. These caregivers would function to help older adults with geriatric mental health problems, make communities geriatric friendly or help in the practice of Healthy Ageing. At present, the caregivers are mostly family members who form the largest resource of older adult care. However, they do require training and support. In future there would be a great need to have a pool of formal caregivers, who could be hired for caregiving roles with the elderly. The governments and other agencies involved with care of the elderly should develop training programs that are tailored for the care needs of the older person.



Training in basics of Geriatric Healthcare

All undergraduate and postgraduate courses that deal with health programs, especially that of the elders, should have mandatory training curriculum that covers geriatric health and mental health. This would include all personnel (like doctors, nurses, health workers) involved in different National health programs for geriatric mental health. The health and social services personnel should have regular training updates or Continuing Medical Education (CMEs) to keep aware of the recent trends in geriatric healthcare. This will ensure that the senior citizen has access to good quality mental healthcare.

Providing Home care/Tele Consultation Services

Older persons must be provided geriatric care services at their homes or nearby clinics as they are not able to visit facilities at a distance due to transportation and access. There must be provision for community geriatric nurses or health workers to visit the homes, to provide healthcare through regular Tele contact with the physician. Telemedicine and Tele psychiatric practice would be a good solution to provide care at the doorstep and provide access to healthcare for the elderly person. This has become possible especially following the COVID-19 pandemic. The Telemedicine Guidelines for India that were brought out by the Government and the recently launched National Tele Mental Health Program (Tele MANAS, 2022-23) should go a long way “to better the access to quality mental health counseling and care services”.

Providing Long Term/Tertiary Care Facilities

In addition to providing primary and secondary healthcare, there would be a need to provide tertiary care services at the community level for persons with serious illnesses and disability. Hence provision must be made, of rural and urban rehabilitation facilities in the form of community day care centres, halfway homes, long term care facilities, hospices for care of persons with severe disability, who may not be managed at home (like dementia, stroke, Parkinsonism and other chronic conditions). These tertiary care centres could also function as training centres for training nurses, nursing aids, health workers and doctors in geriatric care.

Conclusion

The aging of the Indian population is an inevitable demographic change that will happen at a steady pace in India. Old age brings many concerns related to public health, psychosocial issues and human rights. Majority of older adults in India are women or they reside in rural and remote areas with less accessibility and affordability to healthcare services. The past decades have seen



the acknowledgment of the rights of older persons with mental illness and the realisation of the increased vulnerability of these individuals to deprivation of their basic rights.

The human rights principles followed internationally upholds the provision of equal basic and universal rights to all human beings, whatever be their vulnerabilities and limitations. These principles have given rise to laws and regulations in India, that safeguard the rights and entitlements of the vulnerable groups. However, the proper implementation of the provisions of these acts presents major challenges to the realisation of rights of individuals with mental illness.

Measures such as promoting healthy ageing and self-care, increasing public awareness in mental health, utilising all primary health staff in delivery of basic mental healthcare would go a long way in providing for the rights of the elderly for affordable and accessible mental healthcare. Utilising telepsychiatry services as a collaborative model for providing specialist psychiatry services will help to reduce the unmet needs of elderly. Various measures available to assess the ability to consent or the mental capacity of elderly, should be used judiciously to protect and promote the rights of the elderly with mental illness. Combating ageism, stigma and discrimination will be critical for elderly persons to access their rights to healthcare.



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Women's Mental Health

Introduction

Women's mental health is influenced by interplay of social, cultural, and biological factors. This chapter aims to elucidate social determinants of women's mental health and address the strong need for being cognizant of rights of women with mental illnesses. Rights of women and rights of people with mental illnesses have been focused upon greatly, albeit separately, in the past. It is understandable that women with mental illnesses form a vulnerable section of the society. Yet, their rights are less spoken about.

In this chapter we focus on how the rights of women are closely linked with their mental health using the context of social determinants. We then discuss the rights of women with mental illness and describe certain initiatives in India as successful case studies for emulation. Finally, we attempt to provide some recommendations for ensuring the protection of human rights for women in the context of their mental health.

A brief overview of mental health disorders among women

Women have a fourfold higher prevalence of anxiety and depressive disorders compared to men. Research has shown that before the onset of adolescence and after menopause, a gender difference in common mental illnesses such as depression is narrow (Nolen-Hoeksema & Girgus, 2001).

Deaths by suicide in women in the age group between fifteen and twenty-nine are second only to accidents on the road (Vijayakumar, 2015). Although globally, men are more likely to commit suicide, the Global Burden of Disease Data for India shows that most deaths by suicide are in the 15-39 years age group. In this, female deaths constitute 52.6%, in contrast to male deaths of 47.4%. In 2019, statistics show that in India women commit suicide more than anywhere else in the world. Suicide mortality rate among Indian females continues to be 2.1 times the global rate. Injuries which are inflicted upon the self, including suicide, ranks ninth in the leading causes of disease burden for women (Ribeiro et al., 2008). Adverse experiences during childhood, being younger, being a victim of



violence from a partner are all factors which put women at a greater peril of facing suicidal ideas. They can also lead to greater attempts.

The National Health and Family Survey 5 (NFHS 5) has shown high rates of domestic violence faced by women in almost all states indicating the risk for high rates of trauma related disorders. Trauma faced by women is of a different nature than that seen in men. Rates of sexual abuse are higher in women than in men (Martin et al., 1999) (Sardinha et al., 2022). These experiences can lead to disorders related to trauma such as the Post Traumatic Stress Disorder (PTSD). Women are at a higher risk of developing PTSD after an inciting event (Frans et al., 2005).

Women are more likely to face stigma when they have schizophrenia or bipolar disorder and may not be able to access services because of this. The stigma persists even after the symptoms have reached remission. This is one of the barriers which come in the way of reintegrating them with the community after a long stay in a mental health institution.

In India rates of substance use are much less among women than in men. Women tend to use smaller amounts of substances and for a lesser amount of time before they become dependent (Lynch et al., 2002) and are also at a greater risk of medical problems due to substance use. Women who face trauma have higher rates of substance use and nonprescription drug use.

What makes women more vulnerable when it comes to mental health?

1. Violence against Women and Mental Health: Trauma experienced by women in the form of sexual abuse in the childhood has been linked both to depression and to psychiatric conditions such as post-traumatic stress disorder (PTSD) and eating disorders. The extent of abuse in the form of duration, relationship to the offender and coping styles all influence the psychological consequences of the triggering events.

Intimate partner violence (IPV) can take many forms with women. It could take the form of physical assault, forced sexual acts, and can even include psychological and emotional abuse. The result can be disorders such as PTSD and depression (Pico-Alfonso, 2005). Women may cope with violence through substance use including nonprescription drug use. Women who experience violence might come into primary care with chronic pain and medically unexplained symptoms (Granot et al., 2018).

Domestic violence and Intimate Partner Violence are the most common risk factors for poor mental health in women worldwide. The NFHS 5 data from India indicates how the high rates of domestic and partner violence in India is a rights issue and can have a huge impact on the mental

health of women and girls. The recent Lancet Commission on Intimate Partner Violence and Mental Health has highlighted how IPV causes mental illness such as depression, anxiety, PTSD and self harm and how those who are mentally ill are subjected to higher rates of violence (Oram et al., 2022).

2. Another major social determinant of poor mental health is poverty and food insecurity. More women are subject to poverty than men are (Bastos et al., 2009) (Singh & Pattanaik, 2019). Lack of financial independence makes women stay in environments with domestic violence and violence from their partners.
3. Events such as migration, calamities such as natural and manmade disasters and pandemics like the COVID-19 pandemic impact women differently as well, leading to higher rates of depression and post-traumatic stress disorder. There is literature to suggest that being married is a risk factor for women when it comes to psychological outcomes in the aftermath of a disaster. This is contrary to the case of men, where it is protective (Norris et al., 2002). Women are more likely than men to experience depression when exposed to stress. Studies have established that stress has a relationship to depression (Brown and Harris 1978).

Gender discrimination that starts in childhood including male gender preference and gender-based discrimination related to education, choice of marriage and work may all add to risks for poor mental health.

4. Women may face several mental health problems related to the perinatal period, menopause and a smaller number of women may have a diagnosable premenstrual dysphonic disorder. It is common for a woman to undergo a gamut of emotions during pregnancy and after delivery. A range of factors including the genetic makeup of a woman and hormonal changes can influence the appearance of mental illnesses in the perinatal period. Pregnant women (or mothers during the post pregnancy period) might feel guilty for experiencing these contrary emotions in a period which is essentially viewed as a joyous and happy occasion in a woman's life. This might preclude a woman from accessing help early on.

Perinatal illnesses can occur during the pregnancy, after the delivery or anytime in the one year following the delivery. A woman might suffer from depression, anxiety or obsessive-compulsive disorder. A small fraction of women goes on to develop a more severe presentation known as psychosis. The illness might generate feelings ranging from passive helplessness to hostility. These feelings might get directed toward the baby. There are a range of consequences of untreated maternal mental illnesses including adverse outcomes in pregnancy and disrupted bonding with the baby (Jarde et al., 2016 & Hildingsson &



Rubertsson, 2022).

A condition that has gone unnoticed for too long is childbirth related trauma and the ensuing post-traumatic stress disorder. Although it is believed that the birth of the baby would compensate for the trauma caused, this is far from true for 3.1 to 15.7% of women who gave birth according to the studies (Grekin & O'Hara, 2014). High rates of obstetric violence and their relationship to poor mental health have been reported from most countries including India. Recollection of the trauma and living the trauma of birthing over and over, having nightmares, physical sensations and numbing might occur. A large subset of these women may struggle to bond with the baby feeling detached from the baby (Ballard et al., 1995).

Women facing infertility and assisted reproduction may also have mental health problems due to stigma and the pressure to have a child. Finally, certain medical illnesses, such as thyroid abnormalities, obesity, PCOS, are more prevalent in women than in men (Voskuhl, 2011).

This brief review reveals that women have different vulnerabilities when it comes to mental illnesses. Many of these vulnerabilities are related to abuse and violence, poor access to care and services as well as higher vulnerability to poverty and food insecurity. Women who are in more marginalized situations such as the LGBTQI + community, commercial sex workers and women with HIV are even more vulnerable. This leads to different needs when it comes to access to mental healthcare. Women with other disabilities including intellectual and neurodevelopmental disabilities face even more rights violations and stigma. Not recognizing this vulnerability and a lack of gender sensitivity can lead to serious violations of rights of women and have an adverse impact on their lives.

Rights of Women with Mental Illnesses in India

The new Mental Healthcare Act (MHA), 2017 aimed to endorse, uphold, and fulfill the rights of people living with mental illnesses. Emulating the provisions of the United Nations Convention on Rights of Persons with Disabilities (UNCRPD) the MHA, 2017 lays emphasis on rights of people with mental illnesses (Kaur, 2018).

The rights which are mentioned in the Act are:

- Right to access mental healthcare
- Right to community living
- Right to protection from cruel, inhuman and degrading treatment
- Right to equality and non-discrimination



- Right to information
- Right to confidentiality
- Restriction on release of information in respect of mental illness Right to access mental records
- Right to personal contacts and communications
- Right to legal aid
- Right to make complaints about deficiencies in provision of services

Right to access mental healthcare

The Human Rights Watch in 2014 (Sharma, 2014) brought out a report which elicited the dire conditions in which women were kept within several mental health institutions in India. This report was based on a visit by the Human Rights Watch to mental health facilities in Delhi, Kolkata, Mumbai, Pune, Bengaluru and Mysore. Excerpts from women in patients describe in detail how they have been forced to swallow medications with medications being shoved down their throats, subjected to electroconvulsive treatment without an indication, deprived of access to sanitation such as soap, towels and made to live much like animals. Women were expected to stay naked when their laundry was done at institutions, deprived of their basic right to education, threatened with the prospect of being punished in the “ECT room” when they do not comply. The range of atrocities women reported included neglect, physical violence, unsanitary conditions, and care. The report emphasized a serious gap in gender-sensitive healthcare.

Box 1- Analysis of concerns of women admitted in Psychiatric Institutions across India – a study by NIMHANS and the National Commission of Women

The National Commission for Women (NCW) collaborated with NIMHANS to seek information regarding long stay women patients in different psychiatric institutions in the country. From each region within the country, hospitals with the largest number of women long-stay patients were chosen for onsite visits and 10 such psychiatric institutes were visited for onsite evaluation by multidisciplinary teams of mental health professionals. In some institutes the wards were dimly lit, overcrowded, hot water was lacking, bathrooms were found to be inadequate and slippery with some patients defecating in the open. The overarching themes which emerged were that of abandoned women who were shunned by families, staff shortages and lack of regular surveillance, lack of legal aid and lack of safe and supportive community based rehabilitation services.

There is no doubt that women with mental illness should have access to quality mental healthcare which is affordable and accessible regardless of gender, sex, orientation, class etc. Although the notion is well-intentioned, this



has not translated into mental healthcare services. Mental healthcare needs to get integrated with primary healthcare in order to have increased accessibility. A subset of women suffers from a breach of their basic human rights within their own households in the form of intimate partner violence (Ellsberg et al., 2008). It might not be unreasonable to say that for women there are several barriers which hinder the access to mental healthcare. Women in mental health establishments are abandoned even after they have achieved remission in their illness. Even though the MHA, 2017 has made a provision for voluntary admission and discharge, lack of an income and the stigma faced outside of a mental health institution might prevent a woman from leaving the institute of her own accord even when such an opportunity is available (Kaur, 2018). It is noted that at times the institutions don't make enough efforts to reunite the women with their families.

Right to community living

It is a fundamental right to be able to live as an integral part of the society, not be isolated from it just because a woman is homeless or there aren't enough community based facilities.

Homelessness, mental illness and poverty interact with each other in a cyclical manner with one impacting the other. Faced with housing instability and a lack of appropriate resources for rehabilitation women often choose to stay incarcerated in long-stay institutions or resort to menial ways of living such as begging on streets

The MHA, 2017 also upholds the rights of a mother in a mental health establishment to not be separated from her child less than the age of three even if she were to have a mental illness. In the rare event that the mother poses a risk to the infant or the toddler due to her mental illness, the mother still retains the right to meet her child under supervision. A mother is not incapable of caring for her baby just because she suffers from a mental illness.

The unethical nature of conducting hysterectomies on non-consenting women with the excuse of a mental illness has been detailed in the annals of several journals of medical ethics (Pradhan et al., 2022). The flimsy excuse (for hysterectomies) of preventing the woman from getting pregnant if abused or raped reflects upon the lack of scrutiny in mental health establishments, state run hospitals and in the households. These vulnerable women have a right to be protected against these gross violations of their rights rather than being subjected to hysterectomies or tubal ligations without their consent.

As mentioned above, a team from the National Commission for Women (NCW) and the National Institute of Mental Health and Neurosciences (NIMHANS)



concluded that a subset of women reside in wards with poor lighting, lack beddings, live in dire unsanitary conditions and the bathing rooms lack privacy (National Commission for Women, 2016). Several institutions did not provide women in chronic wards menstrual hygiene products. There are some institutions within the country where the women with mental illnesses are not provided with adequate undergarments, are tonsured, and made to wear uniforms. The ward staff might argue that these measures are taken for the sake of convenience, for instance to prevent the spread of lice in the ward. It is the call of the day to find various ways to circumvent this problem in a way that the woman can exercise the fundamental right of what is done with her body or what she wears.

Finally, a woman has a right to information: to be able to know why she was admitted and to be able to opt for a person who represents her to make treatment decisions in her stead (also known as a nominated representative). She can also choose confidentiality such that the matters of her treatment for her mental health are dealt with sensitively. A woman in a mental health establishment has a right to access her basic medical records, and have visitors, make calls and receive calls and to have legal aid. In the event that the woman finds that any of the said rights are being violated or if she finds the care given to her in the institute to be unsatisfactory, she should be able to make a complaint to the concerned board about the deficiencies (Kaur, 2018).

Marriage and women with mental illnesses the “triple tragedy”

The Schizophrenia Research Foundation (SCARF) study demonstrated how stigma, negative attitude toward the woman from husband and in-laws often prevented a marriage from continuing. These women were separated although not legally from their husbands. The husbands went on to remarry and live parallel lives with legal separation in only 21.3% of cases (Thara et al., 2003). It has been noted that there is a wide disparity between the provisions of marriage acts in the country and the social means of treatment of the institution. Legal provisions need to be made to bridge this gap (I. Sharma et al., 2015). Despite stringent laws, a subset of husbands of women with severe mental illness abandons them and goes on to remarry and have parallel lives.

What can be done to empower women with mental illnesses and prevent the violation of their rights? – Some positive Case Studies

The next few boxes highlight attempts and initiatives by several organizations to ensure some restoration of rights of women with mental illness.



Case studies:

Box 2- Exemplary attempts by Anjali based in West Bengal

One such NGO based in West Bengal called “Anjali” aspires to translate the aims of the MHA, 2017 into reality. Some of their initiatives include surpassing roadblocks and barriers to help women in Behrampore Mental Hospital and Calcutta Pavlov Hospital achieve their basic individual right to vote. Dhobi ghar is an initiative by Anjali which was launched in May 2016 where the participants worked in shifts to wash the linen of the Calcutta Pavlov Hospital. The organization attempts to provide vocational experience to expedite reintegration into the community. One example of this is providing work at a tea stall within the campus of the hospital. During the COVID pandemic the organization conducted workshops on Trauma counseling. These attempts at rehabilitation and securing rights of people with mental illnesses are exemplary.

Box 3- Banyan, NGO in South India and its model methods of rehabilitation

The Banyan is an NGO instituted in 1993 in South India which has worked to create alternative institutional care and rehabilitation for independent community living. Their initiative to rehabilitate led to the starting of Adaikalam, Clustered Group Homes (CGH) and Home Again. These initiatives strive to provide a long-term safe space and rented accommodations in the community for women with mental illnesses. One of the key priorities is reintegration with family and continuity of care to prevent abandonment and homelessness.

Ten Recommendations to ensure Rights for Women’s Mental Health:

1. Gender sensitive mental health services including information

While the above rights are to be upheld for all, irrespective of gender, increased sensitivity is needed when it comes to women. The need for gender sensitive mental healthcare has to be emphasised as women are more vulnerable to violation of their rights than men are. Higher rates of gender based violence are reported among women with mental illnesses. Women might also lack access to their rightful mental healthcare due to having to care for children or lacking transportation. An expert survey found poor satisfaction levels for standards of gender sensitive care in both high-income countries and low and middle income countries (Chandra et al., 2019). One of the first steps to prevent rights violation is establishing and improving gender sensitive mental healthcare. Separate special treatment environments are needed for women to feel safe, to build on strengths, and peer support. to have a life stage focused care, and to channelise trauma informed care.

2. *Access to respectful maternity care*

The clinicians who deal with gynaecological and obstetric needs of a woman with or without a mental health problem should be sensitive toward the nature of the woman's illness. As discussed above, childbirth PTSD is now a well-recognised occurrence and is most often due to obstetric violence. It is objectionable if a woman with mental illness is subject to further trauma in maternity care or denied access to adequate healthcare altogether due to her disposition. More liaisons with the obstetric team would prevent gross violations of rights such as forced hysterectomies or abortions. Further, early disruptions in bonding can be prevented by emphasising on the right of a woman with a mental illness to be with her baby unless she poses a threat to the baby.

3. *Perinatal Mental Health and Mother Baby Unit models of gender sensitive care*

In a survey to evaluate gender sensitive care and satisfaction among mental health professionals, it was noted that experts endorsed the need for mother baby units and childcare, separate wards and an effort to prevent violence faced in the in patient care setting, trained and compassionate staff especially mental healthcare professionals and integrating the feedback of women to enhance services. Experts from both low and high income countries reported poor satisfaction when it came to the existing delivery of gender sensitive care (Chandra et al., 2019).

One area where some development has occurred in terms of increasing sensitivity to the needs of a woman in mental healthcare is perinatal mental health albeit in a few places in India. As discussed elsewhere in this article, mental health after the delivery of a baby can play a crucial role in how the mother bonds with the baby. About two to four women per thousand women have a mental illness severe enough to warrant an admission into speciality wards. These speciality wards are also known as a Mother and Baby Unit. These units are specifically designed to house a mother and baby together when the mother is suffering from a mental illness. Supportive staff help the dyad in nurturance and in developing a bond despite the mother's illness. The presence of MBUs ensures that a woman's right to be with her baby is upheld. A woman should not be separated from a growing infant due to the mere presence of a mental illness unless she poses a threat to the infant.

The National Institute of Mental Health and Neurosciences has a one of its kind mother and baby unit (MBU) which provides mental healthcare services to vulnerable women in the peripartum period with severe mental illnesses (Chandra, 2015). India needs many such units to provide sensitive care to the mother infant dyad in accordance with the MHA, 2017.



4. *Trauma informed care*

Many individuals with a severe mental illness display signs of trauma. Dissociation is characterised by a disconnect from one's thoughts, emotions, from the environment. The individual might lose a sense of identity or the way he/she perceives time. He might feel detached and disconnected and at times develop amnesia for events. Symptoms of dissociation have been linked to trauma. Studies have found a higher prevalence of dissociative symptoms among individuals with a severe mental illness such as schizophrenia (Renard et al., 2017). Being informed about the various forms of trauma and being attentive to the signs of trauma becomes very important when working with women who have Severe Mental Illnesses (Chandra, 2019). Finally, the aim should be to create a safe space for women with mental illnesses and to prevent further traumatization.

5. *Legal Aid*

Article 12 of the CRPD gives agency to persons with disability to enjoy legal capacity. Access to justice is difficult for the disadvantaged in our country. Women with disabilities face a bigger challenge when it comes to this. In mental institutions in our country there is no adequate mechanism to report abuse. Reporting the abuse to the staff doesn't constitute an adequate mechanism as more often than not the perpetrator of abuse could belong to the staff. The barrier to reporting also comes with a lack of trust in the testimonies. Women with mental illnesses are often labelled incapable of making sound testimonies (K. Sharma, 2014).

It is therefore recommended that legal aid be made accessible in all mental health institutions and these should closely work with the mental health review board (MHRB) in the institutes (Malathesh et al., 2021).

Box 4: Centre for Mental Health Law and Policy with Quality Rights Gujarat initiative

Centre for Mental Health Law and Policy funded by the WHO has developed interventions such as the Quality Rights Gujarat which strives to promote human rights and empowerment of the mentally ill. The Quality Rights Gujarat offers a set of lessons for recovery-oriented and rights-oriented care.

6. *Alternative solutions to rehabilitation and more community-based integration*

Women who have the capacity to make their mental healthcare decisions shouldn't be left to languish in mental healthcare institutes. These women should have adequate access to rehabilitation services so as to make a smooth transition

into community living. Efforts in this direction have been largely put in by NGOs in our country. The Banyan recommends large scale institutional transformation of state mental health hospitals (Narasimhan et al., 2020).

7. *The basic right to vote and to be able to have a bank account*

The ability to have a unique identity card such as an Aadhar card, a voter ID card and a bank account are essential means to empower and provide autonomy to patients. Having a mental illness should not prevent a woman from being able to exercise her right to vote or have a unique identity as a citizen of the country. As aforementioned, certain NGOs have taken strides toward making this happen. In a unique venture which set an example, the process of getting voter cards and Aadhar cards was initiated in NIMHANS. This was a dedicated effort to provide voice to the “voiceless” mentally ill in long stay wards (Sivakumar & James, 2019).

8. *Clothing, food, housing and medical care and fee waiver offs*

According to the universal declaration of human rights the right to an appropriate standard of living is a universal right. According to a preliminary study, women with mental illnesses who were below the poverty line lacked necessary and affordable housing and living conditions. Women in long stay institutions shouldn't be made to wear uniforms with lack of underclothing. The access to menstrual hygiene and underclothing is a basic right for sanitation. As mentioned before, this basic need is not fulfilled in several institutions throughout the country. In a study in NIMHANS when monetary incentives are provided in tasks to patients they gain the ability to exercise their choice when it comes to purchasing items for hygiene and personal use (Waghmare et al., 2016).

It has been noted that literate women with mental illnesses are impacted emotionally and perceive a lack of emotional connection with family members more so than their illiterate counterparts (Poreddi, Ramachandra, & Math, 2015). However, more women who have mental illness and have low levels of education are prone to face a lack of basic amenities when they have a mental illness.

Individuals who are below the poverty line have to lose a day's wage or more per visit for a consult (Poreddi, Ramachandra, Thimmaiah, et al., 2015). In India, once a woman is married, to qualify as being below poverty line (BPL), certain conditions must be met. These women struggle to get BPL benefits and are reliant on their husbands to make changes to include them into official documentation required to obtain BPL benefits. This further precludes a woman from obtaining affordable mental healthcare especially if there is separation or domestic violence.



9. *Reproductive and Sexual Rights of Women and Mental Health*

Having a choice related to contraception, parenthood, childbirth, and sexuality has a major impact on a woman's mental health. Women with mental health problems also have a right to these choices. However, decisions related to pregnancy are often not in their hands.

10. *Spaces that are Safe and free from violence and harassment*

As exemplified by attempts by NGOs and surveys, rights of women can be protected by providing them with a safe space to voice their needs. In institutions where there is no provision for Legal Aid any attempts at voicing the violations of rights might set off a cycle of perpetration of such atrocities. There also needs to be safe spaces for women with mental illness who face domestic violence. Staff in One Stop Centres and NGOs, as well as shelters needs to be trained in supporting women with mental illness who face gender based violence and ways of providing respite care.

Conclusion

Women's mental health is closely linked with Human Rights. Violence, poverty, food insecurity, lack of reproductive choice and unsafe environments with lack of opportunities for education and work, all of which are rights issues, are also risk factors for poor mental health. Gender sensitive policies and care can prevent unforeseen rights violations for all women including those who are most vulnerable. One must strive to view a woman with mental illness from a holistic perspective, as a respectable member of the society rather than someone who is identified just by the illness itself. Women with mental illness including those in institutions must have the freedom to express their choices, creativity, and potential.

As a nation which endorses inclusivity, we must constantly strive to advocate and ensure rights for women especially those who are "voiceless" and unheard.

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LGBTQIA+ and Mental Health

This chapter on LGBTQIA+ (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual +) Community, Mental Health and Human Rights takes a detailed look at the mental health (MH) needs of the LGBTQIA+ community. What are the stressors that LGBTQIA+ clients face, and can a human rights framework be applied in responding to their concerns? How can the affirmative lens be applied such that mental health implications of living in an unequal social system can be understood and responded to? This chapter is divided into two parts. The first part- 'Setting the Context' attempts to elaborate the connections between individual mental health and human rights in the context of the LGBTQIA+ community. Part two- 'Human Rights in Practice' uses an affirmative lens to describe Unique Life Stressors (ULS) of the LGBTQIA+ community. It details affirmative guidelines that mental health practitioners (MHPs) can incorporate to address individual concerns while upholding the human rights of the community.

Part 1: Setting the Context

Mental Health and Human Rights is an interesting intersection. We seek to identify linkages between two spaces that have not only traditionally seemed disconnected but have also perhaps resisted inter-connections. For example, why would mental health services that are traditionally individual centric, be required to carry an imagination of larger systems and social structures? On the other hand, why would the Human Rights discourse engage with an individual-centric field when its vision and mission are collective protection and promotion of rights? Thus, bringing together these two aspects might appear unconvincing at first- to look at seemingly intangible aspects of wellbeing (mental health) with the seemingly concrete aspect of conditions that allow for human beings to build a 'liveable life' (Butler 2004, 2009).

This chapter will discuss the ways in which an affirmative approach to the mental health of the LGBTQIA+ community is in fact work that is in the realm of human rights, albeit in a non-traditional manner. Mental health work has been historically seen as intra-psychic or about the individual seeking services. However, affirmative work with stigmatised populations (in this case LGBTQIA+



persons) can be a means to promote their human rights as it is connected to social inequality. In our society, only a heterosexual man or woman is considered 'normal' in our society. Those who are different from these ideas of man, woman and heterosexuality are immediately stigmatised. Indian culture is preoccupied with 'Indian family values.' Arranged marriages in which family elders match social locations of caste, class and religion before the marriage is socially sanctioned is still prevalent (Menon, 2012; Sen et al, 2011). Within such a culture, Narrain (2004) found "extreme hostility of Indian society to any expression of either same-sex desire or gender non-conformity. Societal institutions function under an imperative to mould the non-conformists into a heterosexist framework" (p. 147). Other studies have shown social exclusion, harassment, violence, being thrown out of educational institutions, jobs and homes, facing violence in public transport and public spaces when sexuality becomes known. Studies also reported that care seeking and redressal for violence was low due to fear of stigma. There has been collusion of various social institutions to maintain these value systems. Social hierarchies create "exclusion, marginalisation, pathologization and violence" (CREA, 2012, LABIA, 2013, Sappho For Equality 2011, 2016). Studies have documented human rights violations that queer people face (PUCL-K, 2001; UNHRC 2015). They report that the LGBTQIA+ community is vulnerable to censure from families, peers, social networks and institutions. There are documented instances of persons being denied access to education, forced separation or isolation and of being forced into heterosexual marriages. These studies indicate that the social system itself leads to adverse effects on queer and trans people, on a daily basis. This further leads to adverse mental health impacts.

In addition to a negative social system, queer sexuality and trans lives has been pathologized by mental health systems. Research as well as practice has continued to use a range of conversion practices against LGBTQIA+ clients (Ranade, 2009; Ranade & Chakravarty, 2013). Attempts to treat, incarcerate and gatekeeper gender affirmation processes are common. Only as recent as 2018, did the Indian Psychiatric Society finally declare "homosexuality is not a psychiatric disorder." The historical pathologisation within the mental health space has meant that there is a good chance that an individual from the LGBTQIA+ community will, at some point in their lives be 'taken' to the clinic by the family or will end up there themselves to make sense of the distress of living a life of stigma and discrimination.

Living with daily stigma and threat can have a direct negative impact on one's mental health as a LGBTQIA+ person. One's daily life as a queer or trans person is constantly under attack from various social institutions. When engaging with socially induced distress, the practitioner in the clinic is in a

constant space of engagement with individual distress as well as systemic inequalities that are the source of this distress. To understand this distress, an important conceptualisation of Minority Stress has been offered by Meyer. In addition to this, the Mental Healthcare Act (MHA, 2017) takes a strong stand against discrimination on the basis of gender and sexual orientation. Minority Stress and Anti-discrimination are strong points that connect individual mental health to human rights as elaborated below.

Minority Stress and LGBTQIA+ Community

LGBTQIA+ individuals experience high levels of stress due to minority status. Meyer (1995) says that the stigmatized minority's perception of non-acceptance in their social interactions leads to a state of insecurity – and, often, hyper-vigilance – in social situations, adding that ‘a high level of perceived stigma would lead minority group members to maintain a high degree of vigilance – expectations of rejection, discrimination and violence – concerning the minority components of their identity in interactions with dominant group members.’ (Meyer, 1995, p. 39). Minority Stress highlights four processes through which one can understand the lived experience of stigma and how it can cause mental health challenges. These are “prejudice events,” “concealment,” “self-stigma,” and “expectations of rejection” as discussed in Timmins, Rimes and Rahman (2017).

Minority stress model is a useful framework that helps locate the source of individual distress on outside factors, such as- negative attitudes towards certain genders and sexualities. Through this model we understand that, “(...) stressors are unique (not experienced by non-stigmatized populations), chronic (related to social and cultural structures) and socially based (social processes, institutions and structures)” (Meyer, 2003). The UN Human Rights Council Report (2015) clearly spells out how everyday violence and discrimination of a hostile system impacts mental health of individuals. The connections between individual mental health and the unequal social system are made explicit using the minority stress model thus pointing us in the direction of a human rights or affirmative approach to mental health.

Anti-discrimination stand in MHA 2017

The anti-discrimination clauses in the Mental Healthcare Act (MHA, 2017) in particular, the Section 18 (2) and Section 21 (1) (a) of the MHA state:

“18. Right to access mental healthcare. – ... (2) The right to access mental



healthcare and treatment shall mean mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination based on gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and caregivers.” “21. Right to equality and non-discrimination. - (1) Every person with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare which shall include the following, namely:- (a) there shall be no discrimination on any basis including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability;”

The connections between individual mental health and the unequal social system are made explicit using the minority stress model as well as the anti-discrimination stand of MHA, 2017, thus pointing us in the direction of a human rights or affirmative approach to mental health. Therapeutic Practice in the West has made a move towards a human rights approach (APA, 2000; Kort, 2008). In India, a move towards affirmative practice is slowly being welcomed (Ranade & Chakravarty, 2013, 2016; Ranade et al., 2022).

Part Two: Human Rights in Practice

This section focuses on stressors faced by the community and guidelines on how to respond to them. An affirmative approach in working with LGBTQIA+ clients takes into account three crucial factors-

1. That matters of gender and sexuality are matters of social inequality. The heterosexual cis-man and cis-woman is at the top of the pyramid. Non-heterosexual sexualities and trans persons are stigmatized.
2. That mental health knowledge has been historically pathologizing and gaps in knowledge about the LGBTQIA+ community continue and can be damaging towards clients from this community.
3. That mental health of the stigmatised individual cannot be seen in isolation without considering the impact of society's stigma on them.

Thus, the affirmative approach urges all MHPs to equip themselves with additional perspective, knowledge and skills to bridge this inequality gap and promote the human rights of the LGBTQIA+ community.

Unique Life Stressors (ULS)

Unique Life Stressors are experienced by minority groups only. MHPs need to remember that-



1. Being LGBTQIA+ in itself is not the problem. All bodies, genders and sexualities are normal.
2. Being LGBTQIA+ does not directly lead to mental health problems.
3. Distress and stressors are experienced because of the all-pervasive atmosphere of prejudice and stigma in everyday life.
4. Cisgender persons and heterosexual people will not experience the same stressors by virtue of living in a society where their way of life largely fits the social rules and is supported by social institutions. The LGBTQIA+ community faces the following stressors that take a toll on their mental health.

A. Difficulties with Self-Acceptance

Queer-trans people grow up in a world that has no representation of their authentic selves, where literature, media, and family life only showcase heterosexual persons and their lives. It is very hard to believe that one may be different and that that difference is normal and natural. People often grow up feeling a sense of alienation from their own selves, self-hate, shame or disgust because they believe what the world tells them- that it is wrong to be you. Thus, having a healthy sense of self about one's sexuality or gender is hard. Clients internalise incorrect and harmful ideas about themselves. They may believe that their sexuality is a 'phase' or that it is a 'disease' that can be 'cured'. They may attempt many self-corrective measures that may actually be self-harm. They might try to go against their natural feelings and forcefully try to fit the social ideas of gender and sexuality. These feelings of lack of self-acceptance often arise from internalised negativity about one's sexuality. Clients can experience a sense of guilt, hatred, shame, anger, denial, suicidal ideation, low self-esteem, self-doubt, confusion, neglect, repulsion, feelings of having done wrong, feeling different, feeling dirty, and similar negative feelings about their own sexuality or sexual behaviour. This can take an immense toll on their mental wellbeing and can drive queer and trans persons to self-harm and suicide. Sometimes clients may come to MHPs hoping to be 'converted' to heterosexuality or 'cured'. Conversion Practices of any sort are harmful and unethical. There is research to show that conversion practices do not 'succeed' because sexuality is not a matter of cure.

B. Coming out

If one's sexuality/ gender is different from cis-heterosexuality, then at some point one needs to face the truth and perhaps also tell others. This process is known as coming out. Heterosexual people never have to come out about their sexuality because society has already created a space for them. Coming out happens at two levels: coming out to self means realizing 'I am not heterosexual';



coming out to others means revealing to them that ‘my sexuality is different from heterosexuality’.

Coming out is stressful because the responses from others are often hostile and even violent. Coming out is a continuous process. With every new person, every new space, a queer-trans person has to assess whether or not to come out due to fear of negative reactions. This constant vigilance and anticipation of hostile responses impact mental health wellbeing of queer and trans persons. After coming out, they could face loss of friendships, pressures from families to ‘change’, discrimination in the form of losing their jobs or thrown out of rental homes, stopping of education or forced heterosexual marriages. Each of these actions have severe mental health consequences.

For trans persons, coming out would involve telling others that how society sees their gender is not how they experience it. In response, many transgender and gender non-conforming children (TGNC) face “correction” efforts – family members, teachers, and other adults in their lives try to get the TGNC child to fit the gender expression and roles associated with their birth-assigned gender. Not asserting, or being unable to assert one’s gender, and being misgendered in the process, has immense psychological costs.

C. Invisibility

Often due to fear of negative and violent responses, LGBTQIA+ people hide the truth about themselves and their lives. This may lead to double lives and censoring their own truth. Even if they are trying to be fairly open, people around them do not engage with this part of them, leading to erasure and silence. Thus, they end up living lives that are isolated with little or nothing to do with the outwardly heterosexual world. Clients may experience a heightened sense of isolation because they do not see a positive representation of their lives in society. Heterosexual persons receive social validation and benefits through marriage and legal sanction typically known as heterosexual privileges. In the absence of such privileges queer and trans persons may struggle to find any affirmation of themselves and their lives. They may experience a deep sense of loss without such validation which continues to impact their mental health adversely.

D. Discrimination and harassment

Queer and trans folks continue to be pathologized and devalued by healthcare systems, media, policies, education institutions, science and research. Discrimination is manifested in the form of violent responses, such as withholding resources and privileges, curtailing access and mobility, refusing equal rights. Clients are likely to have experienced some form of harassment and



discrimination on account of their sexuality – without any redressal, or even so much as an acknowledgment of such treatment.

Particularly to trans persons, right from their early years, they have to struggle against constant attempts – by parents, at home, by teachers, in school, by playmates and friends – to “correct” their gender presentation. Apart from social correction, with instructions on gender-appropriate ways of dressing, walking, talking, and so on, many TGNC children and young persons face correction efforts from professionals such as school counselors and child psychiatrists/mental health professionals, who are supposedly “helping” the child to fit into the birth-assigned gender. One result of this is that trans persons may get pushed out of educational systems as well as family homes at an early age. This often means fewer years of formal education, lack of access to familial resources and social capital, lack of access to vital documents related to one’s citizenship and educational qualifications. All these together lead to reduced life opportunities for trans persons.

E. Gender dysphoria

Specifically in the lives of trans persons, who experience body- and gender-related *dysphoria* which means distress due to the non-congruence between one’s gender identity and the sex-gender assigned to one at birth. This distress that arises from alienation from one’s own body is a major unique life stressor. A transman may have no difficulty in accepting the fact that he is a man – the distress comes from a body that feels ‘not right’ or from people who refuse to affirm his gender as he experiences it. Society insists that certain bodies fit certain genders. This social construction of the body binary and the gender binary- the classification of all bodies and genders into only two- results in an alienation from self and one’s body leading to severe, often chronic distress.

F. Gender transitioning

This refers to the process of changing one’s gender presentation or sex characteristics to match with one’s inner sense of gender identity. Getting appropriate medical intervention and care during gender-affirming procedures is very hard as medical systems can hold negative attitudes towards trans persons. Preparing for and undergoing transitions is essential but unfortunately a stressful and often dehumanising process. Gender transitioning may include social, medical and legal transitioning and in all these areas transpersons are met with prejudice and stigma.

G. Trans-erasure

Trans-erasure means to ignore, deny, minimise or even refuse to



acknowledge the existence of transgender persons. This takes the form of active discrimination or as corrective measures to make the person ‘fit’ social gender norms, as described earlier.

Mental Health Implications of unique life stressors

Having to live on a daily basis with such stressors is bound to have an adverse effect on mental health wellbeing of queer and trans persons. Depression, anxiety, panic attacks, low self-esteem, low confidence, self-harming tendencies, suicidal ideation – these are just some of the issues that queer and trans persons face. Diagram 1 describes how with each ULS there is a range of negative emotions that the individual goes through and resulting MH implications.

Table 1: Unique Life Stressors and Mental Health Implications of LGBTQIA+ clients

Difficulties with Self-acceptance	Coming out	Invisibility	Discrimination	Mental Health Implications
Sadness Shame Confusion Numbness Vulnerability	Severe self-doubt Hyper-vigilance Rejection	Self-doubt Fear Sense of having an irrelevant existence	Anger Feeling wronged Humiliation Paranoia	Depression Despair Suicidal thoughts Anxiety
Feeling ‘I don’t matter’ Anger Disgust Self-loathing Anxiety	Vulnerability Distrust Sense of loss Terror	Exhaustion Anger/Rage Hatred Feeling wronged	Fear Self-doubt Helplessness Despair	Shame Panic

Guidelines to do queer affirmative therapy and counseling (QACP, 2022)

So far in this chapter, we have tried to propose why working with mental health concerns of people from the LGBTQIA+ community is not just an individual matter but the social system plays a huge role in it. Being subject to prejudice leads to active discrimination against LGBTQIA+ persons thus making their everyday lives difficult to live and impacting their mental wellbeing. Thus, it becomes necessary to address their concerns through a human rights framework where MHPs can provide additional support that goes beyond their traditional training. This practice is generally referred to as Queer Affirmative Counseling Practice (QACP). Below are listed some guidelines on how MHPs can include an affirmative lens in their therapy work with LGBTQIA+ clients.



A. Tenet 1: Knowing and using queer affirmative language

Language is the primary tool through which counselors reach out to their clients and language is not free of context. Thus, if the context assumes that heterosexuality is the “only”, “natural”, “normal” form of sexuality, and homosexuality is “abnormal”, then this assumption will get reflected in the language used as well. It becomes the task of the queer affirmative counselor to identify and eliminate such heteronormative biases in language, where they exist, in their communication with clients. The queer affirmative counselor may also want to think about adopting – as part of a new language – new terms that convey inclusion, respect and trust.

Learning new language, and the deliberate use of queer affirmative language–

- Using respectful language for all sexualities and genders.
- Using gender neutral, open-ended language.
- Using the terms and pronouns that the clients use.
- Building a vocabulary of language that queer and trans communities are using for themselves.
- Supplying affirmative language to clients; helping them to find language that feels affirmative to them.
- Using “normative” (or equivalents) to refer to the mainstream/power centres, instead of the loaded descriptor “normal people”.
- Not using deadnames (A deadname refers to the name that the person was assigned in their infancy, but which does not reflect their gender or their felt reality.)
- Foreground the client’s gender and sexuality in sessions.

B. Tenet 2: Having – and publicising – a queer affirmative setup

A significant aspect of the counseling process is its physical environment. The physical space in which counseling takes place, like the attitudes counselors carry within those four walls, has an impact on the client. Affirmative approach gives importance to making the counseling setup a queer and trans inclusive space.

Setting up and publicising a queer affirmative space–

- Put up posters in the counseling room to indicate that people across a range of gender-sexuality identities and relationships are welcome here.
- Add books on queer and trans subjects to your bookshelves.
- Keep queer and trans friendly magazines in the reception area.



- Print brochures that include queer- and trans-related information.
- Advertise on your CVs and visiting cards that you are a queer affirmative practitioner.
- Advertise on your social media by following queer and trans handles and posting queer affirmative news.
- Use inclusive intake sheets/forms that ask open-ended questions about name, pronouns, sexuality, gender, and relationships.
- Train any attending staff to be sensitive towards these issues (particularly gender presentation, which is often the most visible marker of non-normativity).

C. Tenet 3: Avoiding assumptions and learning to respect diversity

MHPs must be careful about not making assumptions about their clients based on ingrained prejudices and stereotypes about clients' gender, sexuality, relationships, sexual behaviors. Connected to the need to guard against assumptions and misconceptions is the issue of diversity. The tendency is to see heterosexual individuals as “whole people” with multiple identities, roles, and social affiliations – and not merely in terms of whom they have sex with. We think of them as Tamilian, Maharashtrian, Hindu, Christian, old, young, educated, unemployed, upper caste, poor, rich, artists, engineers, dusky, fair, and so on. However, when it comes to queer and trans people, the entirety of their being often gets reduced to the sexuality or gender.

D. Tenet 4: Challenging the misinformation that clients have

This tenet amplifies the need for QACP counselors to take an educative stance in counseling sessions. Very often, queer and trans people grow up surrounded by silence about their realities. They have little information, limited access to resources, and distorted media representations of themselves. As a result, clients may lack information, be confused, or even have inaccurate notions about queerness or about LGBT communities. They might come with misinformation related to sexual acts and behaviour, sexuality, gender identity and expressions, medical/health issues, legal rights, societal attitudes.

QACP practitioners must–

- avoid confirming or validating misinformation
- explore the source of the misinformation, and then supply the client with new knowledge and information
- increase the client's access to queer and trans affirming materials like books and films, resources such as websites, organizations, support groups



and – should the client require medical assistance – genuinely queer and trans-friendly general physicians, or specialists such as gynecologists, psychiatrists, dermatologists, and so on

- build a data bank of locally available resources that they can give their clients (*see Tenet 6 below*)

E. Tenet 5: Facilitating self-acceptance

Growing up with distorted images of oneself, or in silence and shame, can make it extremely difficult to develop an integrated, “whole” self. Accepting oneself as one is, in the face of opposing social attitudes and cultural imagery, is no easy task; finding oneself worthy and feeling proud of oneself seems even more arduous. Yet it is a core goal to strive towards in affirmative practice.

Research studies have documented the stages that queer individuals typically go through in the process of self-acceptance. A denial of one’s feelings of attraction to people of the same sex is common – individuals might try to avoid these feelings by wishing them away, seeking distractions, and so on. Eventually, while they might learn to live with the feelings, acting on them could be associated with intense shame and guilt. Comparisons with the experiences of cis-het friends are likely to be frequent, and unhelpful. A sense of being “the only one” with such desires, and fears about being “abnormal”, may plague the individual. The person might seek information, and search for reading materials on same-sex sexuality, to try and make sense of their feelings and desires which do fit into the heterosexual script that is assumed to be universal. They may come across prejudiced information and continue to experience turmoil until they find safe spaces that normalise their reality and provide them with affirmative information. Getting in touch with the community, real or virtual, is often a milestone. Meeting others like themselves and being able to explore their sexual attractions and desires enables a person to develop some comfort in their own skin.

The counselor’s role in facilitating self-acceptance:

- A counseling space is often among the first few spaces where individuals are able to talk openly about their queer desires. And so the responses that clients receive here are vital to their future journey. If clients experience prejudice, discomfort, stigma, then their process of self-acceptance is likely to receive a severe setback and they may feel driven further into the closet. On the other hand, if the first such interaction is validating, where the client feels accepted, is assured that they are not alone – and that their feelings are not pathological, and is given information on resources for queer/trans people, then their journey of self-acceptance is likely to be quicker.



- Mirroring is another important process in the development of the self. All of us need to see positive images of ourselves being reflected back to us by significant persons in our lives such as family members, friends and neighbours, besides people in society at large. However, most queer/trans persons tend to be deprived of this experience in their growing-up years, especially when it comes to aspects of themselves that are not in conformity with prevailing norms. This lack of positive images can cause considerable trauma to the developing self. Providing, in the counseling space, affirming, validating experiences of mirroring to queer/trans clients with respect to their sexual and gender expressions is thus very important. It may provide the client with an emotionally corrective experience that is vital to self-acceptance.
- Encouraging clients to place the onus of their problems outside of themselves, and on the homoprejudiced society they inhabit, is useful. From where is your client's distress coming? From the social rules that are not made for your client's experience. Helping the client make this connection is a crucial step forward.
- A therapeutic group is another effective strategy to enhance self-acceptance in clients with a high degree of internalised homophobia. Group sessions can help to reduce the isolation that clients may have faced while growing up. They also provide safe ventilation spaces.
- Counselors, just like doctors, are seen as being in a position of authority. Clients and their families ascribe considerable power to the counselor. Thus, when a counselor offers basic information about queer sexuality and trans lives that is non-pathological, normalising, affirmative, and informative about resources for queer and trans people, the fact that all this information is coming from an "expert" helps both clients and their families to better accept the non-normative sexuality of one of the family members.
- Homoprejudice, stigma, discrimination, internalised homonegativity, and difficulties with self-acceptance – this forms a vicious cycle. The more the number of negative life events and experiences of violence and discrimination related to one's sexuality, the more the individual is likely to be isolated; to feel ashamed, inadequate and unsupported; and to face greater difficulties with self-acceptance. Counselors must recognise this cycle and help clients make the links between their experiences of stigma and their mental health situation in counseling sessions.
- Providing resources about – and connecting clients to – community (see *Tenet 6 below*).



F. Tenet 6: Knowing about – and engaging with – resources and community

Three main reasons to do so:

- Counselors who not only know of but also engage with, both resources and community spaces, become better acquainted with the problems their queer/trans clients typically face, and with other services for queer/trans individuals.
- If a counselor is able to put queer/trans people in touch with relevant resources, this could be of significant help in reducing the client's sense of isolation.
- Knowing about resources and services for queer/trans individuals would help counselors to make better referrals and provide more effective services to their clients.

Resources that the QACP practitioner should make themselves familiar with, and be able to suggest:

- books, magazines, films, websites with information on queer/trans issues including resources to do with health, mental health, stressors
- social media links for social events for queer/trans people – parties, film festivals, public events, pride marches
- contact details of reliable NGOs, support groups – forums that have drop-in spaces and meetings
- community-run phone line numbers for groups and individuals doing crisis intervention work – including housing, support with employment, etc.
- queer/trans affirming services that include doctors, gynaecologists, endocrinologist, MHPs, surgeons, lawyers, NGOs, activists, and so on

G. Tenet 7: Maintaining confidentiality

Confidentiality is an inherent part of counseling ethics. However, it becomes an additional concern for queer/trans persons, because–

- The societal stigma towards queer and trans people heightens the possibility of violent consequences towards them if confidentiality is breached and clients are outed.
- Queer and trans communities, like most other marginalised and minority communities, are often close-knit. Hence information tends to circulate quickly, and breach of confidentiality regarding various personal matters can cause the client avoidable distress.



- Most cities and towns have a limited number of mental healthcare providers that are friendly and accessible to queer/trans folks. This means that most people access the same limited number of clinics/therapy centres. The mental healthcare provider would need to be mindful of this while fixing back-to-back appointments for queer/trans clients, using examples from other clients' lives in therapy sessions, and so on.

H. Tenet 8: Self-awareness and enhancing competence

Self-awareness on the counselor's part is vital in all counseling processes. Knowing about one's own biases and inadequacies and seeing oneself as fallible – and therefore open to correction, change and growth – lie at the heart of this tenet.

With respect to working with queer and trans clients, the MHP needs to–

- reflect on one's own gender-sexuality journeys – taboos, and ideas of propriety, morality, disgust: where do these come from? What has changed? What was responsible for these changes?
- ask oneself – not limiting oneself to issues of gender-sexuality, although these can be significant – 'what does the client evoke in me? and what do I evoke in the client?'; reflect on what aspects of their life and realities are easy to empathise with, and where empathy becomes difficult; think about what evokes judgement, and when is one's struggle to keep from judging at its most intense
- recognise one's own locations of power and privilege with respect to gender, sexuality and other social locations
- become aware of and challenge internalised homonegativity/ trans-negativity and prejudices
- be willing to change personal beliefs, and manner of professional practice
- recognise one's share in the collective responsibility for stopping harmful treatments of every kind and for promoting an affirmative approach

Conclusion

One can hardly expect an ideal state of wellbeing from an individual who is constantly being seen as undeserving of respect and regard. The mental health costs of living a life like this are immense. Not only are LGBTQIA+ identities pathologized in mental health, but so are effects of living a life of discrimination. Everyday discrimination does not make for rosy mental health. Those on the margins need multiple forms of support to survive in this hostile world. Mental health or counseling support goes a long way in helping queer individuals cope with everyday stressors of being queer. In addition, to combat



the inequality in society and pathology in mental health systems, MHPs need to consider participating in demands for dignity, equality, inclusion, and social justice. Is it enough to be a therapist who engages with queer and trans clients in a therapeutic space but is otherwise not aware of, or connected to, any of the larger struggles that contribute to each client's distress? For instance, the widespread opposition to The Transgender (Protection of Rights) Act, 2019, which discriminates against trans communities more than it protects them – is it enough to attempt to address the distress such laws evoke in trans clients, or do MHPs see themselves as participating in broader campaigns to promote social justice? It is important to recognize that affirmative therapists need to be advocates of human rights and demonstrate their commitment to social justice by promoting the wellbeing and rights of the LGBTQIA+ community.



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Mental Health at Workplaces

Introduction

Non-communicable diseases (NCDs), including heart disease, diabetes, cancer and chronic lung diseases, cause 2 out of 3 deaths today, both globally as well as in developing countries like India. Leading experts suggest that mental health should also be included among the NCDs. According to WHO and Harvard economists, the impact is staggering – some \$47 trillion is the estimated global cumulative economic output loss over 20 years, 2010-2030, if mental health and NCDs remain unaddressed (Harvard 2022).

One-third of the global burden is from mental health (WHO, 2020). Mental ill-health is a leading contributor to the Global Burden of Disease, impacting approximately 450 million people and one in every four across the lifespan. Within low and middle-income countries, over 80% of people in need do not access mental healthcare (Gururaj et al., 2016) due to a lack of awareness and stigma around mental health and a lack of availability of quality services. Young people are particularly at risk, with suicide being a leading cause of death and depression the leading cause of disease burden amongst adolescents and youth (WHO, 2022). A total of 1,64,033 suicides were reported in the country during 2021, showing an increase of 7.2% compared to 2020, and the rate of suicides has increased by 6.2% during 2021 over 2020 (NCRB, 2021).

Thus, addressing mental health is a recognised global and national health priority, to be realised through a continuum of care which includes promotional, preventative, treatment, and long-term support and recovery interventions. The Universal Declaration of Human Rights (UDHR), a milestone document in history adopted by the UN, recognises that “the inherent dignity (and) the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world. The second Article of UDHR emphasises the universal nature of rights:

“Everyone is entitled to all the rights and freedoms outlined in this Declaration, without distinction of any kind, such as race, color, sex, language, religion, political or other opinions, national or social origin, property, birth

or other status.” While mental illness was not mentioned explicitly in the list of factors which were not to form the basis of discrimination, it undoubtedly belongs under the term “other status.”

In 1991, the UN made this more explicit in its Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare that, ‘Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights’.

The Workplace and Mental Health

More than half the world’s population is working, and decent work is essential for mental health. However, one out of 15 working adults may have a mental disorder, and an estimated 12 billion working days are lost globally due to depression and anxiety (WHO 2022).

According to World Bank estimates, India has 0.5 billion people in its labour force, and this is expected to grow to over a billion working Indians by 2050 (United Nations Development Program, 2016). It is estimated that India is adding 12 million people to the working population each year and that the proportion of the working-age population will increase to 65% by 2036.

Risks to mental health at work include workplace-related factors (organisational culture, poor safety conditions, duration of work, the quantum of work and pacing of work, poor control over workload, poor physical working conditions, poorly defined job roles, lack of support, lack of access to healthcare, violence harassment and bullying as well as poor job security and lack of work satisfaction. Age, gender, and other socio-demographic factors can also complexly interplay with other factors at work. Factors outside the workplace, including conflicts at home, can impact a worker’s ability to meet the demands of the workplace and lead to further stress. It is said that the workers are seldom able to leave their problems at home ‘outside the factory gates’.

Poor mental health strongly correlates with reduced productivity, sickness absences, and accidents. A 2017 study by Deloitte found that mental ill-health costs UK employers up to £42 billion annually, a figure which is possibly even higher in settings such as India with such high unmet needs for mental healthcare. Mental health costs to employers include reduced employee productivity exhibited as “absenteeism”, burnout and stress (Deloitte, 2017).

The ecological model of mental health suggests that a person’s mental health is influenced by personal factors (individual vulnerability to mental disorder, temperament), workplace factors mentioned earlier, and factors outside the workplace (including family, community and society). Sadly, people with severe mental illnesses may either get left out of the workforce, or, if they



develop the illness while employed, may not be able to retain their jobs, leading to distress for themselves and their families.

COVID-19 and its Impact on the Workplace

There is evidence from all over the world on the impact of COVID-19 on mental health in the community and the workplace. For example, more than one-third of employees (36%) surveyed in a study reported experiencing mental problems, and half of the sample (50%) were worried about an uncertain future due to the COVID-19 pandemic (Pandya et al., 2022).

Studies from India have also described higher levels of emotional distress, burnout, sleep disturbances, anxiety, depression and post-traumatic stress among police officers. (Khadse et al., 2020) Healthcare workers also reported higher anxiety, depression, suicidal thoughts and alcohol use (Parthasarathy et al., 2021). The impact of COVID-19 is not only through the loss of life and ill health from the illness but also the subsequent problems emerging from job loss, financial strain, isolation and readjustments.

Integration of Mental and Physical Health

In India, we have the dual problems of communicable disorders such as tuberculosis and HIV, and NCDs. Both communicable diseases and NCDs are associated with significant mental morbidity, and unless the mental disorders are addressed, the person does not recover fully. People with severe mental illnesses also die 10-15 years prematurely from NCDs. Thus NCDs, including mental illnesses, are now one of the century's leading health and development challenges. Since the workplace is a microcosm of the larger community, the need to look at physical and mental wellbeing and disorder in an integrated fashion (Muliya and Murthy, 2021), particularly at the workplace, becomes critical.

Fortunately, these diseases are largely preventable. According to the World Health Organization (WHO), 80% of heart disease, 80% of diabetes and 40% of cancers can be prevented with three lifestyle changes – eating right, exercising and avoiding tobacco. It is commonly said that controlling preventable risk factors can reduce the risk of NCDs and improve their outcome.

Addressing Workplace Mental Health

Corporates and large organised workplaces are beginning to show interest in workplace mental health programmes. There has been a paradigm shift towards a proactive and preventive approach towards workplace mental health. A WHO/ILO (International Labor Organization) brief advocates an approach which aims at reducing the risk of mental distress, protecting and promoting mental health at work, reshaping the work environment, addressing stigma and social exclusion

and ensuring that persons with mental health conditions, are supported and protected (ILO, 2022a).

However, addressing mental health issues in smaller workplaces and the unorganised sector is a greater challenge. The broad principles of the ILO in promoting mental health and substance use prevention at the workplace can be beneficial in developing such programmes. The ILO approach (primarily for alcohol and drug use prevention) advocates the traffic light approach of classifying people in the organisation into three zones - the green zone with people who are healthy and would benefit from health promotion activities (Keeping the green, green). The orange or amber zone can be viewed as having people with mild problems, where self-recognition and self-help may be essential strategies and making support available. The red zone would consist of employees with a diagnosable condition with a consequential impact on the workplace. Such employees may need treatment, referral, and efforts to integrate them into the workplace once their acute problems abate. Mental health literacy at workplaces, mental health promotion activities, more open dialogue about psychological distress and reaching out, and making employees aware of strategies of self-help, peer support and where they can seek help within and outside the organisation are all practical and helpful steps to promote mental wellbeing and treat illness. Understanding that psychological and physical conditions often influence one another and the need to address both holistically is also very important. The ILO-SOLVE presents one such integrated approach at the workplace (ILO 2012).

Pre-Induction Training- Addressing Mental Health Promotion

Many people in their 20s and 30s are in productive work and would benefit by improving their lifestyle habits. This effort to bring change can be initiated in the formal, organised workplace sector. Workplaces which employ millions of young working Indians can be smart platforms for change. There is a need to build a culture of health in workplaces in India to address employees' physical and mental health. Mental health programs can improve literacy and longer-term improvements in working conditions and job quality—given adequate organisational commitment, support, and time to achieve organisational change. A workplace mental health platform can help to take care of employees' mental health, and to evolve the most innovative ways to improve their performance sustainably.

A Culture of Health at Workplaces

According to the definition from The US Centers for Disease Control and Prevention: *a culture of health is a working environment where employee health and safety is valued, supported, and promoted, through worksite health & wellness programs, policies, benefits, and environmental supports.*



Broadly aligned with the above and WHO's Framework of Healthy Workplaces, Healthy Workplaces are those that invest in quality employee health and wellness programs to encourage healthy eating, no tobacco use and physical activity, that provide sound mental health support, where leadership credibly and visibly champions healthy living, where health is a core part of the companies' growth strategy, where the companies track metrics and use the data for continuous improvement.

The Arogya initiatives

Efforts by the Arogya World, an NGO working on workplace health have included bringing together multiple stakeholders (public health and medical experts) and business and human resource leaders to deliberate on the characteristics of a healthy workplace. Common opinions on what constitutes a healthy workplace included a no-tobacco policy, access to healthy foods, exercise, adopting a work-life balance and the need for a shift in mindset. The NGO has recognised 175 companies, spanning 5.5 million employees as Healthy Workplaces (Arogya World, 2022). This list includes the Indian Railways, India's largest employer, with 1.3 million employees and a small 50-person organisation. These healthy workplaces were identified across various sectors, including manufacturing, information technology, public sector undertakings, airports, shopping malls, hotels, garment factories, etc., all over India.

The organisation has also worked with global experts to develop a checklist of mental health criteria and cross-cutting organisational values that include:

- **Parity:** Mental health concerns should be treated with the same degree of compassion, urgency, and access to care as physical health concerns.
- **Equity:** Inequity is an essential social determinant of mental ill-health. As such, workspaces must provide equitable working conditions and benefits for all employees. The inequitable impact of workplace policies on mental health must always be acknowledged and addressed. Mental healthcare should be available and accessible to all employees regardless of the level of seniority or job description.
- **Inclusion:** Diversity of identity, for example, gender, age, ethnicity and sexuality, should be recognised, respected and emphasised. There should be zero tolerance for any form of discrimination.
- **Confidentiality:** Confidentiality and privacy of employees must be maintained for all HR-related matters, especially in relation to health (including mental health), and should not be shared with anyone in the workplace or externally without explicit consent of the person concerned.
- **Dignity:** All persons must be treated equally with dignity and respect

regardless of their place in the hierarchy of the workforce, their identity or their experience of a mental disorder.

Based on pre-defined metrics, 40 companies have been listed as Platinum Healthy Workplaces (2022).

The National Institute of Mental Health and Neuro Sciences (NIMHANS) has collaborated with Arogya World to develop stress reduction text messages for working Indians. This is an example of leveraging technology to provide mental health and NCD prevention training to workers and consumers across the country.

Other workplace initiatives to prevent mental health problems and substance use in India

More than two decades ago, a joint initiative of the ILO, United Nations Office on Drugs and Crime (UNODC) and the Ministry of Social Justice and Empowerment, Government of India, focused on developing workplace programs for drug abuse prevention. These narratives highlighted the benefit of partnerships in developing programs focusing on drug use prevention, early detection, treatment and rehabilitation (ILO, 2002). NIMHANS has also engaged with workplaces in Bengaluru to highlight the importance of psychosocial interventions at the workplace (Murthy and Sankaran, 2009).

More recently, mental health interventions in India have included corporate wellness programs (with a focus on work-life balance); employee assistance programs (counseling services both outsourced, in-house and through digital means), employee wellbeing programs (focusing on physical and mental health); peer support programs (including mental health advocacy, peer support and peer to peer counseling) (Pandya et al 2022).

A recent survey of human resource leaders from 400 organisations across India from 15 different industries found that half reported offering health benefits such as screening or health awareness programs and dedicated resources to address the spectrum of wellbeing, including mental wellbeing. However, only 40% had a documented wellbeing plan, and impact assessment and documentation of workplace mental health interventions were lacking (Pandya et al., 2022).

Future directions to ensure mental health and wellbeing at the workplace

COVID has taught us that health is now more critical than ever before, from the boardroom to the factory floor, and that NCD prevention is vital. It is also imperative to address mental health – workplaces can view it as a significant talent retention effort. Employees who can cope with stress will be more productive and contribute more to the organisation. It is necessary to evolve



metrics to get a good grip on employee health and health risk indicators.

Ensuring a healthy workforce is critical for India's future, meeting its Sustainable Development Goal (SDG) commitments, and maintaining its competitive edge as an economic powerhouse on the global stage. Organisations need to own workplace health programs and ensure that individual employees make responsible behaviour change and commit to leading healthier lives. This will ensure a win-win situation for employers and employees. Multi-sectoral action and public-private partnerships are essential. The government can quickly make a dramatic impact on health through effective workplace policies on integrated physical and mental health. Civil Society Organisations (CSOs) can build a healthy living movement and take prevention to the last mile. Academic institutions can help with making evidence and adding expertise and research capability. Companies can support the health of their employees and their families and help communities emerge stronger. Modern technology, including mobile phones, social media, Artificial Intelligence, telehealth and new medical devices, can help to scale prevention in many exciting ways. Together, these approaches can make a meaningful impact.

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Homelessness and Mental Health

Homelessness on the background of mental illness is evident in urban India. It is estimated that there are 1.7 Million people in the country, representing 10% of the global homeless population (Census India, 2011). The reason for such a plight is related to many complex factors like changes in socio, economic, familial, political and urban development-related issues. Lastly, monsoon-dependent agriculture, irregular migration to cities and towns, and subsequent lack of low-cost housing are reasons for the growing homelessness among mentally ill people. Mitigating the needs of the homeless mental population is directly proportional to the mental healthcare resource available within the country. For example, 43 mental hospitals in the country create about 20,000 hospital beds at any given time. However, only 50% of these beds are occupied.

Moreover, 723 District Mental Health Programs are distributed across 27 States and 9 Union Territories. Paradoxically, the treatment gap for people with mental health problems lies in the range of 70-80 percent, and this proportion is likely to vary across different diagnostic groups. In total, the plight of people with respect to mental health problems is far from satisfactory and deprives them of basic access to food; healthcare violates their fundamental rights. In addition to the above, women and the elderly are subjected to a much harsher reality of physical, emotional, and sexual abuse resulting in absolute misery and suffering. Furthermore, many homeless mentally ill persons on the move experience accidents, resulting in permanent disability due to a lack of appropriate medical/surgical care. It is widespread to cause malunited fractures, joint dislocations, shortened limbs, and bone marrow infection due to road traffic accidents. Unfortunately, such individuals have to live with triple trauma of homelessness, mental illness, and physical disability due to bone injury.

Addressing the need of the homeless population with mental health problems are possible today since economic effective, safe interventions are available. Further, rights-oriented, user-friendly, recovery-enhancing models such as Emergency Care and Recovery Centre, developed by The Banyan in Chennai, Tamil Nadu is a potential model that can be replicated in different



States and Union Territories within the Indian Union, provided adequate resource allocation is made. It is also crucial for the Government and society to collaborate so that resource pooling is done transparently and creatively so that monies can be used for the welfare of the most neglected sections of society, like the homeless. Further, some of the states in the country have a system of collecting beggar cess; if this is appropriately used, a lot of resources can be pooled to provide good care for the people suffering from neglect.

Profile of Homeless Mentally Ill

The homeless mentally ill population represents a high risk for physical ill health and premature mortality due to under-nutrition, mental health problems and substance misuse. Homelessness, defined as house-less-ness (Census India, 2011), is a state where people live in places other than a house with a roof. Although there are many reasons for these circumstances, the combination of mental illness and homelessness is bi-directionally associated. The issue gets entangled with so many other social and economic factors that turn into a vicious cycle, driving the said person into the lower strata of society. Considering the population of India and the prevalence of severe mental disorders (likely associated with homelessness), the issue becomes one of public health importance (Gopalrao et al., 2019). Common mental health problems in this population include severe mental illnesses like schizophrenia, bipolar disorders, other psychotic disorders, substance abuse disorders and personality difficulties. Persons with such problems gravitate to the centre of the city, which does not require great skills to survive. Therefore, most of these populations are found in central markets, railway stations, bus stations, large temples, pilgrimage places, and so on.

Further, an environment such as this is an ideal ground for abuse, particularly the women. Periodic surveys of such locations can facilitate early identification and admission to emergency care recovery centres, psychosocial shelters, and other mental health facilities run by Non-Governmental voluntary agencies in urban areas. Factors associated with homelessness amongst mentally ill women are described by Preetha K et al. 2021. It is estimated that there are 620 urban shelters in operation following the directive from the Supreme Court of India in 2011. Though the numbers appear prominent, it is far from satisfactory.

Evolution of efforts to protect the rights of individuals and Mental Healthcare Act 2017 – Provisions to protect the rights of homeless mentally ill

In light of the unprecedented humanitarian atrocities of the Second World War, the United Nations (UN) was established in October 1945 to promote

international peace and security and reduce the possibility of further wars. One of the primary aims of the new organisation was to articulate an intellectual and legal framework that would support the observance of human rights among member states and promote a culture of human rights throughout the world. To promote these goals, the Universal Declaration of Human Rights (UDHR) was adopted by the UN General Assembly at Palais de Chaillot in Paris on 10 December 1948. The UDHR was presented as a nonbinding statement of rights, the first stage in a process which continued with the drafting of the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, adapted by the UN General Assembly in 1966. This emphasis on universality is both valuable and necessary, not least because previous declarations of rights had commonly been interpreted in such a way as to exclude certain groups. While mental illness was not mentioned explicitly in the list of factors not to form the basis of discrimination, it undoubtedly belongs under the term "other status". In 1991, the UN made this more explicit in its Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Healthcare.

"Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment' (UN 1991).

The Mental Healthcare Act, 2017 (MHA, 2017) was enacted in compliance with India's obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD) with the objective "to provide mental healthcare and services for persons with mental illness and to protect, promote and fulfil rights of such persons during delivery of mental health and services and for matters connected therewith and incidental to." The MHA, 2017 is guided by universally accepted principles based on the CRPD as rights-based legislation for providing mental healthcare and treatment. These principles include:

- All individuals are entitled to fundamental human rights, including the right to equality, liberty, and dignity;
- Every person must be given the autonomy to make the choices they consider the best for themselves, and this extends to decisions about their mental healthcare and treatment;
- Everyone has the right to full participation and inclusion in society;
- No person can be discriminated against on grounds such as caste, class,



ethnicity, sex, gender, sexual orientation, religion, disability, or social, political, or cultural beliefs;

- Receiving appropriate and varying levels of support (supported decision-making) is integral to exercising one's right to make their own decisions.

The MHA, 2017 recognises the rights of all persons with mental illness while receiving mental healthcare and treatment. It also acknowledges the right to access mental healthcare and treatment for all persons without discrimination. For this purpose, the MHA, 2017 prioritises mental health professionals, caregivers, law enforcement officials, and the Government to provide rights-based mental healthcare and treatment. Further, it also puts in place procedures and safeguards to ensure that persons with mental health problems are protected and not discriminated against. The MHA, 2017 makes it mandatory for all mental health professionals in India to make changes to their clinical practice to comply with the law.

Conclusion

Mental illness and homelessness is a universal phenomena. Even though effective treatment is available, close to 70-80% of persons with severe mental disorders do not receive treatment. Lack of treatment results in worsening disability, reduced quality of life, and descent into homelessness, and withdrawal is very well known. Amidst the above, the violation of the rights of mentally ill defenceless individuals is a matter of great concern. Therefore, efforts to protect these individuals' rights, including food, shelter, medical and psychiatric care, social care, and welfare benefits, are of paramount importance. Only one State in the country, Tamil Nadu, has evinced particular interest regarding this voiceless group in post-independent India to develop a policy to protect their rights. Establishing psychosocial shelters, National Urban Livelihood Mission (NULM) shelters, and increasing access to care for the homeless through innovative approaches and initiatives by the NGOs is a step in the right direction. Increasing fund allocation, increasing the number of urban districts' mental health programs to explicitly cater to the needs of the homeless mentally ill population by increasing outreach services, setting up low-cost housing through panchayats, municipalities, and corporations, regular monitoring the ground situation by the national human rights commission goes a long way in strengthening this aspect of care.

Key suggestions

- All homeless persons should have access to mental healthcare, general healthcare and social welfare benefits.
- Homeless, mentally ill persons, especially women, should receive



protection and safety in railway stations, bus stations, and other public places.

- All homeless persons should be registered in the city and provided shelters as soon as possible. This ID card should be how they access food, shelter, healthcare, and other benefits.
- The jurisdictional police should register crimes against homeless mentally ill women expeditiously, so that they feel secure.
- They should be linked to resources such as kind people and happy cities where they can access food and clothing.
- The jurisdictional police should rescue them and reach them to a public health facility or any other mental health facility in the local area.
- The number of psychosocial shelters, emergency care, and recovery centres should be increased so that homeless mentally ill persons can access care.
- Police personnel should receive adequate training in MHA, 2017 and the rescue process



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Addictive Disorders Treatment and Human Rights

Introduction

Substance use disorders (SUD) and behavioural addiction are serious health issues, with a significant burden on the affected individuals and their families. There are also significant costs to society including lost productivity, increased healthcare costs, and various negative social consequences. The global status report on alcohol and health, 2018, estimates that there were 2.3 billion current users of alcohol in 2016 (World Health Organization, 2018). Similarly, the world drug report, 2022, estimates that 284 million people aged 15–64 years used an illicit drug within the last 12 months (UNODC, 2022). While cannabis remains the most used illicit drug (209 million users in 2020), the use of opioids (61 million in 2020) causes great concern due to severe health consequences associated with opioid use. In terms of disability, it was estimated that 99.2 million disability-adjusted-life-years (DALYs) equivalent to 4.2% of all DALYs were attributable to alcohol use (GBD 2016 Alcohol and Drug Use Collaborators, 2018). Similarly, 31.8 million DALYs equivalent to 1.3% of all DALYs are attributable to illicit drugs.

Individuals with addictive disorders face human rights violations at multiple levels. The production, supply as well as the use of most psychoactive substances is illegal as per existing laws. As a result, the user is not only stigmatised and discriminated against, but also faces criminal sanctions on account of their substance use. With scientific advancement, addictive disorders are now recognised as mental illnesses, and biological factors play a major role in their onset and treatment. Unfortunately, outdated models of ‘managing’ addictive disorders still exist, and the user is subjected to human rights abuse (including physical punishment) in the name of treatment. This has tacit approval from the family and even other stakeholders due to poor knowledge and negative attitude towards the user. Lack of treatment facilities that provide evidence-based treatment and care for people with addictive disorders also contribute to this situation. Even if the individual comes out of addiction, they are not able to reintegrate themselves into the society due to lack of employment opportunities and prevailing stigma against them. This further pushes them to the brink and contributes to relapse and poorer outcomes. The individuals also have other



psychosocial issues including marital problems, physical ill health, etc.

The present chapter would discuss the existing treatment gap, models of services that exist for addictive disorders, existing laws and policies for addictive disorders, standards of care for treatment of addictive disorders, and recommendations to improve human rights for individuals with addictive disorders.

Use of Addictive Substances

Magnitude of the problem and treatment gap

India has a sizeable number of people using various psychoactive substances and suffering from SUD. The first national-level survey to assess the extent of substance use in India, the National Household Survey, 2004, reported alcohol (21.4%) as the primary substance used followed by cannabis (3.0%) and opioids (0.7%) (Ray et al., 2004). Another national-level survey, the National Mental Health Survey (NMHS), assessed the prevalence of mental illness in the country, including that of substance use disorders (Gururaj et al., 2016). The survey estimated the prevalence of tobacco use disorders to be 22.4%, followed by alcohol use disorders (AUD, 4.6%) and other drug use disorders (0.6%). The most-recent national survey to assess the extent and pattern of substance use in India, 2019, reported alcohol as the most used substance in India (tobacco was not studied in this survey). About 14.6% of the population aged between 10 and 75 years use alcohol, while 5.2% suffer from AUD (Ambekar et al., 2019). About 2.8% consume cannabis and 0.6% suffer from cannabis use disorder (CUD). Opioids are used by 2.1%, and the proportion with opioid use disorder (OUD) is 0.7%. In terms of absolute numbers, this translates to 5.7 crore individuals with AUD, 90 lakhs with CUD and 77 lakhs with OUD. Along with the large burden of those with problem substance use documented in the survey, the treatment gap is also striking. The NMHS, 2016, reported a treatment gap of 86% for AUD (Gururaj et al., 2016). Similarly, the recent national survey on extent of substance use in India showed that only 25% of those who tried to quit alcohol received treatment (Ambekar et al., 2019). Similarly, only 25% of patients with drug use disorders who tried to quit received treatment ever.

Thus, the data shows that there is a huge burden of substance use in India. Though many individuals affected with SUD want to quit using psychoactive substances, they do not receive treatment. Lack of treatment is, in effect, denying individuals with addictive disorders the basic right to care and assistance for coming out of their addiction.

Legal and environmental policy governing use of addictive substances

The laws governing psychoactive substances differ for alcohol, tobacco, and other psychoactive substances. The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003, (COTPA) governs tobacco control in India. The Act restricts places where smoking or the sale of tobacco products is allowed, bans advertisement of tobacco products and sale of tobacco to those below 18 years of age, and stipulates various requirements for sale and distribution of tobacco products (*The Cigarette and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003, 2003*).

On the other hand, alcohol is included in the state list under the seventh schedule of the constitution of India, governed by the excise laws of the individual states. As a result, the places of sale and consumption as well as minimum legal age of drinking differs across the states. Some states such as Gujarat have had alcohol prohibition since independence. Alcohol prohibition in Bihar is a recent phenomenon – the prohibition law came into effect in 2016 (Dutt & Surya, 2022). Analysis of this law shows how such laws run contrary to human rights and science-based evidence even in this day and age. The law not only made manufacturing and sale of alcohol illegal, but also declared the use of alcohol as a criminal offence. The law, in its original avatar, had made the use of alcohol a non-bailable offence with compulsory imprisonment. Though this provision was watered down through subsequent amendments, the law still sees the user as a criminal, subject to punishment than as a sufferer in need of help and treatment if they are suffering from alcohol use disorder.

This is true for other psychoactive substances as well. Most other psychoactive substances, including cannabis, opioids, and sedatives, are governed by the Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 that has been amended from time to time. The Act has strict provisions of imprisonment and fines for those contravening the law, including for those using the substances listed under the Act. Even those caught with small quantities of the substances (most of whom are possibly occasional users or those with addictive disorders) listed under the Act are subjected to imprisonment and/or fine. The Act is harsh on many counts, including placing onus on proving innocence by the accused, and denial of bail to accused (Tandon, 2015). Some studies suggest that as much as 97% of individuals jailed under this Act have been caught for possession of small quantities (Singhal & Ahmad, 2020). Though the law has provision for diverting those caught with small quantities for treatment instead of imprisonment, this provision is infrequently used (Tandon, 2015). As a result, those individuals who have a condition that is recognised as an illness by most scientific bodies and



would otherwise require treatment and care are instead jailed. Most prisons lack adequate treatment facilities for managing withdrawals, especially for those with dependence and providing long-term treatment and care for individuals with addictive disorders. Unfortunately, such laws do not serve to deter individuals from using drugs with resultant failure to serve the basic purpose for which this law was enacted (Bewley-Taylor et al., 2009; Rao et al., 2016). This provision of diversion to treatment can be used once in the individual's lifetime – contrary to the nature of addictive disorders that are supposed to be chronic and relapsing conditions.

Addiction Treatment Systems

With improved understanding of the addictive disorders as well as with scientific advancement the management of addictive disorders has evolved over time and more effective treatment options have been developed. The understanding has shifted from attribution of SUD to religious-moral degradation, followed by social deviation, and later to biological factors (Buchman et al., 2010). Currently, addictive disorders are considered as illnesses caused by a combination of various biological, psychological, and social factors. Biological factors play a distinct and important role in the development of addiction as well as relapse back to addiction after a period of remission (Volkow et al., 2016). With various schools of thoughts guiding the treatment, treatment centres that follow different treatment strategies co-exist with each other.

Treatment of addictive disorders can follow different approaches (World Health Organization & United Nations Office on Drugs and Crime, 2020). The medical approach includes providing medications not only for short-term withdrawal management, but also for longer periods to control craving, chronic withdrawals, and prevent relapse. The long-term treatment can last for months to years. Psychological approaches focus on modifying the thoughts and emotions of the individual through individual and group sessions lasting for weeks to months. Other approaches such as Alcoholic Anonymous involve people with addictive disorders providing support to each other to become and remain abstinent. Some others such as Therapeutic Community are long-term, structured, residential programmes that strive to bring about changes in the individual by teaching the individual to move away from addiction and conform to the values and rules of the community.

Those in the early stages of SUD can be helped in the community through brief interventions that can be delivered by community workers. Most individuals with SUD can be helped on an outpatient basis itself, while some may require a brief period of inpatient stay followed by long-term outpatient treatment. Very few individuals may require long-term inpatient, residential care. Irrespective



of the modality or locus of treatment, it is important that other needs of the individual with addictive disorders are also addressed. This includes addressing their psychological problems, comorbid medical illnesses, occupational needs, as well as interventions with the family. Unfortunately, in India, the treatment services are skewed in favour of inpatient treatment. The existing cadre of community workers are often not trained in helping individuals with addictive disorders, because of which those with addictive disorders are not identified early. Even the medical doctors are not provided adequate training on treatment of addictive disorders during their undergraduate training. As a result, individuals with addictive disorders enter the treatment systems late in their illness trajectory and seek treatment in specialised addiction treatment centres.

For a long time, the addiction treatment facilities supported by different government agencies focused on providing inpatient care. The Ministry of Social Justice and Empowerment (MoSJE) is the nodal ministry for demand reduction activities. Till recently, it used to work mainly with NGOs for setting up and running “Integrated Rehabilitation Centre for Addicts” (IRCAs). IRCAs majorly provide inpatient treatment for patients suffering from all types of addictive disorders (*Revised Manual on Minimum Standards of Services for the Programme under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse, 2009*). The usual length of stay in these centres is about one month, though the duration of stay can be extended for up to three months. The IRCAs have multi-disciplinary staff to run the centres – programme manager, nurses, counselors, and a part-time doctor. Most IRCAs follow a psychological model of treatment in which withdrawals are managed through medications for the initial 7-10 days, followed by counseling for the remainder period of the stay. The Drug De-Addiction Programme (DDAP) of the Ministry of Health and Family Welfare (MoHFW), Government of India, provided one-time funding for construction of Deaddiction Centres (DAC) in various government hospitals of the country, which again shows emphasis on inpatient treatment (Dhawan et al., 2017). Both the agencies, however, have modified their schemes in recent years by supporting outpatient facilities in various government hospitals. However, the number of addiction treatment units are far less compared to those requiring treatment and care. As a result, private centres have mushroomed in almost every region and state of the country.

There is great variation among the private sector providing addiction treatment services. At one end, addiction treatment is provided by psychiatrists. The psychiatrists provide outpatient as well as inpatient services with a major focus on the medical model of treatment. Some psychiatrists also provide long-term medications, including opioid agonist treatment (OAT) for opioid dependence along with appropriate psychosocial interventions. At the other



extreme, there are individuals with no qualification or experience in addiction treatment running 'rehabilitation centres'. Most of these 'rehabilitation centres' have inpatient facilities and admit the individuals for a period of 3–6 months.

Multiple incidences of human rights abuse have been reported by individuals admitted in these 'rehabilitation' centres. These centres serve as detention centres, wherein inmates are subject to verbal and physical abuse, denied food, and punished. Deaths of inmates have also been reported from these centres. Taking cognizance of this, the Delhi high court tasked the Delhi State Legal Services Authority (DSLISA) to conduct inspection of such centres in Delhi in 2018 (Angad, 2018). The DSLISA visited 124 de-addiction centres and interacted with 2135 inmates. The visit found that roughly one-third of the inmates were admitted involuntarily. Most centres did not have adequate infrastructure, including toilets and ventilation. The beddings in some centres were "full of smell and bugs". Inmates reported being beaten with sticks, and verbally abused. They were denied food and were forced to wash toilets and bathrooms. Another study conducted qualitative interviews with former inmates and staff of such 'centres' and reported similar findings (Rao & Kathiresan, 2020). The study reported that most centres admitted patients without their consent and there was no option to leave the treatment prematurely. Some centres also provided pick-up facilities where the patient would be forcibly picked up from their house upon request by the patient's family to be admitted to their centres. Both the patients and the centre staff believed that some physical punishment is acceptable and required for a patient to come out of their addiction. For most inmate respondents, the overall experience in the centre made them afraid to seek treatment for their SUD.

Thus, examination of the addiction treatment systems in India reveals limited facilities providing evidence-based treatment for an individual seeking treatment. In the absence of such facilities, private 'Rehabilitation' centres have mushroomed all over the country, most of whom actively violate basic human rights of the admitted patients.

Laws and regulations on treatment of addictive disorders in India

The laws related to alcohol and tobacco do not touch upon treatment-related issues of alcohol or tobacco users. The NDPS Act permits the government to establish as many centres as required for treatment of SUD. As per the provisions of the NDPS Act, few states have also framed individual state NDPS rules for the addiction treatment facilities.

Many pharmacological agents such as opioids and benzodiazepines used for treatment of drug use disorders fall under the list of narcotic drugs and psychotropic substances. The NDPS Act has also permitted the use of narcotic

drugs and psychotropic substances for scientific and medical purposes. These medicines are also regulated through the Drugs and Cosmetics (DC) Act, 1940. Though the NDPS Act made provisions for the use of narcotics and psychotropics for treatment, the access, especially that of opioids, was restricted. The Act was suitably amended in 2014 and certain opioids, including methadone, were declared as essential narcotic drugs (ENDs). The rules for possession, transport, and sale of these drugs were relaxed compared to other narcotics (Ambekar et al., 2017). Despite these amendments, the use of ENDs such as methadone for opioid dependence continues to be limited. The other opioid used for long-term treatment of opioid dependence, buprenorphine, is a psychotropic whose use is supposed to be easier as per the NDPS and DC rules. However, due to a directive from the Drug Controller General (India), the availability of this medicine is restricted to government-recognised 'de-addiction' centres. This has created much confusion and has led to some private psychiatrists jailed under NDPS Act in the past (Tandon, 2019). The discrimination against medications used for treatment of addictive disorders is seen even in the recently released telemedicine and telepsychiatry guidelines for online consultation and prescription during the COVID-19 pandemic (Math et al., 2020). Almost all the medications used for treatment of addictive disorders are prohibited from being prescribed during telepsychiatry consultations in any mode (video/audio/text) either initially or during follow-up.

There is no law that specifically regulates addiction treatment facilities in India. The Government hospital-based DACs are attached to the larger hospital and are recognised as such by the Government as these are Government hospitals. The other entities such as IRCAs run by NGOs do not have a separate registration; they are usually registered as NGO or a society under the Society Registration Act of the state where these NGOs are located. The private 'Rehabilitation' centres are also registered similarly. Some private centres run by medical professionals, including psychiatrists, are covered under the Clinical Establishment Act, 2010. While the Clinical Establishment Act, 2010, covers all those institutions that provide treatment of any illness, abnormality, etc. in any recognised system of medicine established by a person or group of persons, there is no specific mention of substance use disorders in the Act (*The Clinical Establishments (Registration and Regulation) Act, 2010*, n.d.).

The private centres were not under the direct ambit of any regulations till recently. The recently enacted Mental Healthcare Act (MHA), 2017, enacted with an aim to improve care and treatment for people affected by mental illness in India, can potentially take care of this lacuna. The Act has made specific mention of substance use disorder (SUD) in the definition of mental illness itself. However, some terms such as "abuse" create ambiguity in the definition of SUD as this term is no longer used in the current classificatory systems of mental illnesses



(Rao et al., 2019). The broad definition of mental health establishments (MHE) in the MHA, 2017 allows for covering all government and private centres managing individuals with addictive disorders under the ambit of the Act. However, there is still lack of clarity on many aspects when some provisions of MHA, 2017 are applied to addictive disorders (Mohan & Math, 2019). This includes, for example, deciding the capacity of a person with addictive disorder to make treatment decisions, provisions of supported admissions, provision of law-mandated treatment in NDPS as an alternative to imprisonment, and clash between MHA, 2017 and other laws related to addiction. However, there are a lot of positive takeaways for patients with addictive disorders in the Act. The Act has laid down various rights of persons with addictive disorders including protection from cruel, inhuman or degrading treatment in any mental health establishment. If the MHA, 2017 is implemented effectively and the addiction treatment facilities brought under the Act, then the human rights abuse in most cases can be prevented.

Standards of Care for People with Addictive Disorders

Each Government department/Ministry has set its own standards that are expected to be followed by the facilities funded by the department. It is not clear whether centres not funded by these ministries are mandated/expected to follow these standards of treatment for people with addictive drugs. Both MoHFW and MoSJE have their own documents on standards of treatment and care for people with addictive disorders to be followed by agencies supported by the respective ministries (Tripathi & Ambekar, 2009). Both documents emphasise on providing voluntary treatment with the individual's consent. The MoSJE document clearly mentions no use of corporal punishment, no discrimination, and confidentiality to be maintained (*Revised Manual on Minimum Standards of Services for the Programme under the Scheme for Prevention of Alcoholism and Substance (Drugs) Abuse*, 2009). There are no well-formulated mechanisms in either document to ensure that these standards are followed by these facilities. Some of the practices adopted in the standards do not seem to be in conformity with the recommended standards by international bodies/agencies.

As per the MHA, 2017, the State Mental Health Authority (SMHA) of the individual states have been tasked to frame minimum standards that the addiction treatment facilities of their state are expected to follow. Delhi has already framed minimum standards for addiction treatment facilities operating in the National Capital Territory (NCT) of Delhi (*Minimum Standards of Care for Centres Providing Substance Use Disorder Treatment and Rehabilitation for the National Capital Territory of Delhi*, 2018). However, the document is heavy on standards related to inputs such as infrastructure, staffing and type of records to be maintained, while it is silent on standards related to actual treatment and care. Unfortunately, the implementation of MHA, 2017 at the state level is poor. Few states have created

rules or constituted Medical Health Services Recruitment Board (MHRBs) or SMHAs (Pawar, 2021; Philip et al., 2022). The framing of standards can follow only after the necessary bodies are constituted. Till then, many centres will continue to go unregulated and people with addictive disorders would continue to suffer human rights abuse in these centres in the name of treatment.

Specific Population Groups

Some population groups face not only the challenges mentioned above, but also many other human rights issues that are important to be considered.

Persons Who Inject Drugs (PWID)

PWID constitutes a specific subset of people with addictive disorders which are vulnerable to various blood-borne virus infections including HIV, Hepatitis-C, and Hepatitis-B. The HIV prevalence in this group was 6.2% in 2017, which is more than 20-fold higher than the general population (National AIDS Control Organisation, 2021). Lack of knowledge and stigma often leads to delayed help seeking. The National AIDS Control Organisation (NACO), the nodal agency for prevention and treatment of HIV in India, implements a harm reduction programme for HIV prevention among PWID. Under this programme, NGOs are supported to implement needle syringe exchange programmes (NSEP) in which PWID are provided with new injecting equipment and the used equipment is returned. Earlier, the NSEP could attract legal punishment as this could be construed as abetting drug use. However, the recently enacted HIV and AIDS (Prevention and Control) Act, 2017, provides immunity to interventions that reduce the risk of HIV (Tandon, 2019). The other HIV prevention strategy for PWID, opioid substitution therapy (OST), is available in fewer centres to make any significant impact on HIV prevention, because of which the HIV rates continue to be higher in PWID.

People in Prisons

People who use illegal substances have frequent brushes with the law. The use of these substances, itself, is a crime. The individuals may also resort to acquisitive crimes to sustain their drug use habit. As a result, people with addictive disorders often face imprisonment. Unfortunately, most prisons do not have provisions for treatment and care for people with addictive disorders. The national NDPS policy recommends testing for addiction for every new entrant and compulsory 'de-addiction' if found to be addicted (*National Policy on Narcotic Drugs and Psychotropic Substances*, n.d.). The policy also does not allow for use of either NSEP for harm reduction or OST for treatment of PWID in prisons, which is contrary to existing evidence (Ambekar et al., 2013). It is well known that people in prisons experience withdrawals at prison entry and



these withdrawals and craving can continue for a substantial period during the individual's imprisonment (Rao et al., 2016). In the absence of effective and appropriate treatment, these individuals can resort to drug use within prisons. Drug use within prisons is also documented in Indian settings (Math et al., 2011). In the absence of treatment and strong rehabilitation efforts inside the prisons, recidivism rates are also high in this population.

The Mental Healthcare Rules, 2018, has advocated for treatment and care of prisoners with substance use disorder (Tandon, 2019). The rules stipulate providing appropriate treatment, including the use of long-term pharmacotherapy, for different classes of substances. The rules also provide for screening of inmates for HIV and other blood-borne viruses and provide appropriate treatment as necessary. Unfortunately, the status of implementation of these rules in different prisons is not known. There is an urgent need to conduct assessments to take stock of the situation and help push the prison authorities into implementing these rules, if required.

Women

Women using addictive substances constitute another population group with issues that are different compared to their male counterparts (Murthy, 2008). Women tend to develop addiction faster despite later onset of substance use, often have a male partner, and have higher rates of comorbid mental illnesses (Ambekar et al., 2015; Greenfield et al., 2010). Some complications, including physical complications, occur earlier and at lower levels of substance use in women (Lal et al., 2015). Some women using drugs also resort to sex work to sustain their drug using habit, thereby increasing the risk of HIV manifold. Women also receive lesser support from their families and society, face greater physical and sexual abuse and experience greater stigma and discrimination (Murthy, 2008, 2012). Despite this, it is seen that women are far less represented in treatment facilities compared to men. Women are more likely to experience various barriers to access treatment services ranging from family obligations, economic hardship, to stigma and discrimination faced in addiction treatment facilities. Most treatment services for addictive disorders in India do not bar specific gender groups to access treatment. However, most addiction treatment facilities do not have gender segregated services. Women may not feel comfortable accessing treatment from facilities that have preponderance of males. Few centres have separate facilities for women. Hence, women continue to remain underground and do not openly access treatment for their addictive disorders.

It can be summarised that the population groups described above face greater barriers to access treatment and care for their addictive disorders, which is already inadequate in India. The basic rights to have equal access to

treatment and care is denied to these population groups. There are other such population groups that face similar barriers, including transgenders, children and adolescents, to name a few.

Recommendations

The preceding sections show how people with addictive disorders face violations of their human rights including physical abuse. Multiple factors contribute to these violations. Many provisions in the existing law and policy related to addictive disorders run contrary to the principles of justice and equal treatment for people with addictive disorders. Treatment and help in the informal sector and in general medical services for those in the milder spectrum of the disorder is grossly inadequate that results in delay in identification and treatment. The dearth of facilities that provide evidence-based treatment and care adds to the woes of people with addictive disorders. In absence of such facilities, many unregulated facilities have mushroomed that commit physical abuse and torture in the name of treatment. Though the recent MHA, 2017 has the potential to address these problems, the implementation of this law is slow resulting in people with addictive disorders continuing to suffer. Various steps need to be taken to improve the existing status of addiction management in India that can help improve human rights of people with addictive disorders. Some of these include the following:

- The laws and policies related to the addictive disorders need to be aligned to current understanding about addiction and strategies to reduce addiction. There is a need to examine the effectiveness of the existing laws and policies and assess whether the laws have fulfilled their objectives. Irrespective of the strategy that the policy makers may adopt to address addictive disorders in India, the user should not be seen as a criminal to be prosecuted in the court as that is contrary to the conceptualisation of addictive disorders as a mental illness. With the passing of MHA, 2017, various provisions in the Act can be conflicting with earlier framed laws on addictive disorders. Hence, there is a need to have a fresh look at various laws involving the person with an addictive disorder. A forum consisting of stakeholders from different expertise including affected communities, treatment providers, law enforcement authorities, lawyers and judiciary should examine the provisions under each law to amend existing laws and policies.
- There is an urgent need to fill the treatment gap for people with addictive disorders. A multi-pronged approach needs to be adopted for improving the existing state of treatment for addictive disorders in the country ranging from community-based informal treatment to treatment in general



healthcare and finally outpatient-based specialised addiction treatment facilities. This will help reduce over-reliance on specialised addiction treatment facilities thereby improving access to treatment and care.

- Existing 'de-addiction centres' and 'Rehabilitation centres', irrespective of their source of funding, should be urgently inspected. Those found to indulge in physical abuse and violation of human rights must be closed and the operators should be punished as per law.
- Efforts must be made to implement MHA, 2017 at the earliest as many provisions of the MHA, 2017 are favourable to people with addictive disorders and can help in improving the standards in addiction treatment facilities.
- A model 'minimum standard of care' document that can be adopted by the respective state authorities must be developed for all addiction treatment facilities irrespective of the type of treatment model followed by the facility.
- The undergraduate medical curriculum should provide due emphasis on diagnosis and management of addictive disorders of commonly used substances in India such as tobacco, alcohol, and opioids. For those who have already completed medical education, specialised training programmes on these topics must be conducted and made mandatory for renewal of certification. Similarly, other healthcare providers should be trained on conducting assessment and providing intervention for addictive disorders.
- The existing laws must be suitably modified to ensure that medications that are required for treatment of addictive disorders are available to those in need. Additionally, those prescribing and dispensing these medications must not be treated as criminals if there are procedural or administrative lapses on part of the treatment providers. The telepsychiatry guidelines must be amended to allow use of medications for addictive disorders during telepsychiatry consultations. This will help in making treatment accessible to those in need.
- People with addictive disorders, their families, and the society in general should be educated that addictive disorders are mental health problems and right information regarding treatment available to treat and manage addictive disorders should be provided. In the absence of this, the affected individuals and their families would continue to access treatment from unregulated centres that violate human rights. Additionally, depiction of psychoactive substances in newer platforms should be examined and existing acts such as COTPA should be suitably amended.

- An assessment of prison settings must be carried out to document the availability (or lack of) and quality of existing services for people with addictive disorders. The services conforming to current standards and as laid down in the rules of the MHA, 2017 must be initiated in prisons.
- Women-friendly services and wherever needed, women exclusive facilities must be initiated in most major cities to begin with. This is true in case of children and adolescents as well.

A committee of relevant stakeholders including different ministries must be constituted and timelines for implementation of the recommendations must be set. The committee must meet periodically to monitor the implementation progress with periodic reporting to the NHRC.

Conclusion

Addictive disorders are recognised as mental illness by all scientific bodies. It is also well-known that addictive disorders require treatment and care of those affected by this illness. Punitive measures and involuntary treatment are much less effective than the available evidence-based treatment. However, older, outdated practices continue to exist in India because of which people with addictive disorders continue to suffer human rights abuse. These are the result of existing laws and policies relating to addictive disorders, ineffective treatment systems, and lack of education of the affected community, their families, and the society in general. Various measures adopted as outlined above can go a long way in improving the human rights of people with addictive disorders.



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Mental Health of Prison Inmates

Imprisonment is a major crisis in one's life that negatively impacts their mental condition besides other aspects of life. It can lead to the emergence, re-emergence, and aggravation of mental illnesses in person. The Prison is a place where all the inmates have been lawfully deprived of their personal liberty, which imposes a high possibility of mental health related issues. The sudden detachment from family & loved ones, fear of social rejection, the undesirable environment of prison, forced confinement, prolonged judicial proceedings, interpersonal conflicts in prison, grimy conditions of toilets, washrooms & barracks, compromised ventilation, overcrowding, adjustment issues, the undesirable attitude of staffs, poor medical facilities, sudden cessation of substance, etc. attribute and augment the possible risk of mental disorders and other related issues in prison. Due to a lack of recognition of the broad spectrum of mental illnesses and positive mental health within the criminal justice system, "prisons inevitably become homes for a greater number of mentally ill prisoners of various degrees".

As per the National Crime Record Bureau (NCRB) Prison Statistics of India (PSI), -2021 total number of inmates suffering from mental illness in Indian prisons is 9180 as of 31.12.2021. The data shown is 1.66% of the total population in prison. In NCRB PSI-2019, the total number of inmates suffering from mental illness in India is 7394, i.e. 1.54% of the total prison population as of 31.12.2019. The data shown in PSI by NCRB does not seem to be an actual figure. NCRB does not survey in prison. It is entirely dependent on the reverence of prison authority. The prison authority neither has sufficient resources for a psychiatric assessment of prisoners according to standing statutes and orders nor are they willing to do so with available resources. They would have adopted to collect the data per their suitability and convenience.

In February, 2020 the Karnataka State submitted data to Karnataka High Court that 5153 prisoners, of a total of around 15000, approximately 34.35%, are suffering from various mental disorders, and 237 among them are in the severe category. Two months before submitting this report to the Honorable High Court, the government had submitted figure 358, approximately 2.39% of the

total prison population, to NCRB. It is pertinent to mention here that the data was submitted to the court after conducting a psychiatric assessment of all the prisoners in the 36 prisons of the total 43 prisons in the state as assessment in the rest seven jails was under progress at that time. It should not be construed that Karnataka has submitted false data to NCRB; actually, the data revealed in the court has been gathered after psychiatric assessment in prisons across the state, whereas data submitted to NCRB would possibly be data served by the prison department based on record available in the medical unit of the respective jails. Despite the court's cognizance, the convenience of a prison official and other higher-level officials seems paramount. In PSI-2020, Karnataka again served the figure 436 and in PSI-2021 figure is 480. Symptomatically, it shows gross non-willingness and mental health issues have the least priority in prison except in words. If a proper psychiatric assessment could be done across all jails of the nation, almost 1/3rd the population may be found to be treated for mental disorders.

Inmates in prison are twice as likely to die of suicide as the general Indian population, reported by the Commonwealth Human Rights Initiative (CHRI). NCRB outlines, nationally, there is only one psychologist/psychiatrist for every 16,503 prisoners. Consequently, suicides account for 70% of unnatural deaths in prisons. With poor mental health professionals, Uttar Pradesh witnessed the highest number of suicides and mentally ill prisoners. The International Red Cross and the World Health Organization have also noted that circumstances like inadequate healthcare facilities, overcrowding, sexual violence and physical violence increase the possibility of mental health issues among prisoners. Prisons in India have a shortfall of medical staff by 41 percent, while in 35 of 36 States/UTs, prison occupancy exceeds 50 percent of inmates, according to the Tata Trusts' India Justice Report (2020).

The mental health issues in prison are not a current question; it has been decades since several committees and court orders outlined its necessities on many occasions. Mulla Committee's recommendation is almost four decades old, and it also outlined the need to address the overall mental wellbeing of prisoners. The committee also emphasized that *'merely imprisonment cannot bid farewell to one's fundamental rights as a human being'* guaranteed in the constitution. In a well-settled case *State of Andhra Pradesh v. Challa Ramakrishna Reddy and Ors.* (2000) 5 SCC 712, Honorable Supreme Court held - *"...the prisoners, whether a convict or under-trial, does not cease to be a human being and, while lodged in jail, enjoy all his fundamental rights guaranteed by the Constitution of India including the right to life guaranteed by the Constitution."*

The legislative body has taken many steps in this direction from time to time, and the Mental Healthcare Act, 2017 is a landmark in this way. Protection of



the Human Rights of prisoners with mental health issues is an obligation of the government under Section 103 of the Mental Healthcare Act, 2017. In the Mental Healthcare Act, 2017 u/s 103 (6), there is a proviso: *'The appropriate Government shall set up mental health establishment in the medical wing of at least one prison in each Union territory or state and prisoners with mental illness may ordinarily be cared for and referred to in the said mental health establishment.'* But except for a few states, none have established the same in their respective prisons. Section 82(1)(f) of MHA-2017 provides: *'Function of Mental Health Board shall include; to inspect and visit prison or jails and seek clarifications from the medical officer-in-charge of health services in such prison or jail.'* Unfortunately, in an (Right to Information) RTI reply dated 12 October 2020, the Ministry of Health and Family Welfare said only three states (Tripura, Uttarakhand, and Himachal Pradesh) had constituted the Medical and Health Recruitment Board (MHRBs). Various petitions have been filed, after which the High Courts of Delhi, Karnataka, and Kerala took cognizance and sought responses from their respective state governments regarding the constitution of MHRBs. In the absence of these authorities, it seems unclear how the recommendation with respect to the mental health of prisoners would be properly implemented.

Section 31(2) of MHA-2017 also has a proviso: *'The appropriate Government shall, at the minimum, train all medical officers in public healthcare establishments and all medical officers in the prisons or jails to provide basic and emergency mental healthcare.* It is very disheartening to share that neither the prison authority conducting such training nor the medical officer are enthusiastic about the same. Such training and orientation for mental health will not only enable the Medical Staff to deal with mental health crises thereto but also open the window to train other para-medical and prison staff, along with some inmates, to identify the red flags for mental illnesses at the outset. In most prisons where NGOs are extending their services for prison reforms and mental wellbeing, the prison authorities seem to be least interested in their proceedings. Despite maximizing the number of voluntary organizations (VOs), the prison authority has to see the quality and outcomes of the work they are rendering in prison with good team spirit and a well-decorated manner. No doubt, there are a number of VOs doing well, and several VOs outside are willing to cater their services in prison. The prison should be liberal in opening the door for new VOs following standing rules in good team spirit and in collected and coordinated efforts to escalate the outcomes within limited resources until the requisite resources have not been appointed accordingly. It would also not work to be indifferent with respect to VOs work to let them work independently. The prison would have to fix a goal with VOs to measure the changes collectively; otherwise, it will all be in vain and on paper only.

What was such a problem before prisons; it is now five years since MHA, 2017 was enacted, but no prison across the nation has understood the importance of its provisions. Every time the court door has to be knocked on for remedy. That is unfortunate and shows the non-willingness of concern for authority and officials. In a recent PIL *Kush Kalra Vs Union of India & Ors* filed in Supreme Court and heard on 02.09.2022, the court issued a notice in a plea seeking the establishment of adequate Mental Healthcare Facilities in Prisons across the country. A Bench comprising Justices Abdul Nazeer and V. Ramasubramanian agreed to issue a notice in the plea, which also seeks direction to Union and State Governments to provide training and awareness to the prison staff and law enforcement authorities about Mental Healthcare Act, 2017.

Moreover, it implores the Bench to direct that the concerned authorities ensure that medical examination reports of prisoners are prepared regarding the mental state of the arrested person at the time of admission to the Hospital. It submits that medical examination conducted when the prisoners are admitted into prisons does not include mental health evaluation. The said petitioner had filed an RTI questioning all states and UTs whether they have set up Mental Health Establishment in their prisons as mandated in the 2017 Act. Responses were received from 7 states covering 56 prisons. None of these 56 prisons has a Mental Health Establishment.

Now, it is not in question what the guidelines should be, and boxes of golden lines are available from various court orders, committee recommendations, NHRC guidelines, NGO findings, International Human Rights Organizations observations, etc., concerning prison mental health and reforms. Re-quoting all those here will only be chanting of mantras unless it is not translated into actions. Excuses are always there, but it is years old proverb; 'where there is a will, there is a way'. It is pertinent to point out that there is no question of making new statutes and/or guidelines in this regard. Judicial and quasi-judicial bodies like the National Human Rights Commission (NHRC) and other voluntary organizations have already worked on it. The need is for collected and coordinated efforts with complete dedication and within limited resources. It is a thumb rule that we can never start; if we wait for a handful of resources. We would have to start working with existing resources and continue constituting further ones within them until the requisite resources have not been joined. Once the requisite resources have been fulfilled, the previous optional steps may not let go. It should be amalgamated with later accordingly for better results.

We all are well aware that inmates contribute to running the daily chores of prisons, starting from cleanliness to medical unit and administration. The prison has a heterogeneous range of inmates having different skills. If their



abilities can be utilized to run the prison secretariat and medical team, then why not they may be trained as Psychological First Aid Providers and other related workers per their will and qualification? Humans have excellent skills to learn, except for some basic instincts, our all outer behaviour has been learned over a period of time from society and its institution. Humans are not born doctors, engineers, writers, carpenters, potters, mechanics, painters, etc. They learn all those skills from here only in due course of time. The inmates have plenty of time in prison, and occupying them in meaningful work will reduce their idle time in their diurnal clock to prevent the encounter of recurrent negative thoughts for various reasons. It will also be a self-sustainable model that does not require any burden of new recruitment and procedural delay at the outset. But it cannot be destiny; the new recruitment of professionals and establishment of mental health facilities should always be on top priority in a self-imposed time-bound manner.

Conclusion

- We already have many existing benchmark court orders and observations along with Committee's recommendations, NHRC Guidelines, International organizations' observations, NGO findings concerning prison mental health and reforms. There is no need to prepare more; now, it's the peak need to translate our words into actions for a louder impact.
- Nationally, there is only one psychologist/psychiatrist for every 16,503 prisoners (NCRB, 2019). Consequently, suicides accounted for 70% of unnatural deaths in prisons. Therefore, there is a need to invite the applications for these posts at the earliest accordingly.
- Mental Health disorders due to sudden substance cessation in jail are one of the major among others causing violence, grievous hurt, death, etc. Thereby mental health assessment and SUD (Substance Use Disorder) screening for all prisoners, along with a follow-up, if required, needs to be done at the outset while doing the first medical examination, and the appropriate treatment to avoid casualties arising out of sudden cessation must be taken immediately as per the degree of addiction to it, by the Psychiatrist and/or trained medical officer for this purpose.
- The Prison should be liberal in inviting the study inside jails, especially in mental health. There is a lack of formal research studies in this area that may help decide the yardstick and future measures for effective outcomes. The jail should approach and seek help by writing to government and non-government organizations that are pioneers in this field.
- That most of the discussion on prison mental health revolves around illness. But no discourse on Positive Mental Health in prison covers wellness and

promoting Positive Mental Health thereto. So, apart from illness, we shall also have to come up on the line to promote positive mental health in prison.

- Merely sending the inmates to jail, giving them food and medicines, and producing them before the court does not meet the purpose of reformation. Instead, they must be involved in meaningful and creative activities. That will reduce their idle time to prevent them from encountering negative thoughts. It may also help promote positive mental health in prison.
- The medical team and all prison staff should be provided basic and emergency mental healthcare training for better outcomes with limited resources.
- A Mental Health Squad in each barrack from inmates who are willing to do so should be constituted and trained to identify signs and symptoms for timely reporting to the concerned medical authority for treatment accordingly before it is late.
- Staff's attitude towards inmates must be humane and lawful. The mental health of staff is also a significant concern. The available medical officer/psychiatrist/PSW/Psychologist should conduct the staff training program to promote good behaviour and positive mental health among them.
- The provision of the Mental Healthcare Act, 2017 should be immediately executed in letter and spirit.
- Mental Status Examination and any other appropriate screening for mental state screening should be included while doing a medical examination. In addition, the inmates must be provided Psychological First Aid at that time with a basic orientation about prison to prevent any sudden emotional breakdown and other untoward incidents.
- Prison authorities should essentially take an interest in NGOs work inside the prison. The collective and coordinated effort will augment the reformation process and thereby improve the mental health of all. However, letting the NGOs work on their own and taking the least interest will not be the optimum utilization of the resources for the broader benefit of prisons.
- All National Health Programmes should be implemented in prison.



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COVID-19, Mental Health & Human Rights

Introduction

Novel-SARS-corona-virus-2 (COVID-19) pandemic has greatly influenced the world, with the global count of COVID-19-positive cases being 593 million and the death toll being 6.4 million (as of August 23 2022) (*World Health Organization (WHO) Coronavirus (COVID-19) (Dashboard, 2022)*). While in India, the number of detected cases to date is 44 million, and the number of deaths is 52 thousand (*Ministry of Health and Family Welfare (MoHFW) , Government of India, 2022*). The unprecedented pandemic posed considerable challenges to governments, policymakers, public health experts, healthcare professionals, and police departments, and the sufferings of the general population have been immense.

The nature of the suffering and disability varied across different pandemic waves. For instance, in India, the first wave (2019-2020) was characterised by marked uncertainty about the nature and course of the illness, unavailability of the requisite medical equipment, including hospital beds, and unpreparedness of the authorities and the public, thus challenges in obtaining basic amenities, etc. In contrast, the subsequent waves (2020-21 and after that) had challenges in the form of higher COVID-19 morbidity and mortality rates (particularly in India), constraints in obtaining life-saving medicines, oxygen beds, hospital beds, and the mammoth task of immunising the frontline workers and general population, whose efficacy and safety was still being researched (Gupta & Sahoo, 2020; Jain et al., 2021).

The pandemic has significantly affected all strata of the population; however, the impact has been greatest among the vulnerable populations, e.g., persons with mental illness (PMI) with or without chronic physical illness, frontline workers (healthcare professionals, police personnel, sanitation workers, etc.), children, elderly, socio-economically disadvantaged population, etc. (Rajkumar, 2020).

The primary psychological problems that emerged (or worsened) during the pandemic were anxiety, depression, stress-related disorders, insomnias,



burnouts (in frontline workers), deepening severe mental illnesses (SMIs), such as schizophrenia, bipolar affective disorders, etc. (Anindyajati et al., 2022; Rajkumar, 2020; Tsamakidis et al., 2021).

Although the Government and various international and national agencies have come up with multiple schemes and resources to mitigate the overall impact of the pandemic, including the psychological impact, their timing and effectiveness raised some serious concerns, including their ground-level implementations and implications. Likewise, the existing mental health-related legislation, policies, and frameworks have fallen short in ensuring the rights of the PMI or disabilities (Anindyajati et al., 2022; NgangaNjiri, 2020; Sanghi&Jaswal, 2022).

Scholars and researchers worldwide, including from India, have highlighted that the current pandemic has unleashed the severe shortcomings of the existing mental health services to cater to the needs of the PMI and those with new-onset or subclinical mental health problems (Anindyajati et al., 2022; Ng'ang'aNjiri, 2020; Sanghi & Jaswal, 2022). The major contributors to this poor status of mental health services include general apathy of the policymakers/authorities towards the problems related to mental health, not keeping mental health at par with physical health, poor integration of mental health services with the COVID-19-related services, mental health rights of the PMI have not been adequately envisaged, the stigma associated with the mental illness, inadequate availability, and accessibility (also affordability issues) of the mental health services, etc. (Anindyajati et al., 2022; Sanghi & Jaswal, 2022)

This chapter highlights the epidemiology, preventive measures, and management of mental health problems among frontline workers, general populations, and vulnerable populations, including PMI. Furthermore, it emphasises the human rights-related aspects of these populations, including rights to psychological wellbeing. Finally, it provides future directions for addressing these populations' enormous mental health needs.

Box 1: Summary

- COVID-19 pandemic has unmasked the mental health burden and poor status of mental health services worldwide, particularly in the Low and Low Middle Income Countries (LMICs).
- Anxiety, depression, stress-related disorders, insomnia, burnout, etc. are common psychological problems encountered during the pandemic.
- Vulnerable populations, frontline workers, PMI, migrants, children & elderlies are at greater risk of such problems.
- Human rights violations are rampant during this period, thus, warranting a multi-sectoral & concerted effort.
- The right to mental health, as enshrined in the legislation, should be realised at the earliest by keeping it at par with the physical health

COVID-19 and the mental health of the frontline workers

Ample literature highlights that frontline workers are at higher risk of developing psychological problems during the COVID-19 pandemic, which are attributed to various bio-psychosocial risk factors. For example, frontline Healthcare Workers (HCWs) are more likely to suffer from depression, anxiety, stress-related disorders, insomnia, and burnout than the general population. Moreover, they are at a higher risk of acquiring the COVID-19 infection and acting as contagion to their family members and colleagues (Gupta & Sahoo, 2020; Rajkumar, 2020). Unfortunately, in many countries, including India, their efforts towards fighting against the COVID-19 pandemic are not duly recognised; instead, they often become the victim of societal stigma (related to their work), anger, and abuse, for the things which are beyond their control (Devi, 2020). Although government and healthcare authorities have come up with measures to safeguard the rights of these frontline workers (Ministry of Law & Justice, Government of India, 2022), the very nature of their work and the substantial burden of the pandemic-related problems, coupled with a scarcity of human-resources, often Act as unsurmountable risk factors for various psychological issues. Moreover, the stigma associated with mental illness (and its treatment) further complicates the problem, thereby limiting their access to professional mental health services.

Prevalence of psychological problems among frontline workers

A substantial proportion of the frontline HCWs during the pandemic suffered from moderate-severe burnout syndrome (as high as 83%), emotional fatigue (41%), loss of empathy (22%), and loss of confidence (52%) (Anindyajati et al., 2022). Likewise, the prevalence of clinically significant psychiatric disorders is also high among the HCWs: anxiety and depression (16–28%), self-reported stress (8-26%), insomnia (35%–38%), etc. (Anindyajati et al., 2022; Gupta & Sahoo, 2020; Rajkumar, 2020). Likewise, police personnel, another key frontline worker, is 8.78 times more likely to get affected by COVID-19 compared to the general population (Khadse et al., 2020). For example, the latest online survey among police personnel in Maharashtra (India) reported that 50% of the respondents feared the COVID-19 virus. In comparison, 32.4% reported being stressed for multiple reasons at the workplace (Kokane et al., 2020).

Risk Factors for the psychological problems

Various bio-psychosocial risk factors predispose the HCWs to develop psychological problems or mental disorders.

Biological risk factors include young or older age group, female gender, pre-existing psychiatric illness or chronic medical problems, family history of psychiatric disorders, etc. (Gupta & Sahoo, 2020).



While the psychological risk factors comprise anxious avoidant personality traits, fear of scrutiny, avoidant or emotion-focused coping mechanisms, role conflicts, potential moral injury exposures, etc. (Gupta & Sahoo, 2020). In contrast, vigour, hardiness, reflective thinking, altruistic acceptance of the situation, and problem-focused coping skills are protective factors.

During the pandemic, several socio-economic-cultural factors played a critical role in the development of various psychological problems among frontline workers: job stress/occupational stress, inadequate communication and lack of information, risk of exposure to infection, social distancing, lack of social capital, lack of Personal Protective Equipment (PPE), stigma, the stress of isolation/quarantine, lack of support from the organisation and crowd behaviour (Gupta & Sahoo, 2020; Pereira-Sanchez et al., 2020; Xiao et al., 2020).

Likewise, the unconventional responsibilities, demanding working environments, and role confusion of the police may lead to job stress and burnout and are established risk factors, as per earlier studies, of occupational stress among Indian police personnel (Khadse et al., 2020).

Human rights aspects of frontline workers

During the pandemic, frontline workers rose to the occasion and delivered, often overstretching their physical and mental capacities. However, the health disaster deprived them of the necessary social (from the family members during the isolation/quarantine), professional (from colleagues who are infected or overburdened with the work, hospital administration, etc.), and emotional support (from close family members or friends). Despite their tremendous efforts, they often had to work in unfavourable hospital environments (Intensive Care Units, COVID-19 wards, etc.), often being discriminated against by the public, even, at times, by their family members (Devi, 2020). Moreover, there were several instances where frontline workers faced abuse, anger, or assault from the general population and patients or their family members.

Although governments have come up with laws or amendments to safeguard the rights of frontline workers, like the India Epidemic Diseases (Amendment) Ordinance 2020 in India, their ground-level implementation has been poor, or they are insufficient to guarantee the complete protection of the frontline workers.

Most importantly, despite the substantially higher proportions of frontline workers suffering from psychological problems or stigma, there is evidence supporting the effectiveness of various psychological interventions (teleconsultations or in-person counseling), the availability, accessibility, or feasibility of availing such services are limited. Latter can be attributed to the

lack of awareness or unavailability of time to avail of such services. Thus, not withholding their health rights, standard of living, and wellbeing.

Prevention of psychological problems or illnesses

Various macro and micro-level interventions can prevent the onset or perpetuation of such mental health problems among frontline workers. These include public health measures to improve awareness about the COVID-19 pandemic, mitigating the pandemic-related panic or fear among the general population, practical guidelines and information systems for the frontline workers and public, optimal imposition of infection control measures (including the lockdowns) and warning the public about the legal consequences of harming frontline workers and prompt action against such perpetrators.

The institute-level measures to mitigate the psychological problems of frontline workers are effective risk communication by the hospital authorities/governments, involving mental health professionals (MHP) in the core leadership (Grover et al., 2020; Rozatkar, 2020), tangible support from the authorities, mental health support system and services, involving them while developing strategies, mitigate the psychological impact of the isolation/quarantine by making it less-restrictive, ensuring availability of PPEs, and priority-based vaccination for them (which has been rolled out by most of the governments in an effective manner), better information and e-resource system, etc. (Gupta & Sahoo, 2020).

While the microlevel or person-centric interventions to improve the psychological wellbeing of the frontline HCWs are recognising (e.g., corona warriors) or incentivising their efforts (through monetary or insurance schemes), enhancing their resilience through stress management or relaxation training, COVID-19 support team, promotion of teamwork, buddy support system. Also, it is crucial to make psychological support systems available to them as per their preference (telephonic or physical, in the COVID-area or a place where it would be less stigmatised) (Gupta et al., 2021).

Management

The first and foremost step is identifying the psychological problems among the frontline workers by sensitising programs and peer training to recognise their colleagues' psychological issues and provide psychological first aid. Regular active screening for mental health problems among frontline workers is an important step; it would also reduce the mental illness-help-seeking stigma among them. Furthermore, normalisation of the natural emotional or physiological response to a stressful situation (death of the patient or their colleagues, physical or psychological impact of the COVID-19 infection acquired by them, etc.) should also be emphasised.



Those who suffer from clinically significant psychological problems can be provided with telepsychiatry services (counseling or pharmacological) or in-person care, depending upon the need. Utilising online platforms for relevant resource materials (how to face mental illness related stigma, facts or myths about mental health problems), behavioural strategies (relaxation exercises, sleep hygiene, craving management, etc.), or cognitive therapies (cognitive behavioural therapy, mindfulness-based stress reduction techniques, etc.) is an essential step in this regard.

Box 2: Summary

- Frontline workers suffered from depression, anxiety, stress-related disorders, insomnias, and burnout during the pandemic
- Various psychosocial vulnerabilities place them at a higher risk for these problems
- Despite their exceptional work during such disasters, they often become victims of human rights violations (stigma, abuse, assault, etc.)
- Adopting effective preventive strategies (macro/micro-level) can mitigate these issues
- Early identification and prompt interventions, which are accessible and non-stigmatising, can address this issue to a great extent
- Tele-psychiatry services, including non/pharmacological interventions, including the normalisation of their emotional reactions, are a cornerstone of management

COVID-19 and the mental health of the general population

COVID-19 and the subsequent lockdown imposed by the national and international authorities across the globe led to significant hassles in the daily routine of the public, which subsequently gave rise to mental health issues. The initial period of the COVID-19 pandemic (i.e., the first wave in March- July 2020) was characterised by widespread chaos in the general public, mostly related to the uncertainty of the disease, the nature of treatment and isolation carried out at various COVID-designated hospitals, and strictness of contact tracing and forceful admission to COVID wards (being separated from family members). Furthermore, widespread stigma and hatred for those who acquired the illness (being considered super-spreaders of the infection) and adverse reports and visuals of patients suffering or dying due to COVID-19 prevailed in the social media/television news channels compounded the already fearful and anxious public across the country. Likewise, various myths with no scientific evidence were prevalent in the community, which added to the ongoing stigma, fear of

contamination, and, subsequently, psychological distress among the general public (Sahoo et al., 2020).

All these issues also gave rise to violence and widespread resistance against health personnel and government officials on COVID-19 duties (Devi, 2020). Moreover, such fear and negativism in the media evoked negative sentiments among a large group of the general population. For instance, negative emotions against a specific community/religious group occurred in India following a religious gathering event during the initial lockdown period (March-April 2020), adding more distress among the general public (Lancet, 2020). The problems of the general public in all aspects of life increased as the duration of lockdown and restrictions extended from time to time. There was a loss of livelihood (daily wage workers and migrant population), economic downfall (of middle and low socioeconomic strata of people), increase in the prices of the commodities, etc., in addition to the widespread fear of COVID-19 infection and hospitalisation further added to the ongoing daily hassles of the public.

Prevalence of psychological problems among the general population

Various online surveys were conducted to estimate the psychological impact of COVID-19 on the general public. A landmark online survey conducted under the aegis of the Indian Psychiatric Society in the early part of the pandemic (April 2020) revealed about 40% of the surveyed people (n=1685) reported experiencing common mental disorders (depression-10.5% and anxiety-38.5%) due to lockdown and the prevailing pandemic situation (Grover, Sahoo, Mehra, et al., 2020). Studies from different parts of the world (China, Spain, Iran, Italy, USA, Turkey, Nepal, and Denmark) also reported elevated rates of anxiety, depression, and post-traumatic stress disorder in the general population (Xiong et al., 2020).

Risk factors for developing psychological problems among the general public

Critical risk factors for developing psychological problems during the pandemic are female gender, younger age, chronic medical illness or psychiatric illness, unemployment status, student population, and frequent exposure to COVID-19-related news or social media (Xiong et al., 2020). In addition, social factors such as loneliness, separation from near ones, boredom due to reduced socialisation, being homebound, economic crisis, etc., also emerged as significant risk factors (Serafini et al., 2020). Furthermore, increased psychological distress was evident in the increased number of suicides and self-harm attempts during the lockdown period reported across the country (Sahoo et al., 2020; Thakur and Jain, 2020). Furthermore, in addition to the COVID-related anxiety and stressful environment, the general public had to experience sudden and unexpected grief due to the loss of family members/near ones (after the COVID-19 infection), and often, the guilt of not being able to perform a proper cremation (Ingravallo,



2020). Further, the second wave was more marked by excessive fear due to the unavailability of life-saving drugs and oxygen, which increased psychological distress and anxiety in the general public.

Psychological issues among the vulnerable groups

Migrant workers: Migrant workers can be said to be affected the most by the COVID-19 pandemic and subsequent lockdown. They experienced the sudden and unexpected loss of their livelihood, hence started to travel back to their homelands/native places. However, they had to face public discriminations and confrontations from the Government authorities, which added to their psychological distress (Singh et al., 2020). Few studies have looked into the mental health of migrant workers, and these have revealed that a substantial proportion of migrants had psychiatric morbidity during the assessment (Kumar et al., 2020). Additionally, the migrants had difficulty understanding and following COVID-19 containment rules, leading to frequent skirmishes with healthcare authorities during contact tracing procedures. All these factors affected the migrant population psychologically.

Children: The COVID-19 pandemic and the subsequent closure of schools led to home confinement of children and resulted in children being hooked up to computers and mobiles for online classes leading to increased internet use. Parents also had concerns about unsupervised internet exposure by the children and the task of handling them at home throughout the day (Singh et al., 2020). Few studies have reported increased irritability, inattention and clinging behaviour, uncertain and disturbed sleep, nightmares, poor appetite, and other behavioural problems in children (Jiao et al., 2020; Viner et al., 2020). Children with special needs (autism, ADHD, cerebral palsy, intellectual disability, etc.) had worsening behavioural problems due to the lockdown, and parents had a tough time handling them (Cortese et al., 2020). Further, children who got infected with COVID-19 infection or were under quarantine went through significant psychological distress ranging from feelings of sadness, anxiety, fear of death, fear of parents' death, and fear of being isolated in a hospital (Liu et al., 2020; Sahoo et al., 2020b). Furthermore, the severity of anxiety and depression is higher among girls and older adolescents. Some of the critical correlations for these psychological issues are reduced physical activity; delayed time of sleep; increased sleep duration, screen time, internet use; sedentary habits, and poor quality of life. Therefore, it is prudent to improve the timing and quality of sleep, optimising their screen time, and encouraging them to do regular physical activities to prevent these psychological issues (Chawla et al., 2021).

Elderly: Elderly population was the most vulnerable to getting infected, with higher mortality and severity of infection. They also have problems following COVID-19 protocols. Issues such as following social distancing, home

confinement, fear of getting an infection, hearing news of deaths of near ones of contemporary age groups, staying alone, lack of ability to use audio-video aids to connect with family and friends, etc., were some of the stressful situations which made the elderly more susceptible to develop mental health problems during the pandemic (Vahia et al., 2020). Several cases of worsening or relapse of previous mental illness in the elderly during the pandemic have been reported (Mehra et al., 2020).

Human rights aspects

The rights of the children and adolescents population (CAP) need to be observed and ensured during a pandemic, esp. during the lockdown, as CAP is at an increased risk of domestic violence and maltreatment; they also have limited access to mental health related services (including rehabilitative support) (Human Rights Watch, 2020). More so, CAP, who are placed in institutions (child-care institutes, mental health institutes, children of migrant workers, orphanages, etc.), may get deprived of basic amenities and a minimum standard of care, more so overcrowding in the institutions predispose them for COVID-19 infection. In addition, they may also be denied the basic Right to Liberty to meet their guardians during the pandemic, which can adversely impact their mental health (Human Rights Watch, 2020).

The Government made various provisions to safeguard the fundamental rights of the general public. The lockdown and the imposition of the Epidemic Disease Act (1987) were needed to contain the spread of the COVID-19 infection. The people were made aware of the various provisions of testing, contact tracing, hand hygiene measures, etc., regularly by local authorities as well as through the social media and television programs on COVID-19. The Ministry of Health and Family Welfare held regular meetings with healthcare officials and updated the testing and quarantine protocols from time to time. At the same time also made efforts to create awareness among the public about the developments in COVID-19 treatment.

The Government also focussed on safeguarding the mental health needs of the public. For example, awareness and entertainment programs were telecasted on national television to keep the general public stress free at home and motivated to carry out all work with online technologies. However, despite the best efforts by the Government, there were many instances where human rights, particularly the mental health rights of the general public and migrant population, were curtailed or went for a toss. This include, in the name of infection control or public health measures, not being allowed to meet their loved ones (who were in hospital or under home isolation/quarantine), movement restrictions, thereby substantial difficulty in obtaining basic amenities, not being allowed to properly cremate their loved ones or have access to their dead body, right to access of



health and standard of care, including community-based mental health services, etc. (Human Rights Watch, 2020; Sekalala et al., 2020).

Prevention

Various macro- and micro-level interventions can prevent mental health problems among the general public and vulnerable groups. These include public health measures such as awareness programs on major television channels and radio channels to educate the common people about the COVID-19 infection and its mode of spread, ways to prevent and contain the disease, treatment measures at home during the quarantine period, and sensitising the public about the usefulness of the lockdown restrictions imposed.

Psychological interventions that can be undertaken to improve the psychological wellbeing of the general public and at-risk, vulnerable groups are early identification of mental health issues by sensitising the public about common mental health disorders, demystifying the myths related to mental illness and educating about the harmful consequences of substance abuse during home confinement. In addition, health authorities stressed preventive measures like encouraging the public to improve mental health or enhance resilience by engaging themselves in yoga and relaxation training, home workout physical exercises, and practising mindfulness through various platforms.

Management

The initial steps to manage mental health crisis in the public involves early identification of the psychological problems faced by the public and vulnerable groups; this can be achieved through awareness programs. In addition, various hotlines/helplines are available to register mental health problems, such as suicide helplines, which are then contacted by MHPs, and appropriate help can be provided at the earliest. The general public should be aware of such facilities, and information about telepsychiatry helplines available in their town/city should be circulated in local newspapers/print media/social media so people can contact them without stigma.

Children and adolescents placed in institutions during the pandemic can be shifted to a family-based care institute. Mental health support should be extended to the vulnerable CAP to ensure timely and accessible services. Humanitarian agencies or civil societies should extend support and volunteer to take care of the children of migrant workers, orphaned children, internally displaced children and adolescents.

Box 3: Summary

- The general public suffered majorly from COVID-19-related anxiety due to fear of the spread of the infection and loss of livelihood during the pandemic
- Migrant workers were affected the most during the initial part of the lockdown, and significant psychological distress was noted among them
- Suicides and self-harm attempts were on the rise during the pandemic
- The elderly and children also face several psychological issues ranging from home confinement/loneliness to excessive internet use, which needs to be taken care of
- Adequate awareness programs and educating the public about various government facilities can have a significant impact in mitigating their psychological problems
- Early identification and prompt interventions through telemedicine can reduce the psychological impact of COVID-19 on the public to a large extent.

COVID-19 and mental health of persons with mental illness (PMI)

PMI is one of the vulnerable populations that suffered substantially during the COVID-19 pandemic. Since such populations already had various risk factors for developing psychological problems during the challenging times, the stress associated with the COVID-19 pandemic either worsened their mental illness or caused a relapse of psychiatric episodes among those who were maintaining well with the ongoing biological or psychosocial treatments.

Literature suggests that patients with SMIs, because of the premature discharge from psychiatric units, are more likely to suffer from relapse and have higher suicidal behaviour, anxiety, depression, and post-traumatic incidents, including insomnia (Tsamakis et al., 2021). In addition, research shows that individuals who have schizophrenia and psychotic disorders, but not those with mood disorders or anxiety disorders, are at higher risk of COVID-19 mortality (within 45 days following a positive SARS-CoV-2 infection) (Nemani et al., 2021).

Literature from the United States (US) suggests a bidirectional association between COVID-19 infection and psychiatric disorders. Researchers report that patients with no previous psychiatric history and a diagnosis of COVID-19 are associated with an increased incidence of a first psychiatric diagnosis in the following two-thirteen weeks compared with six other health events, with the hazard ratio being most significant for anxiety disorders, insomnia, and dementia (Taquet et al., 2021). Furthermore, the incidence of any psychiatric diagnosis after COVID-19 diagnosis was 18.1%, including 5.8%, which was a first-time



diagnosis. Interestingly, a psychiatric diagnosis in the previous year was found to be associated with a higher chance of COVID-19 diagnosis (relative risk: 1.6). Further, there are recent studies that have suggested that PMI, particularly those with SMI, were at increased risk of mortality due to COVID-19 infection (De Hert et al., 2022; Fond et al., 2021).

Furthermore, evidence also exists that persons suffering from SMIs require in-patient or rehabilitative services more often than those with common mental health concerns (Grover et al., 2021).

The limited access to mental health services, including community-based psychosocial rehabilitation services, has compounded the situation. Not to forget the socioeconomic disadvantages they were already at, which worsened due to COVID-19 infection or related curtailment measures. Furthermore, the caregivers of the PMI, particularly those patients suffering from SMIs, had to face many challenges during the pandemic that substantially added to their caregiving burden.

Risk factors (or contributors) of psychological problems among PMI:

Research points out that COVID-19 infection has a direct neuropsychiatric effect on patients, including among the PMI. Apart from the COVID-19 disease, the drugs used in its treatment can have a direct deleterious impact on the neuro-psychological health of individuals (Kumar et al., 2022).

Likewise, as highlighted above, the psycho-socio-economical adverse impact of the pandemic also acted as a significant stressor in worsening the psychological health of the general population, more so of the PMI (Tsamakis et al., 2021).

Furthermore, the disruption of mental health services, out-and-in-patient services, and limited access to community-based mental health services have greatly affected previously stable patients or those recovering from psychiatric disorders. In most developed and developing countries, furloughing personnel involved in mental healthcare has left the PMI to seek treatment from private psychiatrists (which often is unaffordable) or resort to resource-constrained government mental health establishments (Grigutyte et al., 2021). Latter includes a higher risk of burnout among the limited available workforce at the mental healthcare institutes or a higher risk of acquiring an infection, also transmitting to the PMI (Grigutyte et al., 2021).

PMI with comorbid COVID-19 disease suffers from dual stigma. Stigma about mental illness (and its treatment) has only worsened during the pandemic. PwMI either did not come forth for treatment, or the health services did not give their psychological issues due credence. The fear or stigma is compounded if one has a COVID-19 infection, which is hugely stigmatised in society. Furthermore,

instances of human rights violation of the PMI or forced curtailment in the house or mental health institutions during the pandemic has also been reported, adding to mental illness-related stigma (Anindyajati et al., 2022; Sanghi & Jaswal, 2022).

Literature suggests PMI are at higher risk of acquiring the infection and transmitting it to others, along with an increased risk of mortality determined by several illness-related or psychosocial factors (Fond et al., 2021). As a result, they were more likely to remain isolated/quarantined at home or in COVID-19 treatment facilities (Yao et al., 2020), furthering their psychological problems.

Differential treatment of the mental illness with or without COVID-19 disease vis-à-vis COVID-19 disease with other physical comorbidities further comprises the rights of the PMI. Such disparity not only adversely impacts the health of the individuals but also adversely affects the governments'/authorities' attempt to control the ongoing pandemic holistically. It also widens the gap in providing mental health services to the PMI.

Human rights aspects of PMI

Despite legislative and international conventions to ensure the rights of PMI under the respect-protect-fulfil framework, their ground-level implementation is abysmally poor. The reality has only worsened or unmasked during the pandemic. For instance, as per the International Covenant on Economic, Social and Cultural Rights (ICESCR) (Article 12), "everyone has a right to the enjoyment of the highest attainable standard of physical and mental health" (*International Covenant on Economic, Social, and Cultural Rights*, 1966). Likewise, as per the United Nations (UN) special report (2017), to which most of the countries are the treaty, mental health is to be considered at par with physical diseases without hierarchical prioritisation of physical illness over mental illness (OHCHR (United Nations), n.d.). Similarly, adopting a holistic approach to care for an individual irrespective of the type of illness (physical, mental, or both) has been envisaged under various international guidelines. However, mental health is still a low-priority area for policymakers and health professionals.

Such disparity not only violates the human rights of the persons with mental health concerns but also acts as an impediment to realising the sustainable development goals, such as "ensure healthy lives and promote the wellbeing for all at all ages" (Goal-3) with Target 3.4 specifically referencing the promotion of mental health and wellbeing. While Target 3.8 emphasises issues of clear relevance to mental health within universal health coverage (Votruba et al., 2016).

There have been several instances during the COVID-19 pandemic across the globe where human rights of mental health have been violated, whether in the form of closing/curtailing mental health services (out-patient, in-patient,



community-based services) or forcing PMI in home confinement or the mental health institutions without adequate facilities and no access to their family members, thereby depriving them of the necessary right to freedom, quality living, and exercising their agencies. Moreover, the available services during the pandemic have primarily been limited to the bio-medical model of care, not ensuring psychosocial services, including rehabilitative ones.

This issue further gets complicated when such persons suffer from the COVID-19 infection, where their ongoing psychiatric disorders Act as a hurdle in their rights to receive adequate treatment for the infection. Therefore, there is an urgent need to realise and exercise an equal mental health right (at par with the physical health) of the PMI and implement adequate checks and balances to prevent such violations.

Prevention of psychological morbidity among PwMI

The higher risk of acquiring COVID-19 infection, suffering/worsening mental health problems, and violation of their human rights during the pandemic can be prevented by:

- Information, education, and communication (IEC) activities must be undertaken during the pandemic to enhance the community's awareness about mental health problems and improve the availability and accessibility of mental health services for the PMI.
- Exercising non-derogability of the Right to Mental Health and considering it a part of holistic health, respecting the right of freedom as an integral component of the right to mental health, and Impermissibility of Unjustifiable Non-Retrogressive Measures, including during the pandemic/disaster, and linking the rights of mental health with to an adequate standard of living for the health and wellbeing of an individual (Sanghi & Jaswal, 2022).
- Integration of mental healthcare in general healthcare or COVID-19-specific care.
- Community involvement and continuing community-based mental health services, including rehabilitative services. Training community health workers in primary mental health services.
- Maintaining continuity of care of the PMI, especially those in remission or stabilisation phase, by robust telepsychiatry services, provision of longer follow-up, and dispensing medications for a more extended period.
- Mobile mental health units provide services to remote places and prevent travel-related acquisition or transmission of the infection.

Management

First and foremost, treating an individual holistically where mental health issues are considered at par with physical or COVID-19-related physical problems. Effective integration of the services would ensure an effective treatment of the underlying condition (mental or physical or both) and support the public health measures to fight against the COVID-19 pandemic.

In many centres, the organisation of the mental health facilities was remodelled to cater to the needs of the PMI, such as prospective follow-up through telepsychiatry to know the current status of previously registered patients and redirecting for physical appointments for those who require admission/immediate intervention, enhancing consultation-liaison model along with telepsychiatry in emergency settings and regular screening for COVID-19 infection in the in-patients of psychiatry wards to control the spread of infection to other patients (Grover et al., 2020; Grover, Sahoo, & Mehra, 2020).

The management of the new episode of mental illness or worsening of psychological disease during the pandemic can be managed by effective telepsychiatry services (being run by a team of psychiatrists, psychologists, psychiatry nurses, and social workers). However, this also requires ensuring the availability of essential psychotropic medications.

Likewise, strengthening the resilience of the PMI through various educative (normalisation of the COVID-19 related stress reactions, information about the COVID-19 infection and preventive measures and help-seeking) or behavioural interventions (sleep hygiene, relaxation exercises, coping skills, craving management, etc.) through online resource materials or letter-based intervention tips may be helpful.

Facilitation of access to a hospital or community-based mental healthcare, including in-patient-, emergency-psychosocial intervention- services, wherever warranted, may also be helpful. In addition, the provision of a longer follow-up in the stable patient, so that the latter do not have to travel frequently to get their prescriptions or medicines may be done.

Home-based services (rehabilitation services, counseling) are to be strengthened where access to clinic-based services is unavailable due to the COVID-19 pandemic-related curtailment measures.

The curtailment measures should be optimum, not too restrictive, so that the occupational and recreational opportunities of the PMI, including activities that help in their recovery, are not jeopardised.

Box 4: Summary

- Persons with mental illness (PMI) are at higher risk of suffering psychological problems/worsening their problems during the COVID-19 pandemic
- Anxiety, depression, post-traumatic stress, insomnia, suicidality, and relapse of psychotic/mood episodes are common mental health issues during the pandemic
- The right to mental health must be an integral component of the right to health, the standard of living and wellbeing
- The provision of mental healthcare for these individuals should be integrated into the existing COVID-19-related health services, with emphasis on right-based care
- Telepsychiatry services, community-based care, home-based rehabilitative/counseling services & mobile-mental health units are the feasible & effective models of care during the pandemic.

Recommendations and future directions

Based on the recent experience with the COVID-19 pandemic, for the effective preparedness for health services to combat such emergencies and mitigate their psychological impact, the following recommendations are made:

At the Policy level: Mental health needs to be integrated with physical health while framing the policies. The treatment of mental health (or PMI) by policymakers, authorities, health service agencies and insurance agencies should be at par with physical health. While framing any health or disaster-related policies or guidelines, the National Mental Health Policy (2014) or Mental Healthcare Act (2017) should be referred to. Having an MHP in such a policy group would be paramount.

Mental health as a part of the disaster management plan: To effectively manage the mental health aspects of the disaster (man-made or natural), it is worthwhile that psychological aspects of the disaster must be integrated into the disaster management plan; furthermore, personnel involved in disaster management must be trained in the mental health aspect of the disaster.

IEC activities: The mental health aspects of the disaster (such as the COVID-19 pandemic) and measures to address them must be informed or communicated to the general population from the beginning. Such activities

would increase awareness among the public, mitigate the untoward psychological impact of the disaster, and prevent society's ill-treatment of frontline workers or PMI.

Strengthening health infrastructure, including mental health services:

The current pandemic reiterated that those States/ Countries need to enhance their health services, including mental health services, to better combat health emergencies. The key strategies are to increase the mental health budget, sensitise the allied government department, and effectively collaborate with international agencies.

Community health services: Community health services need to be strengthened, including mental health outreach services, to better address the burden of psychological problems of the general population and PMI. In addition, ensuring the availability and accessibility of standard of care in these clinics would substantially prevent or reduce mental issues/disorders during the pandemic.

Improving social support and community participation: As health emergencies are unexpected, at times, unprecedented (e.g., the COVID-19 pandemic), encouraging community participation and effectively mobilising community resources (including human resources) can significantly complement the Government's effort to fight against the health crisis. Furthermore, community cohesion and participation add to the social capital of an individual or society, which is a protective factor against mental problems during a disaster.

Mental health advocacy and collaboration with the international/national bodies: Health advocacy, particularly mental health advocacy, must be vigorously undertaken by various stakeholders. It includes increasing the health budget in general and the mental health budget in particular, linking health services with other social-welfare schemes and domains of life (education, economics, workplace, etc.), and effective implementation of the various government policies/legislations. Roping in different national (Indian psychiatry society, human rights commission, etc.) and international agencies (WHO, United Nations, World Psychiatry Association, etc.) in this regard could be a valuable step.

Research promotion on COVID-19 and mental health: The fight against the pandemic will continue even after gaining significant control over the new cases of COVID-19 or associated health morbidity in the form of long-term neuropsychiatric or social sequelae. Therefore, research must be promoted to identify the magnitude of these problems and potential interventions.

Implementing and emphasising human rights aspects of mental health: The right to mental health during the pandemic cannot be thought of if they do not become part of our psyche or social practices where mental health rights are



to be realised as an integral part of the right to health, the standard of living, and the right to freedom.

Improving mental health at the workplace: Workplace mental health promotion and intervention need to be part of community-based mental health awareness programs and services, and its need must be realised. Moreover, it becomes imperative during health emergencies where the service providers, such as frontline workers, are also the most vulnerable population to suffer from the illness they are fighting or developing psychological problems. Therefore, having regular mental health screening at the workplace and mental health support system is vital.

Targeting vulnerable population: The needs of the vulnerable population, such as migrant labours, including those working in the informal sector, children, elderly, homeless persons, PMI, and those suffering from chronic medical illnesses, etc., must be considered and addressed during COVID-19 pandemic like disasters while framing guidelines or policies (e.g., lockdown measures, isolation/quarantine rules, etc.). Without this, they will likely suffer from various psychosocial problems, which would deleteriously affect the Government's initiative to fight against the pandemic. Therefore, all efforts should be made to ensure the wellbeing of such individuals, including safeguarding their human rights.

Box 5: Summary of recommendations to mitigate the psychological impact of the COVID-19 pandemic

- Both macro and micro-level changes or enforcement are required to ensure the psychological wellbeing of the general population and vulnerable groups
- Having MHP(s) in the disaster management policy group, integrating mental health in the disaster management plan, and mental health advocacy is paramount
- Strengthening mental health infrastructure, efficient community health services, IEC activities (mental health), and workplace mental health promotion are vital
- Focusing on the mental health needs of the vulnerable population and having effective preventive and therapeutic strategies are valuable steps
- Research on the long-time neuropsychiatric and psychosocial sequelae of COVID-19 and effective intervention strategies are vital

Conclusion

The COVID-19 pandemic has substantially impacted, though at varying levels, frontline workers, PMI, and the general population. Anxiety, depression,



stress-related disorders, insomnia, and burnout (in frontline workers) are the common psychological problems noted during the pandemic. Various bio-psychosocial factors have contributed to the onset of mental health issues or the worsening of the pre-existing mental health problems of the population. Human rights violations, particularly of the vulnerable people, including PMI and frontline workers, are bothersome. The pandemic has exposed many countries' poor mental health infrastructure, including India. Although government/ agencies have come up with various mitigating measures or interventions to address the mental health needs of the population, they are largely ineffective in the absence of poor mental health awareness in the country, poor status of the community mental health services, non-integration of the mental health services with the routine physical illness treatment, including COVID-19 care. Policymakers, mental health professionals, and related departments or agencies must design effective COVID-19 management plans and policies to prepare us for future disasters better.

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Disaster and Mental Health

Early Historical Aspects

Historically, disaster management in India suffered from limitations of the conceptual frameworks and the absence of value for the right to life, including health, with dignity. The common disaster situations encountered in the time before the independence and early years of post-independent India were related to agriculture and weather- acute droughts, protracted famines or floods being the most common. So, while more than three-fourths of the population lived in the villages, disaster management focused on rural agrarian. The responsibility of the Nodal Agency in the Government of India has been with the Ministry of Food & Agriculture. Expectedly, services for the Persons with Mental Illnesses (PMIs) or Persons with Disabilities (PwDs) did not figure as points of concern. Of course, the task of the affected populations dealing with the trauma and/or psychological after-effects was left to the communities.

The pattern of a discriminatory approach to PMIs of European origin living in India, and the local population referred to as “Natives”, was quite evident in the pre-independence era, is amply exemplified by the fact that the town of Ranchi had two separate “mental hospitals”, across the road from each other, for the European patients and the patients from the local native population. Unfortunately, there is a minimal record of the plight of PMIs in disaster situations, especially those from the local people. Still, it can be surmised that the prevalent neglect would have continued or indeed exacerbated in disasters & crises.

Partition at the time of independence 1947-48: First Major Crisis

By all accounts, the massive carnage around the time of independence, involving deaths, rape and murders, and exceptional dislocations or forced migrations in 1947-48, had been managed, in terms of the basic needs in the immediate aftermath and long-term rehabilitation, in humane consideration by the country and its new government, with very little, if any, focus on the circumstances of PMIs or the psychological impact of the massive trauma.



However, these aspects of the affected populations have begun to be studied and documented in the last few years and decades.

Post-independence period and initial studies

The phenomena of weather & agriculture-related crises situations continued in the immediate period after Independence. However, the more significant issues of health-related activities and concern for the disabled populations, including mental health concerns, did not figure in the relief & rehabilitation activities in those situations. It can be said that these aspects either did not merit attention or it was expected that the psychological issues and mental health problems would be taken care of through relief and rehabilitation work and /or by the local community resources.

In possibly the first such study effort, the National Institute of Mental Health and Neuro Sciences (NIMHANS) team explored the pattern of reactions of grief in the bereaved families of a fire tragedy at a Circus site in 1981, wherein 70 persons had died. It was found that 74% of the bereaved family members reported persistent sadness, crying, sleep and appetite disturbances, and in about 35% of these persons, there was evidence of psychiatric symptoms requiring treatment (Narayanan et al, 1987).

Types of Disasters and Crisis Situations

In addition to the apparent classification of natural and manmade disasters, one method of classification of disasters described three types viz. Central, Intermediate and Peripheral. Peripheral disasters create a crisis wherein the affected from diverse locations and communities may have come together for an event and become affected by a disaster, for example, an airplane crash or a fire tragedy at a public place. Intermediate disasters create a crisis for a localised community in a geographically defined location, wherein government agencies in the city and/or state step in for relief, for example, a fire tragedy in a local slum area. Finally, significant disasters involve large masses of populations, which get affected by natural or manmade disasters and generally require external help in terms of governance as well as professional services. These are the types of disasters that get the most media and public attention, whereas the mental health aspects of all kinds of disasters may deserve attention.

Of course, crisis situations leading to civic and other basic amenities and professional health services, including mental health, involve ethnic riots, political demonstrations, long-term ethnic conflicts or political unrest. The mental health aspects of these situations are similar yet quite different and require much more tactful handling.



Bhopal Gas Tragedy, 1984: Rude Shock and Awakening

The sudden and extensive effects of the Bhopal gas leak in December 1984, in terms of the loss of lives and continued health effects, seem to have been a significant turning point in the history of the country in many ways. The Government of India seriously took up the emphasis on healthcare service delivery and generating research information by the premier medical research agency, the Indian Council of Medical Research (ICMR), immediately following the disaster and in the long term. The need and the relevance of the mental health aspects, both in terms of the impact and the other psychological factors of the apprehension, were considered and implemented. Teams from ICMR, NIMHANS, and other health settings made pioneering efforts to obtain the preliminary trends and train health professionals and relief workers. Based on the international experience and information available, as well as the inadequacy of trained mental health human resources, it was considered appropriate to carry the relevant mental health messages to the affected population through these health professionals and relief workers. The need for a distinctive focus on mental health aspects was recognised, and a trend of integrating mental health aspects in the overall general service delivery was initiated, which strengthened subsequently.

Sethi et al. (1987) reported on the outpatient population attending government sector general health clinics and found a higher rate of mental disorders in the adult outpatients in the gas-exposed area. The reported this to be higher than the non-exposed areas. Bhiman (2001) reported the psychosocial impact of the Bhopal gas tragedy of December 1984. The study estimated that 20% of those who approached medical facilities and half of the community had mental health problems. He found that people commonly suffered from depressive neurosis (37%), anxiety neurosis (25%), adjustment reactions with prolonged depression (20%) and adjustment reactions with predominant disturbances of emotions (16%).

Latur, Marathawada Earthquake 1993: Systematic Mental Health Field Research

The earthquake at Latur in the Marathawada region in Maharashtra provided an opportunity for studying the mental health sequelae of natural disasters. The ICMR-funded centre for Advanced Research at the Maharashtra Institute of Mental Health (MIMH), Pune, examined the psychiatry and mental health morbidity over five years and, in a modified cohort design, found evidence for increased morbidity in the earthquake-affected population. This long-term study adopted an operational research model, thus demonstrating the feasibility and the suitability of combining service delivery with data generation in research



mode for mental health aspects of natural disasters like earthquakes. The ICMR reported in 2000 that

“Marathwada earthquake that occurred on 30th September 1993 had a massive impact on human beings in terms of loss of life and damage to property. It had claimed 8000 lives and left 14,000 injured. The community-based modified cohort study conducted by ICMR was designed to determine the nature and prevalence of psychiatric morbidity as one of the objectives through longitudinal epidemiological methods. The study found a significant increase in psychiatric morbidity in the disaster-affected group. Overall prevalence was 139/1000 in the affected group compared to 68/1000 in the control group” (ICMR, 2000).

Gujarat Earthquake, 2001: Public Health Approach to Disaster Mental Health

This large-impact earthquake at Bhuj town in the Kutchh region of Gujarat became a milestone in the task of prevention of infective outbreaks following natural disasters through remarkable work from the Ministry of Health & Family Welfare and the ICMR, also a significant event in the evolution of the field of disaster mental health in a public health perspective. This approach included the provision of appropriate services as well as the integration of these into the larger framework of disaster preparedness and response. Many national agencies and Mental Health Organisations joined hands with the State Government in systematising and implementing the lessons learnt from earlier experiences and with the emerging initial and pilot studies. The Ministry of Health & Family Welfare, Government of India; the ICMR; NIMHANS, Bengaluru; Tata Institute of Social Sciences (TISS), Mumbai; and Institute of Human Behaviour & Allied Sciences (IHBAS), Delhi had their field teams for initial service delivery and pilot findings from the first few weeks into initial months. Many of these agencies, including the ICMR-IHBAS project team, had a larger conceptualisation of service delivery and research information being generated to have evolved to the next level. The ICMR-IHBAS team, as did other agencies, emphasised a more comprehensive public health approach, going beyond the estimation of mental health problems to include mental health service needs & perceptions, combining the classic epidemiological approach of modified cohort design with the anthropological qualitative research methods, and also datasets from health systems and long term epidemiological studies. The conclusions of the ICMR- IHBAS pilot phase were reported by Desai et al. after one year (Desai et al, 2002) as follows:

1. There is evidence for a definitive need to focus on the emotional and psychological needs of the population in dealing with the post-disaster situation.
2. Three levels of psychological disturbance have occurred or can be

expected to occur (i) mild to moderate psychological transient disturbance of emotions and/or thoughts, which occur in a substantial proportion of the population (70% to 90% of the population) (ii) moderate to severe psychological disturbance, subsyndromal psychiatric problems and acute stress-related disorders (30% to 50% of the population). The indications are that these start after a few months and can benefit from intervention by the general healthcare providers and relief workers, although these aspects need further study. (iii) diagnosable psychiatric disorders, mainly related to stress, which may begin to occur any time after the 2-3 months of the disaster and will require a specialist in psychiatry and mental health services (5%-15%)

3. Communities and populations can and do take care of their emotional and psychological needs with their resources to a considerable extent. Indeed, there are many success stories of good to extraordinary copy by individuals, groups and communities in the face of severe adversities due to the disaster. Moreover, the strong sociocultural traditions and the psychological resilience of the population of Gujarat, and the people of Kutchh in particular, seem to have helped to a great extent.
4. The mental health service needs of large proportions of the affected population can be served by relief and rescue workers and healthcare providers, as well as by strengthening and supporting the sociocultural coping mechanisms of the local communities. Specialist mental health experts can be helpful and are required for (a) services for a relatively smaller proportion of the population, (b) sensitisation and training of the rescue/relief workers and healthcare providers who can take care of the needs of a more significant proportion of the affected population.
5. Special groups such as women and school children were found to be at higher risk of developing psychological disturbances. Hence, in the initial few months, adequate attention should be paid to these groups while planning mental health services in earthquake-affected areas. In the later period, it was seen that the proportion of men and women was nearly equal in the treatment-seeking population from the hospital data. Epidemiological evidence for any possible gender difference needs to be generated for the occurrence of psychiatric disorders in children.
6. The psychological recovery was seen to be closely related to issues of socioeconomic and political nature. The psychological recovery in the initial period was linked to the local community's support systems and the promptness and quality of immediate relief and rescue work. In the later stage, psychological recovery is expected to be more linked to micro and macroeconomics and rehabilitation and reconstruction programs.



Many communities and their leaders favour indirect relief measures like employment generation schemes over direct assistance schemes for food or housing for the social as well as mental health of the affected population.

7. Many relief and healthcare agencies do not recognise their work's emotional and mental health aspects or do so minimally. Over the initial weeks and months of the relief work, some agencies did get involved in issues of emotional and psychological nature, with differing nomenclature, e.g. counseling, psychiatric services, psychosocial intervention, psychosocial rehabilitation etc. The interaction and involvement of such agencies with different backgrounds can enrich the delivery of services, but it also has the potential for not being well targeted or coordinated.
8. Relief and rescue workers were, as a general pattern, sensitive to the emotional and psychological needs of the population. They made spontaneous and intuitive efforts to assist the population in dealing with psychological disturbance. These efforts can be enhanced by training. Training programmes for such sensitisation have been carried out by various agencies and are seen as one of the mental health service delivery models.
9. Physicians and other healthcare providers were moderately or less than moderately sensitive to the emotional and psychological aspects. They also operated under the constraint of the enormity of the workload against the limited time. As such, the healthcare providers saw no apparent effort except for a few individuals or teams. There is a need for sensitisation and training here, which has been addressed up to only some extent.
10. Psychiatrists had a keen perspective on the issues of specific stress-related disorders like acute stress disorders and PTSD and the impact of the disaster on the clinic profile. However, minimal sensitisation was adequate in many instances to help enlarge this perspective to more significant mental health issues in the community and population. Therefore, outreach programmes and mental health camps have been the most commonly used service delivery models besides the common trend seen in psychiatrists and psychiatry teams conducting special clinics at hospitals and compiling hospital-based data on patients seeking treatment.
11. There was a significant need to focus on the emotional and psychological aspects of the experience of the relief/rescue workers and the healthcare providers, including support groups. This has taken place only to a minimal extent.
12. Media played a vital role in the timely mobilisation of national and

international support in the earthquake-affected area. The media, especially the local print media, has played a very significant role by publishing and reinforcing regional sociocultural protective coping mechanisms of the people. However, in many people, the psychological disturbances did get perpetuated due to repeated visual images of the devastation of earthquakes displayed by the audio-visual media.

13. There is a long-term need to continue to focus on the mental health service needs of the disaster-affected population. It should be possible to combine the service delivery and service research aspects within the long-term plans of the Gujarat Government and other national and international agencies. Research opportunities are available for generating beneficial scientific information, which needs to be appropriately utilised with the ethical obligations to individuals and communities.

Figure 1: Three-Level Model of Mental Health Service Needs of Disaster-Affected Population



The long-term study of the mental health aspects of the Gujarat earthquake was based on the well-planned modified cohort study, on an extensive community-based sample, with a standardised two-stage epidemiological method, using General Health Questionnaire (GHQ) & SCAN (Schedules for Clinical Assessment in Neuropsychiatry) -based interviews, supported by vast field based Qualitative Research Methods (QRM). The long-term project was carried out at three research sites in Gujarat, with active cooperation and involvement of the Government of



Gujarat, with IHBAS, Delhi, as the Coordinating Centre. Desai et al. have reported the conclusions in detail, with the following as the significant summary points (Desai et, 2010; Desai et al., 2017):

1. In the long term of 5 to 8 years after the disaster, the prevalence of psychiatric disorders in the adult population is high (49.09/1000) in the heavily affected population (Bhuj and Kutchh (n=8495).
2. In the long term of 5 to 8 years, after the disaster, in the affected adult populations where modified cohort comparisons were possible (Study group n=7614 & control group n=6899), the prevalence is statistically significantly higher as compared to the control group (66.1/1000) v/s 22.6/1000).
3. In the large epidemiological samples of a single group, the prevalence was heavily affected non-comparable groups in the Bhuj &Kutchh region and the modified cohort comparison groups in Ahmedabad & Rajkot, the rate of Post Traumatic stress disorder (PTSD) is very low or non-existent.
4. The above findings are supported by research information from extensive qualitative research methods.
5. Although PTSD as a clinical syndrome and public health priority in post-disaster situations may require some appropriate attention, the exaggerated & excessive emphasis on PTSD as psychiatric or mental health sequelae is a myth in the early and later phases.

Tsunami 2004: Comprehensive Public Health approach to Mental Health

The unprecedented havoc of the Tsunami in December 2004 in the Andaman & Nicobar Islands and the coastal part of Tamil Nadu was the next major natural disaster that provided an opportunity further to expand the public health approach to mental health aspects. Teams from top-level academic institutions like NIMHANS, Bengaluru and others, on behalf of the Emergency Response Division of the Ministry of Health & Family Welfare, Government of India spent focused not only on providing immediate and short-term psychological relief but also focused on building capacity for the local teams of the Government and the Non-Government Sectors. The development and standardisation of the training modules for different categories of health staff and relief workers got particular emphasis with this experience for remote areas (Math et al., 2015).

The ICMR-IHBAS study across four research sites in Tamil Nadu, with the active involvement of the State Government and the local collaborators, examined the mental health consequences as well as the health service utilisation at 6 to 12 months following the disaster. Desai et al. (2006) summarised the essential

findings from the public health perspective of such disaster situations (Desai et al., 2006):

1. The study has established a definite pattern of increased attendance for psychiatric problems in all mental health and general health settings in the first 6-12 months after the disaster. The need for strengthening and augmenting this demand has to be recognised, balancing it carefully with the common trend of sending outreach teams to the community from a healthcare setting. The possible fallacy of a converse flow of professionals reaching out to the community while the needy affected population reaches the health service settings may be well worth avoiding. There was an increase in the new cases and cases having relapsed of already existing psychiatric illnesses.
2. In the immediate period of the first 48 hours to a few days after the disaster, an enormous rush and overload in the emergency room setting of the general hospital are contributed to by psychological fear and the need for reassurance. This can be effectively tackled by introducing mental services. Well-organised and effective rescue and relief measures are appreciated by the community and help in psychological wellbeing and possibly in the prevention of psychological distress and psychiatric disorders.
3. There was a large proportion of *psychologically* disturbed people, besides a small proportion of persons with psychiatric disorders and specialist psychiatric services are required only for a smaller proportion of populations, whereas counseling and psychosocial support services are needed for the more significant proportion of the psychologically disturbed persons
4. Depression in women and alcohol-related problems in men were the most common psychiatric problem among disaster-affected people. In addition, the occurrence of alcohol dependence, alcohol use disorders and increased patterns of alcohol use were found to be related to the ready cash available as assistance to the affected population, with significant implications for the impact of the type of relief services.
5. The rates of PTSD were much lower than expected by western standards. The common myth of PTSD being the sole/significant mental health consequence of disasters needs to be corrected, and the possible cross-cultural aspects of lower rates of PTSD in some cultures needs to be examined.
6. It was also observed that the emotional panic component in the emergency room triage in the immediate post-disaster period was vast



and unmanageable. It could be quickly addressed by paramedical staff/ local resources if appropriately trained.

7. There was a "converse flow" of healthcare facilities in which, during earlier phases of disaster, healthcare teams were sent to the field while the people requiring services rushed to healthcare facilities which is the opposite movement of the people and service providers, leading to chaotic situations. Secondary data from tertiary mental health services at different sites but in 3 different kinds of settings (Institute of Mental Health (IMH) Chennai, General Hospital Psychiatry Units (GHPUs) and Private Clinics) as well as from primary non-psychiatric settings (General practitioners (GPs) and Primary Health Centre (PHCs)) showed that there was a definite increase in the total number of registered cases which included new cases and cases with exacerbation of pre-existing psychiatric illnesses.

Other Disasters in the Late 20th & Early 21st Century

Kar et al. (2004) reported on the short-term psychological aspects of the survivors of the Super Cyclone in Orissa and found that the affected people, who were close to the epicentre of the Super Cyclone and suffered loss of family members and/or property had experienced more anxiety, depression and post-traumatic stress as compared to those people who were at a distance from the epicentre (Kar et al., 2004).

The earthquakes in Sikkim in 2003 and Kashmir in 2005 also offered more opportunities for field relief work and the development of modules by NIMHANS teams to train the local workers, which were implemented locally.

Compared to these major disasters, although there have been plenty of local action in many intermediate disasters, there is very little research evidence for the mental health consequences of such disasters, which affect a localised community, as much as the larger well, known disasters. One such fire disaster in a large slum area of Delhi in 1999 had also been taken up for service delivery and operational research. Gupta & Desai, 2003 and Desai et al., 2004 have reported that

A Modified Cohort study on Prevalence, Pattern and Predictors of Mental Health Morbidity following an Intermediate Disaster in an Urban Slum in Delhi in 1276 and 1284 in the study group and control group, respectively, showed that the prevalence of psychiatric disorders was significantly higher (78/1,000 v/s 22/1,000), and the prevalence of psychological ill health was also higher (232/1000 v/s 50/1000), as compared to the control group. Depression, Substance Use Disorders, Generalised Anxiety Disorder, and Somatoform Disorders are the most common psychiatric disorders. In addition, the most typical symptoms of



psychological ill health were suggestive of depression. Only one case of PTSD was identified in a control group related to individual trauma.

Paradigm Shift in Policy & Governance: from Agriculture Ministry to Ministry of Home Affairs-Legislative Provisions for Streamlining of Disaster Management Systems: National Disaster Management Authority (NDMA) and other Agencies

With the shifting nature of natural and manmade disasters beyond floods and droughts and the need for active inter-sectoral collaboration, in the early years of the 21st Century, the Ministry of Home Affairs, Government of India, became the Nodal Ministry for all aspects of disaster preparedness and response. The Government of Gujarat, based on the experiences gained and the felt need for a system for Disaster Management, enacted the Gujarat Disaster Management Act in 2003. Subsequently, the Disaster Management Act of 2005 was passed by the Government of India and notified. As a result, the National Disaster Management Authority (NDMA) was set up under the Ministry of Home Affairs. The National Disaster Response Force (NDRF) oversees the provision of immediate rescue & relief services, and the National Institute of Disaster Management (NIDM) monitors and provides training and academic activities related to disasters.

The NDMA is mandated to provide policy guidelines for different aspects of disasters and technical guidance. As one of the first few National Guidelines sets, the NDMA prepared and published Guidelines for Medical Preparedness and Mass Casualty Management in 2007. (The author was a member of the Core Group, along with medical experts from various disciplines). These Guidelines included specific observations on the Salient Gaps and Recommendations on Preparedness and Management (NDMA, 2007).

The Guidelines recognised two significant gaps in the context of mental health as mentioned below:

Psychosocial Support and Mental Health Services:

Disasters leave a trail of human agony, which requires psychosocial intervention apart from logistic and material help. Our country possesses rich experience and adequate expertise in providing mental health services and psychosocial care. Successful models of mental health delivery and psychosocial care are also available. The National Mental Health Programme (NMHP) of India, through its District Mental Health Programme (DMHP) in coordination with the primary healthcare system, is a potential resource for delivering such services, especially during and in the aftermath of disasters. However, despite colossal resource potential, the available systems have some critical deficiencies.



Rehabilitation, reconstruction and recovery:

No specific mechanism exists for managing various activities during the rehabilitation, reconstruction and recovery phase in the aftermath of a disaster. Immediate emphasis must be focused on physical health problems and acute psychosocial trauma. Simultaneously, attention is required to prevent impending epidemics in the post-disaster phase. Moreover, the activities facilitating recovery and rehabilitation tend to dwindle or reduce differently, especially after the first 6 to 12 months. Currently, there is a lack of adequate facilities for long-term rehabilitation and mental healthcare for disaster victims.

The National Disaster Management Guidelines on Medical Preparedness and Mass Casualty Management (NDMA, 2007) also emphasised the role of psychosocial preparedness as part of medical preparedness and recommended that:

The three principles for psychosocial preparedness to be adopted are

- a) The preparedness of the communities to meet their psychological needs during the disaster planning phase;
- b) Providing the required psychosocial services to the affected population after the disaster;
- c) Integration of these services not only with the health services but also with the general relief, recovery and rehabilitation activities. This integration is necessary for mental health services and psychosocial support effectiveness.

The Guidelines also explicitly elaborated on the psycho-social aspects of post-disaster management and advised that

- a) Appropriate interventions for mental health and psychosocial support be planned and implemented in a phased manner.
- b) Emotional first aid and the mobilisation of community support systems should form the basis of activities in the first few weeks following a disaster.
- c) Trained counselors and community-level workers (CLWs), with a backup of specialised mental health services, as and when required, will be made available for a minimum follow-up period of two years.
- d) Mental health services and psychosocial care integrated with the local delivery systems will be available and accessible for at least five years.



- e) Specific activities and programmes for the psychological wellbeing and care of the rescue and relief workers, as well as the CLWs and counselors, will be made available.
- f) Material for training counselors and CLWs, as well as training of trainers, will be made available and uniformly implemented.
- g) Awareness material about the common psychological and behavioural reactions to disasters will be available and widely distributed.

NDMA Guidelines 2009 “Psychosocial Support and Mental Health Services (PSSMHS) in Disasters”

Further to the National Guidelines for Medical Preparedness issued by the NDMA in 2007, the perceived need for a Guidance document for the mental health aspects, and the collective expertise and experience available across the Country was brought together for a policy document published in 2009 as NDMA Guidelines for “PsychoSocial Support and Mental Health Services (PSSMHS) in Disasters” (NDMA, 2009).

The Guidelines took note of the status and the context to state that the area of disaster mental health has evolved during the last two decades. From a mental disorder-based approach after the Bhopal gas disaster, the approach has been modified to mental health integrated with public health after the Latur earthquake and further broadened to psychosocial and mental healthcare in the Orissa super cyclone, Gujarat earthquake and tsunami, and Kashmir earthquake. The pure clinic/ hospital-based planning and delivery of services has given way to community-based services with active utilisation of community resources. The nature of manpower involved in service delivery has also changed significantly. Earlier, only psychiatrists were visible, but now all mental health professionals, including clinical counseling, psychiatric social workers, etc., professionals, para-professionals, trained CLWs and volunteers, can be seen as service providers. Capacity building encompasses human, scientific, technological, organisational, and institutional resource capabilities. The primary goal of capacity building is to enhance the ability of persons and institutions based on perceived needs. Capacity building is a long-term, continuing process in which all stakeholders participate to improve their skills and knowledge to achieve the desired objectives.

The NDMA Core Group on Psychosocial Support and Mental Health Services (PSSMHS) also noted the following as a salient gap.

The experience shows that the overall approach in PSSMHS has been medical rather than bio-psycho-social. In addition, the activities have primarily been short-term and natural disaster oriented. These perceivable gaps, if addressed, will further strengthen the preparedness and response for PSSMHS.



The PSSMHS Guidelines of (NDMA, 2009) made the following recommendations for psychosocial preparedness:

Institutional Framework

The functionaries of DMHP and infrastructure should be incorporated into the institutional framework for disaster management for planning and delivering mental health services. The proposed expansion of NMHP to cover most of the districts during the 11th plan may provide adequate opportunity for such linkages. The planning of NMHP, including its programme components, training materials, programmes and research, should be appropriately modified to include mental health aspect to disaster management to make such linkages successful

The proper linkages between PSSMHS and developmental programmes will reduce the expenditure on PSSMHS preparedness. It will also improve the quality and impact of developmental programmes. The link will also likely add a humane aspect to the developmental programmes.

Capacity Development

Capacity development in psychosocial support and mental health is a priority area. There is an acute shortage of skilled human resources both in Government and non-government organisations for management of PSSMHS. It requires all-round development of human resource infrastructure, at all levels of the organisations related to PSSMHS in the community. Special attention is given to the development of trained manpower, their availability during disasters, knowledge networking and scientific upgradation at all levels. The capacity building also will provide a platform to link the psychosocial needs of the beneficiaries to practical programming. The training shall include CLWs from the community.

Education

The need for imparting formal education to students has become inevitable, considering the increasing incidents of disasters. PSSMHS is a crucial component of education for professionals. Basic education on psychosocial support is essential and must be included in the syllabi of courses run by various regulatory bodies. Mainstreaming disaster management knowledge in the education system will facilitate preventing and mitigating adverse psychosocial effects of a disaster.

Education on PSSMHS may be included at the graduate and post-graduate levels in various courses in humanities and other professional courses.

Community Participation

The community is the first responder in the event of any disaster and plays a vital role in the response, rehabilitation, and provision of PSSMHS to disaster survivors. In addition, many community-level workers (CLWs) participate as essential team members for psychosocial support to the community.

Public-Private Partnership

The private sector has substantial capacity and infrastructure and plays a vital role in managing disasters. Many community-based programmes collaborated on public-private partnerships and have successfully demonstrated the effectiveness of reaching the needy population.

Technical and Scientific Institutions

Centre and state authorities identify and designate technical institutions that have resources. For example, NIMHANS is designated as a centre of excellence because of its long-time association with various disaster mental health interventions and its expertise in the field of PSSMHS. In addition, Institute of Human Behaviour & Allied Sciences (IHBAS), Maharashtra Institute of Mental Health (MIMH), Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tata Institute of Social Sciences (TISS) and other regional-level nodal institutions have been identified and designated.

Special Care of Vulnerable Groups

Disasters do not affect uniformly; their effect differs from person to person and region to region. Even under normal circumstances, vulnerable groups, due to their physical, emotional and social limitations, do not get adequate help and support and are prone to physical and psychological difficulties. Vulnerability is the degree to which a population, individual or organisation cannot anticipate, cope with, resist and recover from the impacts of disasters. These survivors are more prone to adverse psychosocial and mental health consequences of disasters due to age, gender, ethnicity, disability, poor health and mental illness. Due to these factors, they are at higher risk, varying from region to region.

The vulnerable group consists of children, women, refugees, the internally displaced population, the aged, the mentally ill, the disabled, and people with special needs. They are at increased risk of developing mental health difficulties. These groups need special attention and extra care during disasters. Therefore, it is essential to prepare specific intervention manuals for vulnerable groups.

Identifying these vulnerable groups based on pre-defined parameters is essential as updating them at regular intervals. Therefore, the following factors



must be considered while preparing PSSMHS for vulnerable groups in different phases of disasters.

Evolution of the Approach- From Clinical to Public Health

The missed opportunity of understanding and documenting the mental health aspects of the major event of the Partition and the bifurcation of the Country at the time of Independence, and in the immediate aftermath of that, was understandable due to many reasons. There have been efforts in the recent past to uncover those experiences professionally and scientifically. The humanitarian outreach efforts, including psychological relief, in other acute and short-term riots, as well as long-term conflict situations like in Kashmir, form a similar but parallel track of evolution alongside the field of disaster mental health.

In the context of disasters of different types and severity, the initial efforts in the 1980s and 1990s had been of providing psychological relief and a few noteworthy examples of a systematic attempt at documenting the clinical trends observed and of carrying out field studies- especially after the Bhopal gas tragedy of 1984 and the Latur earthquake of 1993. There were also endeavours to train the health and relief workers. These initial experiences provided valuable insights into clinical and capacity-building domains.

It can be easily surmised from the overall trends, and as described above, that the evolution from that predominantly clinical and humanitarian approach to a public health approach, combining the clinical investigations with mental health service needs, service utilisation patterns and the perception of the communities concerned has occurred in the 21st Century. The watershed moment in that evolution was the Gujarat earthquake of 2001, wherein the national agencies and the State Government adopted the public health approach. Subsequently, in many disaster situations, the larger public health approach has been kept in focus and found useful. This evolution in disaster mental health has also run parallel to a similar evolution in the larger field of public health. Indeed, it can be seen that in this area, mental health research and service delivery aspects have kept pace with the developments in the larger field of public health because of some national agencies and visionary individuals.

Legal Provisions and Rights-Based Framework

As described above, alongside the scientific evolution of the approach, the need for a legal and policy framework was implemented in Gujarat and subsequently at the National level through the enactment of the Disaster Management Act of 2005; and the formation of NDMA and the state and district level coordination agencies on similar lines. This provided a robust mechanism with administrative and legal loci. The contribution of the NDMA in framing



the Guidelines for Psycho-Social Support and Mental Health Services has been outlined above. In addition, the NDMA has regularly provided technical assistance to different states in disaster situations in the recent past.

The inclusion of mental illness-related disability as one of the seven disability conditions in the Persons with Disability Act (PwD) 1995, and the increasing need for emphasis on the psychosocial and mental health needs of all populations and particularly Persons with Mental Illnesses (PMIs), also gained special attention in the mental health initiatives in the early part of this Century. Further, the growing appreciation of the Rights Based Framework received a significant boost with the United Nations Convention for the Rights of Persons with Disability (UNCRPD) of 2006, ratified by the Indian Parliament in 2008. Furthermore, the two major legislative provisions of the very recent past, the Rights of Persons with Disability Act (RPwD) of 2016 and the Mental Healthcare Act (MHA) of 2017, carry provisions which further strengthen the social concern and the scientific evidence for mental health rights in disaster situations.

Right to Access Mental Healthcare, as per MHA, 2017: The single most striking provision in the Mental Healthcare Act (MHA), 2017 in this context is the Right to Access Mental Healthcare under Section 18, which provides that *“Every Person shall have a right to access mental health services run or funded by the appropriate Government”* under Sub Section (1), with many other detailed provisions in 10 other Sub Sections and Clauses therein.

Although the MHA, 2017 does not have any specific sectional provision for Mental Healthcare of psychosocial support in disaster situations, the Right to access mental healthcare enunciated above should continue to operate in these situations.

Right for Mental Healthcare, as part of healthcare and Right to Protection & Safety, as per RPwD 2016: There is a specific overarching provision for the appropriate Government and the local authorities to ensure that persons with disability receive “free healthcare” in the vicinity, under Section 25(1) of the RPwD, 2016. These provisions under Sub Section 25(2) are further relevant, in as much as that Clauses (i) and (j) provide that the persons with disability should receive *“during the time of natural disasters and other situations of risk”* and *“essential medical facilities for life-saving emergency treatment and procedures”*.

The RPwD furthermore provides, under Section 8(1), that *“the persons with disabilities shall have equal protection and safety in situations of risk, armed conflict, humanitarian emergencies and natural disasters”*, with further details of the duties of the NDMA, the SDMAs (State Disaster Management Authority). The DDMAAs (District Disaster Management Authority) are specified in Sub Sections 8(2) and 8(3). The National Guidelines of 2009 for PSSMHS by the NDMA are already available and are being revised.



As such, the provisions of MHA 2017 in general and the RPwD Act of 2016 specifically provide for one identified service need for the continuation and availability of treatment for all persons with disability, including mental illness-related disability, duly certified and registered. The larger issues of different types of mental health service needs and psychosocial support being provided may not be legally mandatory, but carries adequate justification based on our own country's scientific evidence.

Guiding principles from available evidence until the epidemic of 2020

Review articles by Murthy in 2000 and Bada Math et al. in 2015 have summarised this scientific evidence, besides the collective wisdom of all concerned being crystallised in the NDMA Guidelines of 2009. The primary guiding principles are based on all the field experience & the reports available. The evidence generated in the Country until 2020 before the COVID-19 Pandemic hit India can be summarised as below. These are applicable across the Globe, but definitely in India and countries with a similar sociocultural milieu in the Afro-Asian regions.

Normalcy paradigm: The psychological and mental health aspects of disasters must be seen in the normalcy paradigm instead of the disease or pathology paradigm. The twin-track strategy in such situations needs to encourage normal social & psychological coping mechanisms while responding appropriately to those persons and groups in need of professional help.

Universal distress as immediate reaction: Any major disaster or crisis is likely to generate distress and associated symptoms in most affected populations, almost everyone. These are usually self-limiting or ameliorated with minimal support in a large proportion.

A spectrum of mental health consequences: The immediate universal distress or symptoms of anxiety should be seen as a “normal” reaction to an abnormal situation or as part of Acute Stress Disorder. In the medium term, depressive symptoms are moderately common because of the losses suffered, but serious long-term sequelae occur in a small proportion of the affected populations.

Post Traumatic Stress Disorder (PTSD) is less common in India: The misplaced notion that PTSD is a frequent and widely prevalent consequence of disasters is now in serious question, based on evidence. The sociocultural and political-economic determinants of PTSD are well accepted.

Semi-formal and informal coping mechanisms: Alongside strengthening the formal and official response systems for relief and rehabilitation, there should be active efforts to encourage and sustain the informal and semi-formal



sociocultural mechanisms for coping.

Avoid undue labelling and medication: The tendency to label individuals with psychiatric diagnoses and /or to medicate unduly is understandable in all sections of Society but needs to be carefully avoided.

Prompt and effective continuity of treatment services, where required: It is well established that recurrence or relapse of pre-existing psychiatric disorders, especially severe mental disorders like Schizophrenia, Bipolar Disorders and others, is quite common- due to discontinuation of treatment services and/or the trauma is the most significant specific service needs. As such, it must be ensured that the mental health services available at all levels of healthcare delivery systems are maintained and strengthened as and where required.

High-end expertise as technical back up and advisory role: The trend of high-end experts in large teams rushing down to the field must be actively avoided. Such expertise available in National agencies and academic centres ought to be utilised for technical backup and advisory capacity.

Encourage and empower local community resources: The state-supported official programmes for rescue, relief and rehabilitation, as well as the initiatives from the national and international NGOs, would work in collaboration with the local agencies & groups to empower these local resources. Indeed, it would be helpful to elicit the available strengths of the local agencies and synchronise the official activities with them.

Capacity building through training: Alongside the encouragement of locally available semi-formal and informal resources, capacity building of the relief workers, primary healthcare providers and lay volunteer counselors is a necessary strategy.

Recognise and respect innate resilience at different levels: The technical and professional agencies in mental health and social sciences should make sure that the theoretical models or strategies, and methods from the “Western” or the “developed” part of the world, are not followed without the genuine and abiding trust in the inherent resilience of the Individuals, family & neighbourhood support systems and the larger sociocultural mechanisms- including the religious and spiritual practices.

Critical double-edged role of media: Extensive experiential accounts and some research point clearly to the role of the media and how the impact can be double-edged. The responsibility for factual reporting, with appropriate positive stories, without undue sensationalisation of the human suffering or the gaps, goes a long way, especially for the psychological wellbeing and overall mental health of the affected populations.



Integration with administrative and legal systems: This willingness to integrate mental health initiatives with the ongoing activities at different stages in the post-disaster phase, and indeed also for disaster preparedness, is crucial for ensuring a larger reach, avoiding duplication and better acceptance by the population.

Care for the carers: The psychological wellbeing and mental health promotion programmes for all categories of health workers, as well as the rescue and relief workers, often neglected by the concerned personnel and the monitoring systems, need to be addressed appropriately.

The COVID-19 Pandemic and Mental Health Aspects

The Gujarat Earthquake, which became the turning point in the public health strategy of preventing outbreaks of communicable diseases, also applied the public health strategies for the mental health aspects, which got further elaborated in the subsequent disasters in the 21st Century, as described above. At the same time, the mental health aspects of infective epidemics had not received much attention until the COVID-19 pandemic. The HIV-AIDS epidemic has revolutionised the fields of medicine and public health. Still, it was not until much later that the various dimensions of mental health & affected persons or populations received attention. The outbreaks of Coronavirus initially still, the pandemic, for its extensive impact, and the rather obvious psychological, social and mental health dimensions, became the first infective disease outbreak to have been considered a major disaster and so needed effective mental health services.

Contesting viewpoints and evidence will continue to emerge about how effectively India managed the COVID-19 Pandemic from 2020 to 2022. Yet, the bulk of the opinion and the emerging evidence is that all parts of the nation, the governmental agencies, sections of society including the Civil Society, the Legal systems, the media and healthcare professionals, including the mental health systems, rose to the challenge, to emerge with reduced damage and devastation.

The issues of mental health aspects of the recent pandemic are being described elsewhere. Still, it is essential to recognise that while the pandemic required quite a few innovations at all levels for various needs, the above-mentioned Guiding Principles, as crystallised, based on the collective and cumulative learning across the country, in the last few decades, have directly and indirectly contributed immensely to the strategies and programmes for psychosocial and mental health needs. This requires to be recognised more because the pattern of the evolution of the field of disaster mental health, being locally robust for the Country, with all the scientific rigour and the inherent socio-cultural strengths of the society, in the last few decades, continued and gained

even more vigour and confidence during this pandemic.

And yet it deserves to be recognised that various national agencies, most notably the Ministry of Health and Family Welfare and other ministries of the Government of India; professional organisations like the Indian Psychiatric Society; academic institutions like National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, All India Institute of Medical Sciences (AIIMS), Delhi, Institute of Human Behavior and Allied Sciences (IHBAS), Delhi; and the national level statutory bodies like the National Disaster Management Authority (NDMA), the National Commission for Women (NCW), the National Commission for Protection of Child Rights (NCPCR) and of course, the National Human Rights Commission (NHRC) played critical roles and contributed.

NHRC's initiatives for mental health during the pandemic

In addition to the ongoing activities in the field of mental health, especially concerning mental health, the NHRC included the concern for human rights and mental health in its Advisories issued to the State Governments and the Ministries of the Government of India. The NHRC had formed a Committee of Experts in the early phase of the Pandemic, drawing upon the expertise from various disciplines. (The Author was the mental health expert in this broad-based multi-disciplinary committee and played a crucial role in formulating the Advisories for the Ministry of Health & Family Welfare, Government of India and all the States and Union Territories. The first set of Advisories on Mental Health issued by the NHRC on 08.10.2020 identified 12 domains related to mental health with specified sub domains. (*Annexure II*) (NHRC, 2020)

As can be seen, the set of Advisories is comprehensive, covering the concerns for persons with mental illness, the psychological needs of the populations, mental health aspects of COVID-affected persons and their families, as well as the mental health support and help for frontline workers like the health professionals and the Police Personnel.

Advisory 2.0 was issued by the NHRC on 31.05.2021, given the dreadful second wave of the Pandemic, with the clear advice that it be implemented along with the first Advisory issued earlier. Besides elaborating on some of the earlier advisories, this set of Advisory specifically emphasised Access to Vaccination, Suicide Prevention and Media Sensitivity in Reporting. (*Annexure III*) (NHRC, 2021)

Conclusion and future direction

The extensive field experience and the detailed research information



available from the earlier disaster situations in the Country contributed to the effective response of the government agencies, professional groups, and regulatory agencies like the NHRC, the society, and the NGOs during the recent pandemic. This trend of being self-reliant and confident in such difficult situations in the last two years of this pandemic is, besides other essential factors, based on the track record of the mental health agencies and the regulatory agencies, as much as the inherent strengths of individuals, families, communities and the society at large. The leadership position of India is to be further bolstered by this experience and fulfilment of resilience as a mental health and wellbeing dimension.

As in all disaster situations, the gaps and shortfalls must be met through the diligent implementation of the Rights-based framework within the public health approach; while capitalising on the inbuilt strengths of the local communities and the socio-cultural mechanisms. The adage of turning adversities into opportunities, especially for the larger human interest, has been and will need to continue to be adhered to, combining the scientific and the humanitarian perspectives.

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Recent Developments in Mental Healthcare

Introduction

The National Human Rights Commission of India (NHRC) has continuously improved mental healthcare for the last four decades. In this chapter, an attempt is made to summarize the efforts of the NHRC across time and to describe the developments in mental healthcare in the country, with an emphasis on events since 2008, when the second “Mental Healthcare in India” report of the NHRC was released (NHRC 2008). This publication captured the changes in institutional care for persons with mental illnesses since the first report of the NHRC (NHRC 1999). It served as a landmark publication reflecting institutions’ major deficiencies and transgressions of human rights. The NHRC interventions have been described in detail in an earlier chapter. This chapter attempts to provide a narrative review of the country’s recent developments in mental healthcare.

The National Mental Health Programme (NMHP)

Conceived in 1974, the National Mental Health Programme aimed to make care for mental illness available, affordable and accessible, for mental healthcare to be integrated into general healthcare and to promote community-based mental health services. The Bellary Model of district mental healthcare developed and empirically tested by the National Institute of Mental Health and Neuro Sciences (NIMHANS) became the model for the District Mental Health Programme in 1982 (Sinha and Kaur 2011). However, the initial progress in its expansion was slow, and care of persons with mental illnesses, particularly those with severe mental illnesses, occurred mainly in institutional settings, existing primarily in the governmental sector.

Table 1: Summary of major influencing events around mental health and major initiatives by the Hon. Supreme Court and NHRC (Dhanda 1990, Dhanda 2000, NHRC 1999, Channabasavanna and Murthy 2004, NHRC 2008, Sinha and Kaur 2011)

1981	Upendra Baxi vs State of UP and another (status of inmates of protective home in Agra)
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1982	PIL – Veena Sethi vs State of Bihar
1989	Sheela Barse vs Union of India and others
1992	Commission report on mentally ill persons in prisons (Unlocking the padlock)
1998	Quality assurance in mental health NHRC mandated by the Hon'ble Supreme Court to monitor the functioning of hospitals at Agra, Ranchi and Gwalior
2003	Erwadi fire accident and suo moto directives from the Supreme Court of India
2004	NHRC core group on mental health
2005	Focus on under-trial prisoners with mental illness culminating in directives from the Supreme Court of India
2008	Mental healthcare in India report, NHRC review of States and activities
2008-2009	Dialogue with the Medical Council of India to increase Post graduation seats in Psychiatry
2012	NHRC publication on Care and Treatment in Mental Health Institutions
2015	NHRC Technical Report on Mental Health NHRC core group on mental health
2018	NHRC combined core group on health and mental health
2020/ 2022	Human Rights Advisory on the Right to mental healthcare in the context of COVID-19
2022	NHRC review of hospitals at Agra, Ranchi and Gwalior

Table 2: Summary of developments in mental healthcare laws, policies and activities

Time period	Milestones in mental healthcare assessment, policy and programmes
1974	Addis Ababa expert committee meeting on Organisation of mental health services in developing countries
1982	National Mental Health Program (NMHP) and Bellary Mental Health Program

Time period	Milestones in mental healthcare assessment, policy and programmes
1987	Mental Health Act
1995	Persons with Disabilities Act
1996 onward	Currently funded DMHP in 4 districts of the country/ expanded to 27 districts by 2002 (9th Plan), 127 districts by 2007 (10th Plan) and subsequent expansion to almost all districts in the country presently
2010-2011	Revised NMHP guidelines. 11 Centres of Excellence (Scheme A), establishment of 25 COEs and strengthening/ establishment of departments of psychiatry with enhanced human resources
2014	Mental health roadmap
2015	National Mental Health Survey (NMHS)
2016	Rights of Persons with Disabilities Act
2017	Mental Healthcare Act
2018	Digital Academies
2019	National Survey on Substance Use
2020	Mental healthcare resources during COVID-19 and Psychosocial Helplines
2022	Tele Manas

The 1980s - The decade of Public Interest Litigations (PILs)

The languish of prisoners with mental illnesses drew the attention of the Supreme Court of India in the early 1980s, and forthwith action in this regard was directed. There were a series of public interest litigations focusing on the conditions of persons with intellectual disabilities in institutions and prisoners with mental illnesses incarcerated in jails (Dhanda 1990, Dhanda 2000). Such litigations have also been drivers of change for the care of persons in psychiatric institutions. The apex court issued orders from time to time, including orders to monitor such facilities, directions to the NHRC to monitor some of the institutions and a declaration that it was illegal and unconstitutional to keep persons with mental illnesses in jail.

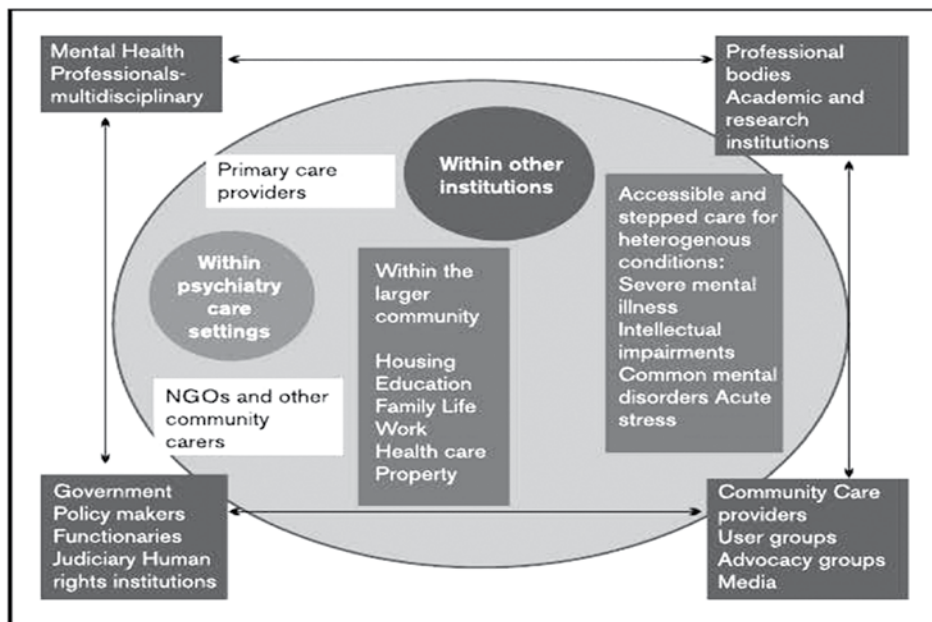
Psychiatric institutions (earlier known as mental asylums or mental hospitals) have been an integral part of the discourse in the area of mental healthcare ever since their inception. They have had their share of disrepute but have also been viewed as an essential part of psychiatric services (Murthy et al. 2016, NHRC 2016). The NHRC Report of 1999 laid bare the deficiencies in public psychiatric institutions and the urgent changes required (NHRC 1999, Channabasavanna and Murthy 2004). However, the report did not lead to any transformation until the

Erwadi fire incident in 2001, where 26 persons with mental illnesses perished in a fire accident. The apex court directed the Government to identify registered and unregistered facilities in the country for mental healthcare and ascertain whether the NHRC recommendations were being followed. The NHRC was directed by the apex court to monitor some of the institutions.

A decade after the initial comprehensive survey of mental hospitals in the 1990s, the subsequent review published in 2008 showed several positive trends, including a reduction in involuntary admissions, improved living conditions and greater monetary allocations. Institutions monitored by the NHRC showed more positive changes in a range of areas, including infrastructure, diet, facilities for occupational therapy and rehabilitation, facilitation of discharge of persons who had recovered, and mental healthcare. However, there were persisting deficiencies in human resource shortage, inadequate psychosocial interventions, ‘closed ward’ operations, unchanged mind sets and delays in training courses for mental healthcare.

In that report, community care was recommended to be expanded, with greater engagement of service users and carers.

Figure 1: Recommendations for the organisation of services for persons with mental illness



(NHRC 2008)

The limited pace of change and the administrative roadblocks led to a petition by the NHRC in 2013 to the Apex Court, seeking its direction to address



and overcome the deficiencies. Health is a state subject also meant that the states needed to play a more proactive role in developing mental healthcare services and look at the larger picture of providing mental healthcare to all.

Mental Health Policy

Released in 2014, the first National Mental Health Policy for India (MOHFW, 2014) mentions the objectives of providing universal access to mental healthcare, providing comprehensive services, increasing access to care for vulnerable groups, reducing risk factors associated with mental health problems, reducing suicide, protecting rights of persons with mental illness, stigma reduction and enhancing human resources for providing equitable mental healthcare.

Better Ground Understanding of the Mental Health Scenario

The first national survey on mental disorders (Gururaj et al. 2016) suggests that one in ten persons suffers from a diagnosable mental health disorder. Three out of four persons with a severe mental disorder experience significant disability in work, social and family life. Mental health systems are unequally distributed, and there is a considerable variation in resource availability across states. The treatment gap varies from 70.4% to 86.3% for mental health and substance use disorders.

Substance Use

Surveys on the patterns of substance use were conducted more recently in 2019 (Ambekar et al. 2019), indicating that 14.6% of the population between 10 and 75 years of age uses alcohol, 2.8% cannabis, and 2.1% opioids. There is a perceptible increase in the misuse of pharmaceutical medications. Inhalants, stimulants and hallucinogens are other drug categories liable to misuse. Adolescent substance use and substance use among women and the elderly are leading to growing concerns. However, there has been no national survey on behavioural addictions.

NHRC Technical Committee Report on Mental Healthcare in the Country

Any comprehensive response to a problem requires a good understanding of the problem, the available resources, the barriers to addressing the problem and solutions to overcoming these barriers.

In 2015, the apex court directed all states to fill up questionnaires regarding the status of mental healthcare in their respective states (based on a set of 4 questionnaires prepared by NIMHANS)- overall state-level questionnaire; details of psychiatric institutions; details of general hospital psychiatric units; details of NGOs involved in mental healthcare; details of the District Mental Health



Programme carried out in each state. Special rapporteurs from the NHRC also visited different states to evaluate first-hand the quality of mental healthcare. Personal visits to psychiatric institutions were carried out by a team comprising the Joint Secretary of Health from the Union Government, the State Health Secretary, a representative of the State Human Rights Commission, the State Mental Health Authority and two eminent psychiatrists. All this information was collated into two major reports of the Technical Committee (TC) on Mental Health (NHRC 2016).

The significant findings of the TC can be summarized as follows:

- a. Incomplete or insufficient information from most states with respect to mental health services in the State.
- b. Inadequate estimation of the mental health needs of the State/UT.
- c. Poor documentation of registration for mental health services and very low numbers of registrations.
- d. Marked variability across states in terms of mental health resources.
- e. Lack of inpatient beds in many places vis-a-vis population needs, no count of beds in the private sector/medical colleges/General Hospitals.
- f. Under-representation of the private sector beds and registrations.
- g. Inadequate documentation of registrations /facilities in the general hospital psychiatry units/medical colleges.
- h. Information regarding the prevalence of suicides and other details in the individual States/UTs is lacking.
- i. Information on homeless persons with mental illness in the different States/UTs and steps to address the same are poorly understood.
- j. Rehabilitation facilities in the country are extremely scarce.
- k. Very few States/UTs had helplines for persons with mental health problems.
- l. Mental health interventions in settings such as correction and remand homes, women's homes, beggars' homes, homes for children, and homes for the elderly through trained professionals are practically non-existent.
- m. Mental health interventions by trained professionals not routinely available in most prisons.
- n. Shortage of psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses across most states. Although post-graduate seats in psychiatry have increased, the total count of psychiatrists (state wise) did not reflect this increase.



- o. Although the undergraduate medical curriculum has prescribed newer recommendations for psychiatric training, these have not been uniformly implemented.
- p. Governance mechanisms to oversee mental health services in many States/UTs are not adequately functional in most states.
- q. No mental health plan or policy in most places. Budgets for mental healthcare not delineated.
- r. Many states did not have State Mental Health Rules (as per Mental Health Act 1987).
- s. Lack of integration of mental healthcare into general healthcare, which was a vision of the National Mental Health Programme in the 1980s.
- t. There were some successful innovations in mental healthcare in Delhi, Karnataka, Gujarat, Kerala and Tamil Nadu, which had the potential for replication in other states.
- u. The Inspection Committee reports on the various psychiatric (mental healthcare) institutions across the country suggest that facilities, in general, have generally improved, barring a few exceptions. However, in a few institutions, older problems still prevailed- overcrowding in a few and poor bed utilization in others, custodial practices, lack of facilities, particularly for special populations, inadequate rehabilitation, and inadequately addressed medical co-morbidity. In most hospitals, admissions are mostly voluntary and the inpatient stay is short, which is very encouraging.
- v. The NGO presence has improved, but this is evident in some of the States/UTs and is very deficient in others.
- w. The details provided by the DMHP are incomplete.

The TC reports emphasized the need for top leadership for mental healthcare service delivery to be established promptly and efficiently. It recommends a National Mental Health Mission with the objective of planning, providing governance, financial support, human resource development, equitable services, strengthening public sector initiatives, developing networks and collaborations, and reconciling services in accordance with provisions in law and evaluation. It also recommends an examination of the possibility of a separate ministerial portfolio for mental health, which has already occurred in some countries, indicating a commitment to improved mental healthcare.

Table 3: Summary of recommendations of the TC (NHRC 2016)

State Government	Central Government	NHRC
<ul style="list-style-type: none"> • State level report • Comprehensive mental healthcare plan • Augmentation of human resources • Training of non-specialists, including community care workers • Engagement with NGOs • Engagement with user-carer groups • Integrate mental health into all health programmes • Training of police and judiciary • Address mental healthcare needs of children, elderly, women, persons with addiction, homeless • Develop forensic services, legal aid services, rehabilitation • Intersectoral engagement (social welfare, labour, education, law) • Periodic mental health service audit 	<ul style="list-style-type: none"> • Realization of objectives set out in National Mental Health Policy 2014 • Active engagement along with the Health Ministry, the Ministry of Social Justice and Empowerment, Women and Child Welfare, Information, Education, Labour, Panchayat Raj, Youth, Rural Affairs • Active engagement of professional bodies to develop guidelines for mental healthcare and roles and responsibilities • Identification of a cross-cutting mechanism to develop a plan of action to guide the states (benefits for persons with mental illness, long-term rehabilitation, crisis shelters, treatment, education and job opportunities, grievance redressal, basic citizenship rights; commitment of resources to support the programmes; special focus on human resource development; commitment to universal healthcare in general and universal mental healthcare national repository of resources for mental healthcare and country-level information systems) 	<ul style="list-style-type: none"> • The mandate needs to be expanded to other facets of mental healthcare – at the community level; medical colleges and district level; government and private sector. • An effective mechanism to monitor the State Mental Health Plans and Central support is crucial. The NHRC could bring together agencies involved with mental healthcare (beyond the health sector to the welfare, rehabilitation, legal and other sectors) for coordinated services for persons with mental healthcare issues. • The NHRC can also play a key role in law review and reform • Bringing the key players together is a critical and necessary step to ensure collaborative and coordinated action.



Mental Health Road Map

Based on the Technical Committee report and the Apex court directive, the (Directorate General of Health Services (DGHS), Govt. of India, constituted a committee in 2016 to develop a mental health roadmap. The recommendations of this committee include ensuring that all government and private medical colleges in the country should have a department of psychiatry, a compulsory module of psychiatry in the undergraduate medical examination, compulsory rotation posting of medicine and pediatric postgraduates in psychiatry, visits to old age homes/rehabilitation centres and shelter homes by mental healthcare professionals, advisors in state governments to develop mental health services, mental healthcare in prisons, attention to gender, adoption of one district by each mental health institution or medical college to provide mental healthcare, the constitution of State Mental Health Authority, inpatient facilities at the district level, development of guidelines for rehabilitation, courses for undergraduates, sensitization of police and the judiciary on mental health and development of an inter-departmental/ ministerial coordination committee by the Ministry of Health.

Mental Healthcare Act, 2017

The Mental Healthcare Act, (Govt. of India 2017), which replaced the Mental Health Act of 1987, is based on a rights-based framework requirement of the United Nations Convention on Persons with Disabilities. The Act focuses on providing access to treatment services as a right, protecting persons with mental illness against any form of abuse, creating a provision of advance directives, and suggesting where a person with mental illness can indicate the care to be provided during an episode of illness, having a nominated representative, setting up of mental health establishments in each state including a state mental health authority and review boards, a central mental health authority, procedures of admission, treatment and discharge of persons with mental illness, decriminalization of suicide, prohibition of direct electroconvulsive therapy, providing penalties for violation of the Act. The Act also outlines the responsibilities of the law enforcement agencies. Presently, the Central Mental Health Authority has been constituted. Many states have formed the State Mental Health Authorities and are at various stages of formation of the Mental Health Rules and the Mental Health Review Boards. The Mental Healthcare Act of India on paper ticks most boxes as an ideal legal framework for mental healthcare (Duffy et al 2020) but the challenge lies in its operationalization.

Minimizing Coercion in Mental Healthcare

Coercion represents a very complex situation, particularly in the care of persons with severe mental illness. From a human rights perspective, it is an



ethical, clinical and legal obligation to address the issue of coercion and to make mental healthcare as voluntary and consensual as possible. Avoiding force to the extent possible, better crisis management plans, family-based interventions, more open-door admission policies, and shorter admissions for acute care and community care are some possible approaches to address this problem.

Other Legal Provisions

The Rights of Persons with Disability Act 2016 (Govt. of India 2016) replaced the earlier Act of 1995. It states that “the appropriate Government shall ensure that the Persons with Disability (PWD) enjoy the right to equality, life with dignity, and respect for his or her integrity equally with others.” Including mental illness and intellectual disability, it now encompasses 21 conditions, including cerebral palsy, dwarfism, muscular dystrophy, victims of acid attack, persons hard of hearing, speech and language disabilities, specific learning disabilities, autism spectrum disorders, chronic neurological disorders such as multiple sclerosis and Parkinson’s disease, some blood disorders and multiple disabilities.

Other Acts that are concerned with mental illness include The Protection of Human Rights Act, 1993; The National Trust Act, 1999; Protection of Women from Domestic Violence Act, 2005; Protection of Children from Sexual Offences Act, 2012, and related legislations. Prominent statutory legislation regulating narcotics is the Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985 (Murthy et al. 2016).

Expansion of the District Mental Health Programme (DMHP)

There has been a gradual expansion of the District Mental Health Programme, which was initiated in four districts in 1996, extended to 27 districts across 22 states in the 9th 5- year plan, re-strategised during the 10th five-year plan and expanded to 100 districts. It has now been initiated in more than 700 districts in the country. Concerns for programme implementation have included inadequate professionals in many states, lack of medication, need to focus on a broader range of mental health concerns, low level of community participation, lack of a monitoring mechanism, lack of detailed operational guidelines for implementation of schemes, poor coordination between the medical education and health departments in the states and inadequate utilization of DMHP funds. However, in the last decade, there has been a visible improvement in some of the States with respect to service provision and training of human resources in some of the states. Many states have introduced innovations. Notable examples can be seen in Karnataka. In the Manochaitanya or Super Tuesday programme in Karnataka, a consultant psychiatrist provides outpatient care twice a month. This has gradually been expanding to a pilot taluk-level mental health service.



Other initiatives in the state include day-care rehabilitation for persons with severe mental illness (Maanasadhara), halfway homes and assisted home care initiatives. Bihar, Chattisgarh, Uttarakhand and Odisha have taken the initiative of increasing trained human resources through online training from NIMHANS and many other states are also looking to enhance trained human resources to provide mental healthcare.

It is often discussed that mental illness treatment must consider the local cultural context. The Government of Gujarat is implementing the Dava-Dua intervention, a combination of psychiatric medicine and faith healing at Mira Data Dargah in Mehsana District (Saha et al., 2021). In 2014, the DMHP in Tamil Nadu initiated a clinic in Erwadi Dargah and started offering its visitors access to professional psychiatric care, diagnosis, treatment, and medication. A community rehabilitation centre and a hospital are located on the territory of the holy site. This novel intervention has invited several other religious communities to request such integration. Some of the other states are also exploring such innovations.

Human Resources for Mental Healthcare

Two decades ago, it was estimated that the country had about 3000 psychiatrists, 500 clinical psychologists, 400 psychiatric social workers and 900 psychiatric nurses. With an impetus in training and relaxation of guidelines of the National Medical Council (earlier Medical Council of India), the number of post-graduate seats in psychiatry was 45 MD/21 Diploma seats in 2002. In 2015, there were 576 annual PG seats in psychiatry (Murthy et al. 2017). The government's initiative to formulate 'manpower' development schemes, which included 25 centres of excellence in mental health and strengthening of 120 departments, has contributed to the enhancement of human resources in psychiatry. Thus, there are presently nearly 1000 post-graduate seats in psychiatry annually. This would mean that there are approximately 10,000-12000 psychiatrists in the country. Still, the growing population, inequitably in the distribution of psychiatrists, limited jobs and better opportunities abroad continue to make this an inadequate workforce in the country. There are estimated to be about 3000 clinical psychologists, 2000 psychiatric social workers and approximately 2500 psychiatric nurses. To improve services, proper mapping of the mental health resources in each state and UT is necessary, as was pointed out in the NHRC Technical report of 2015 (Murthy et al. 2017).

Virtual Knowledge Networks

A huge treatment gap and lack of human resources were the primary drivers for the National Institute of Mental Health and Neuro Sciences (NIMHANS), an Institute of National Importance by an Act of Parliament to adopt digital



modes of training and service delivery. Engagement with the ECHO (Extension of Community Healthcare Outcome) since 2014 and the advent of 4G were enablers for NIMHANS to expand training of human resources for mental healthcare and reach best practices of care to thousands of health professionals throughout the country. These professionals, in turn, have been equipped with the appropriate knowledge and skills to identify mental disorders, offer appropriate care and support and refer those requiring specialized treatment to appropriate services.

Since 2014, NIMHANS has piloted creating a “Knowledge Network” with the mission of capacity building for healthcare providers who can work like local experts in their Community (Mehrotra et al. 2018, Sheth et al. 2021). This operated as a hub and spoke model. The spokes are health providers from various parts of the country who access the training on computers, laptops or smartphones. The training is both live (synchronous) and self-paced e-learning that is non-synchronous. In addition to substance use disorders and addiction, the ECHO training modules have been extended to other areas such as old age psychiatry, rehabilitation, peri-natal psychiatry and cognitive behaviour therapy. The same platform has also been used to train healthcare providers in tobacco cessation and hepatologists in alcohol use disorder management.

Digital Academies

In order to enhance the training of non-specialist healthcare providers and in keeping with the vision of Digital India, the Government of India initiated digital academies in 2018 at NIMHANS in Bengaluru, Central Institute of Psychiatry in Ranchi and the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH) in Tezpur. The Academy focuses on digital training, mentoring and accreditation, and telemedicine.

NIMHANS NDA

At the NIMHANS Digital Academy (NDA), certificate and accredited diploma programmes (approved by the NDA Board of Studies) have been conducted for doctors, psychologists, social workers and nurses. Since its inception in 2018 until mid - 2022, about 10,190 healthcare providers have received accreditation. In addition, the States of Gujarat and Odisha have initiated their state digital academies.

The telemedicine facility has been providing certificate courses and Diploma in primary care psychiatry to doctors nominated from the state governments of Karnataka, Bihar, Uttarakhand and Chattisgarh. More states have expressed their interest in training healthcare providers. The facility offers telementoring, tele-aftercare, as well as video consultations. Collaborative teleconsultations have

been very useful in providing collaborative patient care through doctors working in district hospitals (Guru et al. 2018, Malatesh et al. 2020, Pahuja et al. 2020, Gajera et al., 2021).

Counseling during COVID-19

There were enormous challenges to accessing mental healthcare during COVID-19, stretching the wide treatment gap further. The Ministry of Health and Family Welfare supported a psychosocial helpline, run primarily by volunteer mental healthcare specialists. NIMHANS was the first institute in India to start a helpline for Psychosocial support and mental health services during disasters. The helpline addresses the psychosocial issues of disaster survivors and creates a tertiary-level support system for them during emergencies caused by disasters. It is a 24 x 7 toll-free helpline. Started in March 2020, it is presently run by the Department of Psychosocial Support in Disaster Management (PSSDM) and has catered to 615395 callers until August 2022 and provided interventions to 101268 callers.

NIMHANS developed various manuals to provide intervention for persons with mental illness infected with COVID-19, psychosocial care for children during the pandemic (in collaboration with UNICEF), and care in prison and other settings. The Ministry of Health and Family Welfare (MOHFW) also developed messaging on caring for one's mental health and coping with stress in collaboration with NIMHANS and other institutions. The Indian Council for Medical Research developed a manual for healthcare providers. Various tele-practice guidelines were developed during the pandemic for various mental health disciplines.

The Telemedicine Guidelines (2020) brought out during COVID-19 have provisions for various teleconsultation services and provide norms and standards for RMPs registered under the Indian Medical Council Act, 1956 (Guru et al. 2018). Medicines that can be prescribed are categorized for the specific type of consultation: List O, List A, List B, and prohibited (Dinakaran et al. 2021). The advantages of telemedicine include more accessible access to consultation for people living in remote areas, avoiding expenditure related to travelling long distances for consultation, and reducing hospital congestion for routine follow-up. Limitations include poor network connectivity, limited access to smartphones for video consultations, the healthcare providers' discomfort with the use of technology and the restrictions on what can be done via telemedicine.

The e-Sanjeevani programme of the government enables video doctor-patient consultations and e-prescriptions.

Helplines

Basic mental health counseling is provided by the general health helplines



in a few states. Suicide helplines offered by NGOs include those run by Roshni, Sneha, Snehi, Aasra, Arpita foundation, Sanjivini Foundation, Medicopastoral Association and Samaritans. The Tata Institute of Social Sciences (TISS) runs I-call. National Quitlines are also available for tobacco cessation (1800112356), and substance use (1800-11-0031, run by the Ministry of Social Justice and Empowerment (MSJE)).

Mental Health NGOs

The last decade has witnessed the emergence of more NGOs working in the mental healthcare sector (Thara and Patel 2010). However, there are far fewer mental health NGOs (MHNGOs) than those in developed countries. Still, they work in various areas, from intellectual disability to the elderly, from child mental health to rehabilitation of the severely mentally ill. Some illustrative examples include the Richmond Fellowship Society, the Medico-pastoral Association, Schizophrenia Research Foundation (SCARF), SAA, SEVAC, Sangath, Ashadeep, Ashagram, Manas, Shristi, Live, Love Laugh Foundation, Minds Foundation, JVF Foundation, MPOWER Minds (Mental Health), women's mental health (Banyan, Bapu Trust), Alzheimer's and Related Disorders Society of India (ARDSI), suicide prevention (Sneha, Saarthak), addressing mental health issues in general healthcare (Basic Needs, Voluntary Health Society of India, Neptune Foundation), substance abuse prevention and treatment (TTK, TRADA, Kripa Foundation, Samaritans, Alcoholics Anonymous). Action for Mental Illness (ACMI) India is an advocacy initiative working for the rights and needs of persons with mental illness.

Rehabilitation Schemes and programmes

The Ayushman Bharat schemes have been mentioned earlier.

In addition, the Government offers financial support for subsistence, travel, education, employment, housing, loans, pensions and other allowances. The Deendayal Scheme covers a range of disabilities, including mental illness and makes provisions for halfway homes for psychosocial rehabilitation for 'treated and controlled people with mental illnesses'. It supports costs for infrastructure, medication and other facilities. It also has provisions for home-based rehabilitation and management. The MSJE, under a separate Department of Empowerment of Persons with Disabilities (Divyangjan), also offers an umbrella scheme for persons with disabilities, including children with cerebral palsy and intellectual disabilities. The Scheme for Implementation of the Rights of Persons with Disabilities Act, 2016 (SIPDA) seeks to provide barrier-free access for persons with disabilities (PwD), skill development programmes, composite rehabilitation centres, camps, training opportunities for children with disability, infrastructure and opportunities for sports and recreation.

Table 4. Disability schemes.

Sr. No.	Benefits	Schemes	Beneficiary
1.	Disability pension	40% to 75% disability Rs. 500/ month" ≥75% disability Rs. 1200/ month*	PwD
2.	Travel benefits	Bus pass* (Rs. 660 per year for KSRTC/BMTC) Rail concessions	PwD PwD (MR) & caregiver
3.	Insurance schemes	Swavlamban (Rs. 2 lakh family floater policy per annum) for PwD (except multiple disabilities, autism and cerebral palsy) Niramaya (Rs. 1 lakh per annum) PwD covered in National Trust Act 1999 alon	If PwD < 18 year: PwD and parents/ legal guardian, if PwD 18-65 years: PwD spouse and upto 2 children PwD
4.	Employment	3-5% in government jobs	PwD
5.	Education	Reservation: 3% in government aided institutions Scholarships for PwD who are below poverty line	PwD
6.	IT exemption	Under section 80U: Rs. 75,000/- for ≥ 40% disability Rs. 1,25,000/- for ≥ 80% disability Under section 80DD: Rs. 75,000/- for ≥ 40% disability in dependent PwD Rs. 1,25,000/- for ≥ 80% disability in dependent PwD	PwD Caregiver of dependent PwD
7.	Loans	NHFDC & ADHARA	PwD
8.	Skills training/job placement	Skills training/Employment Exchange Vocational Rehabilitation Centres for handicapped	PwD PwD (MR)
9.	Housing scheme	Financial assistance for Housing preferential site allotment (5% reservation)	PwD (except MR and multiple disabilities)
10.	Marrige allowance	Rs. 50000	PwD
11.	Pension transfer to PwD	Central Pension Accounting Office Ref. No. 1/27/2011-P&PW(E)	PwD
12.	Exemption from routine transfers	No. 42011/3/2014-Estt. (Res.) dated 6 th June 2014.	Caregivers of PwD
13.	National Trust Act Schemes	Disha, Vikas, Samarath, Gharaunda, Niramaya, Shayogi, Gyan Prabha, Prerna, Sambhav, Badhte Kadam	PwD (MR)
14.	Free legal aid services	All district courts, NIMHANS legal aid clinic	PwD
<p><i>*Benefits provided in the state of Karnataka. Kindly verify from the state you reside in. Consult your doctor to know if referral to psychiatric rehabilitation is suitable for you.</i> For details, contact Psychiatric Rehabilitation Services, DPNR Building, (Opposite State bank of Mysore), NIMHANS E-mail : nimhansrehab@gmail.com</p>			

Note: Some of the above schemes have been updated as per the RPWD Act



Rehabilitation constitutes an essential part of recovery and reintegration into mental illness. There have been directives from the Supreme Court in the case of *Gaurav Kumar Bansal vs State of UP and others* (2018) (Indian Kanoon 2016) regarding the setting up rehabilitation facilities. Accordingly, guidelines for discharging recovered patients and setting up rehabilitation facilities in the states have been formulated.

Presently, under the NMHP, there are schemes for financial support for daycare centres (to provide rehabilitation and recovery services to persons with mental illness along with drugs and psychotherapy, to enhance skills of family/caregivers for better support, provide opportunities for those recovering from mental illness for successful community living) and residential/long term continuing care centres (for persons with chronic mental illness unable to return to families, for the provision of a structured programme by a multidisciplinary team). However, the uptake of these schemes is not evident.

As evident from the Technical Report of the NHRC (NHRC 2016), only a few States have good rehabilitation programmes. Apart from the institution-based facilities at NIMHANS, Kerala has established Asha Bhavans, and Karnataka is implementing the Asha Kirana scheme. Project Udaan by the Tata Trust focuses on rehabilitation at the Regional Mental Hospital in Nagpur. In Gujarat, the Quality Rights Project collaboration between the Indian Law Society, Pune and the Hospital for Mental Health (HMH) Ahmedabad is working with six hospitals in the state. In addition, a National Institute of Mental Health Rehabilitation has been set up at Sehore in Madhya Pradesh under the MSJE.

The Hans Foundation report focuses on a national strategy for community-based living for persons with mental health issues based on disability, clinical state, personal preferences and support needs. It suggests family placement, scatter-site housing, congregated housing options, and supportive services (Narasimhan et al., 2019).

Gender-Sensitive, Contextualized Mental Healthcare along a Developmental Continuum

There have been separate chapters focusing on mental health issues among children and youth, the elderly, women, minority populations, elderly, and in contexts such as prisons, correctional centres, and workplaces. This section summarises a few of the developments regarding children and women.

Programmes for children and youth

Under the Rashtriya Kishore Swasthya Karyakram (RBSK), the Ministry of Health, Govt of India has launched the training of Adolescent Health Counsellors on adolescents' emotional wellbeing and mental health. Furthermore, the

Department of Epidemiology at NIMHANS, along with the Government of Karnataka, is implementing a programme for mental health promotion among the youth, Yuva Spandana (Banandur et al. 2021). In addition, NIMHANS, in partnership with the Ministry of Women and Child Development, has initiated the SAMVAD programme, which focuses on developing a model for convergence and transdisciplinary engagement of service providers, stakeholders, duty bearers and citizens to address the mental health and psychosocial needs of vulnerable children (Ramaswamy et al. 2022).

Women's mental health

A report by the National Commission for Women (NCW 2016) raises concerns about the care and aftercare of women in psychiatric institutions. Stigma, the helplessness of families, and the lack of support for community living are important practical issues. Homelessness, particularly for women with mental health problems, poses special challenges. Concerted efforts are required at the social, political, legal and economic levels to improve women's mental health (NCW 2019). The issues related to women's mental health have been discussed in an earlier chapter.

Forensic services

The need for prison mental health services was highlighted in an earlier chapter. A recent report on death row prisoners highlights the need to identify and address mental health issues among them (NLU 2021) and other vulnerable populations. Centres for studies in human rights, ethics and legal issues in mental illness. Institutions like NIMHANS are well poised to lead the development of such centres.

Mental health insurance

Much of the country's health expenditure is out-of-pocket, which is also true of mental illness. Traditionally, mental illnesses have been left out of insurance schemes. In 2018, the Insurance Regulatory and Development Authority of India (IRDAI) directed Indian insurance companies to cover mental disorders as per the Mental Healthcare Act, 2017. However, compliance to this is in question (Ghosh 2021).

During COVID-19, private insurance companies such as National Insurance Company Limited and Oriental Insurance Company Limited have included mental illness in their policy, which will indemnify the hospital or the insurer only in case of hospitalization. More recently, insurance plans for mental health treatment are being provided by HDFC ERGO, Aditya Birla Health Insurance (counseling and consultation cost apart from hospital expenses), Manipal Cigna Health Insurance



(comprehensive indemnity plan only in case of hospitalization) and Max Bupa (coverage for mental disorder under the health recharge insurance plan). However, despite these recent developments, there are significant limitations in health insurance in India compared to the USA and UK (Ghosh 2021).

Tele MANAS

The Government of India announced the National Tele Mental Assistance and Networking Across States (Tele MANAS) in February 2022. It seeks to reduce the wide treatment gap for persons with mental illness by providing 24 X 7 tele-mental health counseling facilities in all states and union territories. Trained counsellors will provide basic telephonic counseling, identify persons in need of acute care and promptly refer them to video consultation or in-person services as required. This offers an opportunity to create a network of services for mental healthcare. It is also proposed to promote mental healthcare by linkages to the Ayushman Bharat Health and Wellness Centres, integrating traditional systems like yoga and ayurveda, and extending services to vulnerable and difficult-to-reach populations. The Tele MANAS will be the digital arm of the DMHP.

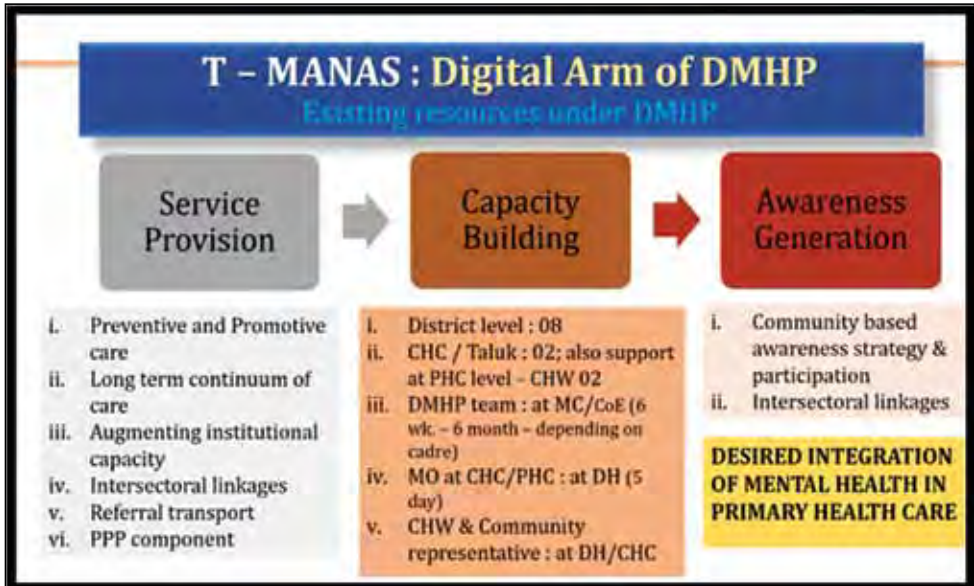
User and Carer Groups

In many high-income countries, user and carer groups are critical to mental healthcare, considering vital user perspectives to improve mental healthcare. Carers also experience significant psychological distress, stigma, and economic hardships, especially in low-income countries, where families continue to be the primary source of support (Chadda 2014, Murthy 2016, Samudre et al., 2016, WHO 2022).

Integrating mental healthcare into general care

At the time of the inception of the National Mental Health Programme, one of the primary objectives was to integrate mental healthcare into general healthcare. The COVID-19 pandemic has highlighted the importance of this approach and focus on mental health in all programmes of health and wellbeing, as well as programmes addressing communicable (e.g. Tuberculosis, HIV) and non-communicable disorders (Cancer, Diabetes, Cardiovascular diseases, Chronic Respiratory and other disorders). Mental illness itself is also construed as a non-communicable disorder itself. Psychological distress and mental illness worsen the course, and the outcome of physical diseases and physical disorders can lead to psychological distress and mental disorders. Thus, there is a case for looking at both conditions in an integrated manner and shifting the focus to public mental health.

Figure 2: The National Tele- MANAS programme



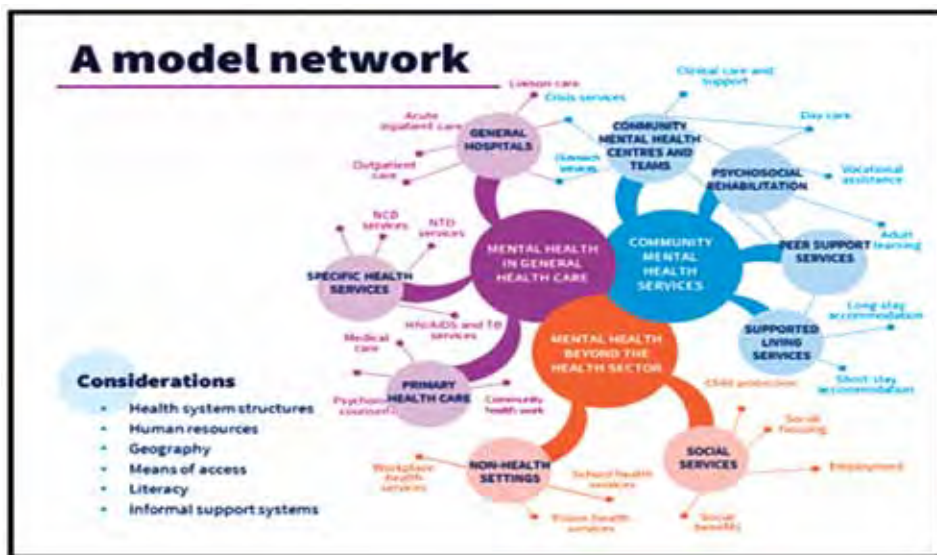
(Ministry of Health and Family Welfare, Govt. of India)

Figure 3: Moving towards public mental health



The recent report brought out by the World Health Organization focuses on developing community-level services and integrating all these services for better care.

Figure 4: Model network of mental healthcare (WHO)



World Health Organization. Mental Health Report 2022

A transformational role for the NHRC

In the last three to four decades, the NHRC has been playing a critical role in improving standards of mental healthcare in both institutional and community settings but focused more on the former. It is now necessary to shift the gaze towards improving mental health literacy among the judiciary, review archaic laws and facilitate inclusive provisions and laws, advocate for better mental health literacy, ensure greater responsiveness of states and centres and function as human rights advocates to take mental healthcare to all citizens, particularly the less-empowered, more vulnerable and those in underserved communities.

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List of Abbreviations

AA	Alcohol Anonymous
ACMI	Action for Mental Issues
AD	Advanced Directive
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immunodeficiency Syndrome
AIIMS	All India Institute of Medical Sciences
APA	American Psychiatric Association
AUD	Alcohol Use Disorder
BPL	Below Poverty Line
CAP	Children and Adolescents Population
CCI	Child Care Institution
CDC	Centers for Disease Control and Prevention
CGH	Clustered Group Homes
CHRI	Commonwealth Human Rights Initiative
CIP	Central Institute of Psychiatry
CLWs	Community Level Workers
CME	Continuing Medical Education
COVID-19	Novel - SARS-Corona Virus-2
CrPC	Code of Criminal Procedure
CRPD	Convention of Rights of Persons with Disabilities
CSOs	Civil Society Organizations
CUD	Cannabis Use Disorder
CVC	Central Vigilance Commission
DAC	De-Addiction Centres
DALYs	Disabled Adjusted Life-years
DC Act	Drugs and Cosmetics Act, 1940
DCPU	District Child Protection Unit
DDAP	Drug De-Addiction Programme
DDMA	District Disaster Management
DGHS	Directorate General of Health Services
DMHP	District Mental Health Programme

DSLISA	Delhi State Legal Services Authority
ECT	Electro-Convulsive Therapy
ENDs	Essential Narcotic Drugs
FIR	First Information Report
GHDx	Global Health Data Exchange
GHPUs	General Hospital Psychiatry Units
GHQ	General Health Questionnaire
GMA	Gwalior Mansik Arogyashala
GPs	General Practitioners
HCWs	Health Care Workers
HIV	Human Immunodeficiency Virus
HMH	Hospital for Mental Health, Ahmedabad
HR	Human Resources
ICMR	Indian Council of Medical Research
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Comment on Economic, Social and Cultural Rights
IEC	Information, Education and Communication
IHBAS	Institute of Human Behaviour and Allied Sciences
ILO	International Labour Organisation
IMH	Institute of Mental health, Chennai
IMHH	Institute of Mental Health & Hospital, Agra
IPC	Indian Penal Code
IPOP	Integrated Program for the Older Persons
IPS	Individual Placement & Support
IPV	Intimate Partner Violence
IRCA	Integrated Rehabilitation Centres For Addicts
IRDAI	Insurance Regulatory and Development Authority of India
JJ	Juvenile Justice
JJB	Juvenile Justice Boards
LASI	Longitudinal Aging Study in India
LGBRIMH	Lokopriya Gopinath Bordoloi Regional Institute of Mental Health
LGBT	Lesbian, Gay, Bisexual, Transgender
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual plus



LMICs	Low and Middle Income Countries
MBU	Mother and Baby Unit
MHA	Mental Healthcare Act
MHEs	Mental Health Establishments
MHNGOs	Mental Health NGOs
MHPs	Mental Health Practitioners
MHRB	Mental Health Review Board
MIMH	Maharashtra Institute of Mental Health, Pune
MOHFW	Ministry of Health and Family Welfare
MSJE/ MOSJE	Ministry of Social Justice and Empowerment
MWPSC	Maintenance & Welfare of Parents & Senior Citizens Act
NACO	National AIDS Control Organization
NCDs	Non-Communicable Diseases
NCDRC	National Consumer Disputes Redressal Commission
NCPCR	National Commission for Protection of Child Rights
NCR	National Capital Region
NCRB	National Crime Record Bureau
NCT	National Capital Territory
NCW	National Commission for Women
NDA	NIMHANS Digital Academy
NDMA	National Disaster Management Authority
NDPS Act	Narcotic Drugs and Psychotropic Substances Act, 1985
NDRF	National Disaster Response Force
NHFS	National Health & Family Survey
NGO	Non-Governmental Organisation
NMHP	National Mental Health Program
NMHS	National Mental Health Survey
NHRC	National Human Rights Commission
NIMHANS	National Institute of Mental Health & Neuro Sciences
NLU	National Law University
NPHCE	National Program for the Healthcare of the Elderly
NPOP	National Policy on Older Persons

NR	Nominated Representative
NSEP	Needle Syringe Exchange Programme
NVLM	National Urban Livelihoods Mission
OAT	Opioid Against Treatment
OHCHR	Office of the United Nations High Commissioner for Human Rights
OST	Opioid Substitution Therapy
ODU	Opioid Use Disorder
PCOS	Polycystic Ovary Syndrome
PHCs	Primary Health Centres
PILs	Public Interest Litigations
PMI	Persons with Mental illness
POCSO	Protection of Children Against Sexual Offences
PPE	Personal Protective Equipment
PSI	Prison Statistics of India
PSSMHS	Psychosocial Support and Mental Health Services
PTSD	Post-Traumatic Stress Disorder
PwDs/PWDs	Persons with Disabilities
PWID	Persons Who Inject Drugs
QACP	Queen Affirmative Counseling Practice
GRM	Qualitative Research Methods
RBSK	Rashtriya Kishore Swasthaya Karyakram
RINPAS	Ranchi Institute of Neuro-Psychiatry & Allied Sciences
RPwD	Rights of Persons with Disability Act, 2016
RTE	Right to Education
RTI	Right to Information
SCARF	Schizophrenia Research Foundation
SCAN	Schedule for Clinical Assessment in Neuropsychiatry
SCPCR	State Commission for Protection of Child Rights
SDGs	Sustainable Development Goals
SDMA	State Disaster Management Authority
SHR	State Human Rights Commission
SJPU	Special Juvenile Police Unit



SMHA	State Mental Health Authority
SMI	Severe Mental Illnesses
SUD	Substance Use Disorders
Tele MANAS	Tele Mental Assistance and Networking Across States
TGNC	Transgender & Gender Non-Conforming Children
TISS	Tata Institute of Social Sciences
UDHR	Universal Declaration of Human Rights
ULS	Unique Life Stressors
UN	United Nations
UNCRC	United Nations Convention of the Rights of Children
UNCRC	United Nations Convention on the Rights of the Child
UNCROP	United Nations Convention on the Rights of Older Persons
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNODC	United Nations Office on Drugs & Crime
UNICEF	United Nations International Children's Emergency Fund
UNPOP	United Nations Principles for Older Persons
VOs	Voluntary Organization
VWDC	Vulnerable Witness Deposition Centre
WFMH	World Federation for Mental Health
WHO	World Health Organisation
WHO TRS	World Health Organization Technical Report Series
WP	Writ Petition

ANNEXURE I**List of Government Mental Health Establishments in India**

S.No	Mental Health Establishments	State/ Union Territory
1.	Government Hospital for Mental Care, Vishakhapatnam, Andhra Pradesh	Andhra Pradesh
2.	Regional Mental Hospital, Papumpare, Arunachal Pradesh	Arunachal Pradesh
3.	Lokopriya Gopinath Bordoloi Institute of Mental Health, Tezpur, Assam	Assam
4.	Bihar Institute of Mental Health and Allied Sciences, Koilwar, Bhojpur, Bihar	Bihar
5.	State Mental Health Hospital, Bilaspur, Chhattisgarh	Chhattisgarh
6.	Institute of Human Behavior & Allied Sciences, Delhi	Delhi
7.	Institute of Psychiatry & Human Behavior, Panaji, Goa	Goa
8.	Hospital for Mental Health, Bhuj, Gujarat	Gujarat
9.	Hospital for Mental Health, Jamnagar, Gujarat	
10.	Hospital for Mental Health, Ahmedabad, Gujarat	
11.	Hospital for Mental Health, Vadodara, Gujarat	
12.	Himachal Hospital of Mental Health & Rehabilitation, Shimla, Himachal Pradesh	Himachal Pradesh
13.	Government Hospital for Psychiatric Diseases, Srinagar, Jammu and Kashmir	Jammu and Kashmir
14.	Psychiatric Diseases Hospital, General Medical College, Jammu, Jammu and Kashmir	
15.	Central Institute of Psychiatry, Kanke, Ranchi, Jharkhand	Jharkhand
16.	Ranchi Institute of Neuro Psychiatry and Allied Science, Kanke, Ranchi, Jharkhand	
17.	Dharwad Institute of Mental Health and Neuro Sciences, Dharwad, Karnataka	Karnataka
18.	National Institute of Mental Health and Neuro Sciences, Bengaluru, Karnataka	



S.No	Mental Health Establishments	State/ Union Territory
19.	Mental Health Centre, Oolampara, Thiruvananthapuram, Kerala	Kerala
20.	Government Mental Health Centre, Kozhikode, Kerala	
21.	Government Mental Health Centre, Poothole, Trissur, Kerala	
22.	Gwalior Manasik Arogyasala, Gwalior, Madhya Pradesh	Madhya Pradesh
23.	Mental Hospital, Indore, Madhya Pradesh	
24.	Regional Mental Hospital, Nagpur, Maharashtra	Maharashtra
25.	Regional Mental Hospital, Yeravda, Pune, Maharashtra	
26.	Regional Mental Hospital, Thane (W), Maharashtra	
27.	Regional Mental Hospital, Ratnagiri, Maharashtra	
28.	Meghalaya Institute of Mental Health & Neuro Sciences, Shillong, Meghalaya	Meghalaya
29.	State Mental Health Institute, Kohima, Nagaland	Nagaland
30.	Mental Health Institute, S.C.B. Medical College, Cuttack, Orissa	Orissa
31.	Dr. Vidyasagar Punjab Mental Hospital, Amritsar, Punjab	Punjab
32.	Mental Hospital (Psychiatric Centre), Jaipur, Rajasthan	Rajasthan
33.	Mental Hospital, (Psychiatric Center), Jodhpur, Rajasthan	
34.	Institute of Mental Health, Kilpauk, Chennai, Tamil Nadu	Tamil Nadu
35.	Institute of Mental Health, Erragadda, Hyderabad, Telangana	Telangana
36.	Modern Psychiatric Hospital, Agartala, Tripura	Tripura
37.	Department of Psychiatry, Tripura Medical College & Dr B.R. Ambedkar Teaching Hospital, Haspania, Tripura	
38.	Department of Psychiatry, Agartala Medical College & GB Pant Hospital, Agartala, Tripura	
39.	State Mental Health Institute, Selaqui, Dehradun, Uttarakhand	Uttarakhand



S.No	Mental Health Establishments	State/ Union Territory
40.	Institute of Mental Health & Hospital, Agra, Uttar Pradesh	Uttar Pradesh
41.	Mental Hospital, Bareilly, Uttar Pradesh	
42.	Mental Hospital, Varanasi, Uttar Pradesh	
43.	Lumbini Park Mental Hospital, Kolkata, West Bengal	West Bengal
44.	Institute for Mental Care, Purulia, West Bengal	
45.	Berhampore Mental Hospital, Murshidabad, West Bengal	
46.	Institute of Psychiatry, Kolkata, West Bengal	
47.	Calcutta Pavlov Hospital, Kolkata, West Bengal	

ANNEXURE II

Human Rights Advisory on Right to Mental Health in context of COVID-19



राष्ट्रीय मानव अधिकार आयोग
NATIONAL HUMAN RIGHTS COMMISSION

मानव अधिकार भवन, सी-ब्लॉक, बीपीओ कॉम्प्लेक्स, आईएनए, नई दिल्ली-110 023
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File No. R-17/8/2020-PRP&P –Part (I)

8th October, 2020

Subject: Human Rights Advisory on Right to Mental Health in context of Covid-19 pandemic


National Human Rights Commission (NHRC) is mandated by the Protection of Human Rights Act, 1993 to promote and protect the human rights of all in the country. Towards fulfilment of its mandate, the Commission is deeply concerned about the rights of the vulnerable and marginalised sections of the society which have been disproportionately impacted by the COVID-19 pandemic and the resultant lockdowns.

2. In order to assess the impact of the pandemic on realization of the rights of the people, especially the marginalised / vulnerable sections of the population, the NHRC constituted a Committee of Experts on impact of Covid-19 pandemic on Human Rights and Future Response including the representatives of the Civil Society Organizations, independent domain experts and the representatives from the concerned ministries / departments.

3. After due consideration of the impact assessment and recommendations made by the Committee of Experts, the Commission hereby issues an advisory on "Right to Mental Health in context of Covid-19 pandemic", as enclosed.

4. All the concerned authorities are requested to implement the recommendations made in the advisory and to submit the action taken report for information of the Commission.

Encl: As above


(R.K. Khandelwal)
Joint Secretary (A&R)

To,

1. Secretary,
Department of Health and Family Welfare,
Ministry of Health and Family Welfare
Govt. of India, Udyog Bhawan,
New Delhi-110011
2. The Chief Secretaries of all States/UTs



Annexure

National Human Rights Commission

Advisory on Right to Mental Health in Context of Covid-19 Pandemic

Background

The Covid-19 pandemic has created an unprecedented crisis in recent times placing huge demands on the health care system of the country resulting in socio-economic instability. It is now recognized as causing a mental health pandemic, with a range of mental health problems occurring during different phases of the Covid-19 pandemic, which requires immediate recognition and intervention. Further, the prevention of mental health crisis in the wake of the consequences of each phase of the pandemic also requires urgent attention.

As per the 'Policy Brief on COVID-19 and the Need for Action' on Mental Health' issued by the United Nations. The COVID-19 as the pandemic has disrupted services around the world. Many people are distressed due to the immediate health impacts of the virus and the consequences of physical isolation, dying, and losing family members. Millions of people are facing economic turmoil having lost or being at risk of losing their income and livelihoods. The key factors affecting services are: infection and risk of infection in long-stay facilities, including care homes and psychiatric institutions, mental health staff being infected with the virus, frequent misinformation and rumours about the virus and the closing of mental health facilities to convert them into care facilities for people with COVID-19. Outpatient mental health services around the world have also been severely affected.

Mental health issues following Covid-19 pandemic emerge from the general population either because of exposure to the overwhelming situations, or because of pre-existing mental health conditions, which may get exacerbated during the pandemic. The country already has a very huge treatment gap of over 75% for severe mental illness. Even those persons with severe mental illness like schizophrenia, bipolar mood disorders and severe depression who were earlier receiving treatment and were stable are likely to decompensate due to lack of access to services for follow-up and continuation of medication and psycho-social services. Their necessities include not just acute and maintenance treatment, but also needs of housing, food, care and rehabilitation.

Increase in mental morbidity:

As per WHO, during the Covid-19 Pandemic people are introduced with working from home, temporary unemployment, home-schooling of children, and lack of physical contact with other family members, friends and colleagues. Studies have indicated that there could be a multitude of symptoms like uneasiness, anxiety, low mood, difficulty in sleep, appetite disturbances, as well as severe mental illnesses and substance use and abuse. One in 3 to 4 persons may experience symptoms of common mental disorders like depression or anxiety, according to recent surveys. The severity would be intense in cases of children, elderly, pregnant women, people with pre-existing mental illness, people living alone and families of those who have died due to Covid-19. Vulnerability to mental health issues are high for front-line personnel, including Health workers

and police, as they are in continuous contact with infected patients, have long working hours and inadequate resources.

It is also recognized that Covid-19 could present with neuropsychiatric manifestations and that new psychiatric symptoms can also develop post Covid-19. Therefore, it is extremely crucial to address the pandemic in the context of mitigating its impact on mental health.

1. Right to Information:

1.1 Providing Information to Patients with Mental Illness (PMIs): Information and awareness regarding prevention from Covid-19 and Rights of Patients should be provided to all patients of mental illness and their caregivers in a language that is understandable to them.

1.2 24x7 Helpdesk: All State Governments may operate a 24x7 centralised call centre facility, linked with nodal person(s) designated in each district for helping the patients and their caregivers, and also for providing the information on availability of beds in hospitals.

1.3 Sharing Health Status with Caregivers: Caregivers or families of the admitted Covid or Non- Covid PMIs should be contacted and updated regarding the health status of the PMI on a regular basis.

2. Right to Access Mental Health Care:

2.1 Accessibility: Every patient with any mental health condition shall be provided access to mental healthcare, treatment and minimum mental health services, run or funded by the State or Central Government.

2.2 Affordability: Mental health care and treatment need to be made affordable and available to all during the Covid-19 pandemic for which the charges for treatment of Patients with Mental Illness (PMIs) in private hospitals / clinics may be regulated.

2.3 Availability: A range of appropriate mental health services such as acute mental healthcare, halfway homes, sheltered accommodation, community based rehabilitation services, medicines and psychiatric emergency and OPD services may be made available at community health centers and public health systems and underserved areas. Suitable, feasible, Isolation ward or facility should be made available in every Mental Health Establishments (MHEs), so as to avoid and minimize the spread to other inpatients till the test reports are awaited.

2.4 Tele-psychiatry: Provision of tele-psychiatry services may be ensured for continuity of mental health services for patients who are accessible through telephone or internet based communication at a regulated cost.

2.5 Screening: All PMIs attending OPD and/or emergency services should be screened for Flu like Illness (FLI) symptoms and tested for Covid-19 as per ICMR Guidelines. All patients being admitted to Mental Health Establishments (MHEs) should also be tested.

2.6 Homeless Persons: Policy should be made for testing and treatment of homeless/ destitute persons with mental illness. If a Photo ID of the person is not available, it may not be insisted upon. Mental healthcare for homeless PMIs in the streets should be ensured, by taking the area Police into loop.

2.7 Non-discrimination: Mental healthcare services should be given without discrimination on the basis of gender, sex, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and care-givers.

2.8 Unconditional treatment: No PMI should be denied treatment in a public or private hospital due to the lack of a negative Covid-19 test result. Covid-19 test may be facilitated by the hospital if considered necessary on clinical grounds.

2.9 Quality Assurance: It should be ensured that the mental health services are of equal quality to other general health services and no discrimination be made in quality of services provided to persons with mental illness and the minimum quality standards of mental health services to patients with mental illness affected by Covid-19 and non-Covid shall be as specified by regulations made by the State Authority.

2.10 Inpatient care for psychiatric illness: It should be ensured that treatment of PMIs in the ward is not denied and continued even during Covid-19 period.

2.11 Health Insurance: Insurance Companies of the private/ public sector should make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness, keeping in mind the increased spread of mental illness during Covid-19 period. Government may operationalise and implement insurance for mental health problems as part of "Ayushman Bharat".

3. Covid Treatment Facilities:

3.1 Attending PMIs with other physical illnesses: Access to appropriate physical care must be ensured for PMIs as they may also have co-occurring physical health problems.

3.2 Supervising Committees: The hospitals treating PMI should have an appropriate committee to advise them on the precautions to be taken to prevent and address COVID infection.

3.3 Ensuring care: The hospitals may ensure standards of care for testing prior to admission, quarantining of patients awaiting testing, isolation of PMI who may turn positive and their appropriate management or referral to a COVID treatment facility.

3.4 Recreational Activities: keeping all precautions in place, adequate recreational activities may be provided for inpatients to reduce their stress and sense of isolation. For similar purposes, patients with COVID, with or without mental illness, may be provided access to video/ audio calls with their family/ friends.

4. Right to Protection from cruel, inhuman and degrading treatment:

4.1 Safety of Patients affected by COVID-19: Any patients with Mental Illness (PMI) should be protected from cruel, inhuman or degrading treatment (such as use of force during transferring the patient to the quarantine centre, etc.).

4.2 Sanitation and Hygiene: Sanitation and hygiene of PMIs should be ensured in the Covid Care Centers or Hospitals. Also, women's personal hygiene should be adequately addressed by providing access to items that may be required during menstruation patients with mental illness affected with COVID-19. Adequate sanitary and hygienic conditions shall be maintained in all health care centers.

4.3 Living Conditions in Mental Health Institutions: All Mental Health Institutions may ensure adequate living conditions, with proper sanitation and hygiene and availability of basic resources like food, clean linen, safe drinking water for the patients.

5. Right to Confidentiality:

5.1 Informed Consent Informed consent of the PMI or person nominated by the PMI must be duly taken during all medical procedure and treatment.

5.2 Confidentiality: A person's right to confidentiality shall be ensured during care or treatment with the following exceptions, namely:—

- a. Release of information to the nominated representative to enable him to fulfil his duties.
- b. Release of information to other mental health professionals and other health professionals to enable them to provide care and treatment to the person with mental illness.
- c. Release of information if it is necessary to protect any other person from harm or violence.
- d. Only such information that is necessary to protect against the harm identified shall be released.
- e. Release only such information as is necessary to prevent threat to life.
- f. Release of information upon an order by concerned Board or the Central Authority or High Court or Supreme Court or any other statutory authority competent to do so; and
- g. Release of information in the interests of public safety and security.

5.3 Respect and Dignity: Human dignity of every patient in all situations must be maintained, with no **stigmatizing or public labeling** of COVID-19 patients or PMI.

5.4 Restriction on release of information in respect of mental illness: No photograph or any other information relating to a person with mental illness undergoing treatment at a mental health establishment/ institutions shall be released to the media without the consent of the person with mental illness.

5.5 Right to Access Medical Records: The right to access all medical records, discharge summary or death summary along with original copies of all investigations,

including COVID-19 test report, which have been performed during the hospital stay, may be ensured. Civic bodies may consider sharing test results online in a confidential manner, whereby patients can check their status through confidential test ID cards provided only to the patient. It may be done through a printed test report, email, or SMS message and it may be given only to the patient or designated caregiver.

6. Promotion of Mental Health and Preventive Programmes:

6.1 Creating Awareness: District wise awareness programmes regarding mental health issues, symptoms, policies and rights should be conducted on a quarterly basis in urban as well as rural areas of the country wherein people should also be made aware to undergo mental health assistance/ treatment under a registered and certified mental health professional only.

6.2 Promoting Community Based Assistance: Participation of volunteers and / Civil Society Organizations may be encouraged with adequate precautionary measures taken for them, to provide logistical help and support.

6.3 Promoting Mental Health Programmes for Frontline health workers: It may be ensured that the front line health care workers have access and availability of mental health services since they work in close contact with patients, have long working hours, etc., making them more vulnerable to mental health concerns

7. Right to Make Complaints about Deficiencies in Provision of Services:

7.1 Grievance Redressal Mechanism: All states may establish an effective and accessible mental health grievance redressal mechanism including provision of Appellate authority and a designated grievance redressal official, to whom patients and caregivers can approach to register their concerns and complaints.

7.2 Complaint Database: A state level, live, dynamic dashboard for publicly-accessible databases may be maintained of all the complaints received with details of the status of complaints (resolved or pending).

8. Filling of Vacancies: Adequate arrangement for filling up of the vacancies should be made by the appropriate government so that availability and quality of treatment during covid period is maintained in MHEs.

9. Extending Outreach of Mental Health Support:

9.1 Telephonic Counseling: Telephonic outreach or video-consultation services for COVID or psychiatric/ psychological difficulties, by mental health professionals such as counseling psychologists, clinical psychologists, rehabilitation psychologists should be promoted.

9.2 Counseling for Families of the Deceased Persons: Counseling services may be provided to families and caregivers of the deceased persons to control the probability of

occurrence of mental health issues such as Depression, Post Traumatic Stress Disorder (PTSD) and development of suicidal tendencies.

9.3 District Mental Health Programme (DMHP): Functioning of the programme should be monitored on a regular basis by the appropriate authorities. Staff of the DMHP should be trained to provide awareness and support for mental distress.

9.4 Mobile Mental Health Units: A mobile van with a multidisciplinary team to identify homeless PMIs in the community and take them for care, treatment and rehabilitation at the appropriate establishment must be promoted.

9.5 Mental Health First Aid (MHFA) and Psychological First Aid (PFA) Training: Training of people in MHFA and PFA should be promoted in order to promote community mental health and immediate emergency mental health service. All front-line personnel may be appropriately trained in the mental health support during COVID.

10. Police Personnel:

10.1 Sensitizing and Training For Police Personnel: Police personnel should be trained and sensitized to be empathetic and compassionate towards patients with mental illness with or without Covid-19.

10.2 Mental Health Support For Police Personnel: Services of one psychologist may be provided in each district specifically to provide Mental Health Support for police personnel to deal with their mental health issues during the period of Covid-19.

11. Post Covid- Management:

11.1 Counseling for patients recovered from Covid-19: All recovered patients of COVID-19 should have the access to counseling, in the language of their choice, either in person or over telephone, regarding their issues like apprehensions, fear, anxiety, stress, or any other.

11.2 Follow-Up Procedure: Follow up procedure including occurrence of any symptoms of Covid-19 for PMIs affected by Covid-19 must be made by the concerned health care unit.

11.3 Post Covid Preventions: It should be ensured that the Post Covid Management Protocol issued by the Ministry of Health and Family Welfare is properly implemented at the ground level.

12. Promoting Research: Since the novel corona virus has no prior history of its genesis, spread and cure; therefore, research on the effect of Covid-19 on Mental Health, following all ethical standards, should be promoted.



ANNEXURE III

Human Rights Advisory on Right to Mental Health in view of the second wave of the COVID-19 pandemic (Advisory 2.0)



राष्ट्रीय मानव अधिकार आयोग National Human Rights Commission

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File No. R-18/6/2021-PRPP (RU-1)

May 31, 2021

Subject: Human Rights Advisory on Right to Mental Health in view of the second wave of COVID-19 pandemic (Advisory 2.0)

The National Human Rights Commission (NHRC) is mandated by the protection of Human Rights Act, 1993, to protect and promote the human rights of all the people in the country.

2. Keeping in view the prevailing situation in the country due to the second wave of Covid-19 pandemic and taking into consideration the ground reports relating to the problems faced in access to health care, impact on mental health of the people and related issues, the Commission hereby issues the "Human Rights Advisory on Right To Mental Health in view of the second wave of COVID-19 pandemic (Advisory 2.0)" (copy enclosed), which may be read and implemented in conjunction with the earlier "Human Rights Advisory on Right to Mental Health in context of COVID-19" issued by the Commission on 08.10.2020 which is accessible from the NHRC website..

3. All the concerned authorities of the Union/State Government(s)/UTs are advised to implement the recommendations made in the said **Advisory 2.0** and need to submit the **action taken report (ATR)** within four weeks for information of the Commission.


(Bimbadhar Pradhan)
Secretary General

Encl: Advisory 2.0

1. **The Secretary to the Government of India**
M/o Health and Family Welfare
D/o Health and Family Welfare
Nirman Bhawan, C-Wing
New Delhi-110001
2. **Chief Secretary (all States) and Administrator (all UTs)**



National Human Rights Commission

Advisory on Right to Mental Health in view of the second wave of the Covid-19 Pandemic (Advisory 2.0)

Background:

National Human Rights Commission, being deeply concerned with severe impact on the human rights of the people due to the COVID-19 pandemic, had issued a comprehensive set of human rights advisories in 2020, including one on Mental Health in the month of October, 2020, to protect and promote right to health as guaranteed under Article 21 of the Constitution of India.

Mental health is integral and closely linked to human rights. The issues that arose during the pandemic have led to adverse mental health outcomes, particularly among vulnerable groups. There is thus a need to protect the rights of persons by adopting an ethical and rights-based approach.

The second wave of COVID-19 has indeed worsened the human rights situation in the country as we are now facing a health emergency, including aggravated mental health issues and concerns. As the majority of public grapples to access basic required health facilities needed at this time, critical gaps in providing access to mental health care in the country are also emerging. This is evident from the ground reports since the pre-existing and recently evolved mental health crises are yet not dealt with efficiently. With a spike in the number of Covid infection positivity rate, non-availability of hospital beds for getting treatment, deficit of oxygen, a relative increase in the number of deaths, the difficulties faced by people for cremation/ burial and more recently, complications like mucormycosis, aspergillosis, etc., have led to a concomitant wave of emotional distress among people. Mental health problems are likely to persist beyond Covid-19, as people need to deal with bereavement and other losses. There have also been anxieties about vaccination including worries about not having access to vaccination.

As per the data of the Ministry of Health and Family Welfare, GoI, the total number of deaths from COVID-19 in India has now reached more than 3.37 lakhs (as on 28th May, 2021). The huge amount of loss of lives is leading to apprehensions, anxiety, fear and panic, which in turn, is increasing the prevalence of mental illness among all age groups.

2
31/51

There are growing reports of increased mental health morbidity including a rise in domestic violence and substance use during the pandemic. Globally, there are concerns about an increase in suicides secondary to isolation, fear around the diagnosis of Covid-19, emotional and financial distress. It is also recognized that Covid-19 could present with neuropsychiatric manifestations and that new psychiatric symptoms can also develop post Covid-19. Therefore, it is extremely crucial to address the pandemic in the context of mitigating its impact on mental health.

Now, in view of the seemingly greater mental health impact particularly in the second wave, this advisory encompasses both mental health care for the entire population and also more focused recommendations for persons with mental illness (PMIs) who are at great risk of worsening mental health morbidity.

Recommendations:

1. Access to Mental Health Care:

1.1 Accessibility and Affordability: Every patient with any mental health condition should be provided access to affordable mental healthcare, and minimum mental health services, run or funded by the State or Central Government during the Covid-19 pandemic. Further, the cost of treatment in private hospitals/ clinics may be regulated.

1.2 Availability of Services: A range of appropriate mental health services such as acute mental healthcare, halfway homes, sheltered accommodations, community-based rehabilitation services, medicines and psychiatric emergency and OPD services may be made available at community health centres (CHCs) and primary health centres (PHCs).

1.3 Availability of In-Patient Treatment: Arrangements must be made to assure inpatient admission and treatment for both Covid-19 as well as for psychiatric care. However, to ensure safety of other patients and healthcare workers in the ward, Covid tests of the patient and the caregiver must be made mandatory before hospitalisation. Every new patient and caregiver may be kept in isolation or on watch for 3-5 days to observe emergence of any symptoms. Facilities must make provision to allow the family member to stay with PMIs for whom it is deemed necessary to have a care provider, making sure that they are aware of and follow all Covid-appropriate behaviours and precautions.

1.4 Availability of Psychotropic Medications: Essential psychotropic medications should be made available across all public health establishments across the country. Nevertheless, to reduce the risk of self-harm such as suicide attempts, precautions should

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be taken while prescribing medications for more than a month to PMIs and the caregivers should be instructed appropriately and adequately to keep vigilance regarding this.

1.5 Universal Availability of Mental Healthcare: Mental healthcare services as well as COVID related services to PMIs should be given without discrimination on the basis of gender, sex, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families/caregivers.

1.6 Trained Human Resources: Adequate arrangement for deployment of trained human resources and filling up of the vacancies should be made by the appropriate government so that availability and quality of treatment during Covid period is maintained in all mental health establishments (MHEs). Each healthcare organisation should have an adequate number of professionals (depending upon the bed strengths of the healthcare organisation) for psychological counselling, mental health screening, and subsequent specialist referral.

1.7 Access to Vaccination: Persons with severe mental illness must be prioritised for vaccination as they are at greater vulnerability to Covid-19 infections, especially when they are unable to follow Covid-19 appropriate behaviours, especially homeless PMIs. Further, Advocacy needs to be actively done for PMIs, as there can be higher rates of vaccination hesitancy and refusal amongst the group.

1.8 Provision of Funds: Adequate funds should be made available timely to the mental health establishments for their smooth functioning.

2. Dissemination of Information:

2.1 Providing Information to Patients with Mental Illness (PMIs): Information and awareness regarding prevention from Covid-19, Covid-vaccination, and rights of patients should be provided to all patients of mental illness, persons with disabilities, and their caregivers in a language that is understandable to them. This can be done by the district administration through distribution of IEC materials and community health education forums, and other existing health education mechanisms.

2.2 24x7 Helpdesk: All State Governments may establish a 24x7 centralised call centre facility, linked with nodal person(s) designated in each district.

2.3 Sharing of Health Status with Caregivers: Caregivers or families of the admitted Covid or Non-Covid PMIs should be contacted and updated regarding the health status of the admitted PMI on a regular basis. A smooth flow of channels of communication

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between the PMIs admitted for Covid without any caregiver and their family members must also be adopted by the hospitals.

3. Awareness:

3.1 Display of list of Authorized Mental Health Professionals: List of registered and authorised mental health professionals must be prepared and widely published including on the websites to curb illegal healthcare practices and inform the citizens about professional help. Further, professional mental health services should be provided by authorized and registered mental health practitioners and the organisations which are into mental health services during this pandemic must be kept under check by the state.

3.2 Spreading Awareness about Preventive and Curative Mental Healthcare: District-wise awareness programmes regarding mental health issues, symptoms, policies and rights should be conducted in urban as well as rural areas of the country.

3.3 Sensitisation of Frontline Workers: Training must be carried out to sensitise the frontline workers including medical and para-medical staff, police personnel, ambulance drivers, crematoria staff, etc., to be empathetic and compassionate towards patients with mental illness with or without Covid-19 as well as their caregivers as they may be in a mentally vulnerable condition due to stress.

3.4 Automated Messages: Mass-automated messages may be sent to PMIs, their caregivers, and to the general population regarding the mental health concerns that may arise due to the pandemic to create awareness, along with sharing information about how to reach a certified professional when needed.

4. Grievance Redressal & Review Board:

4.1 Grievance Redressal Mechanism: All States may establish an effective and accessible mental health grievance redressal mechanism by designating grievance redressal officers and the Appellate Authority, to whom patients or caregivers can approach to register their concerns and complaints. All grievances must be redressed within a reasonable time.

4.2 Functioning of Review Board: The Mental Health Review Board and the State Mental Health Authority under the Mental Healthcare Act, 2017 should be constituted without any delay if not done, and effective functioning of these Boards must be ensured.



5. Extending Outreach of Mental Health Support:

5.1 Mental Health First Aid (MHFA) and Psychological First Aid (PFA) Training: Training of personnel in MHFA and PFA should be done in order to promote community mental health and immediate/emergency mental health service.

5.2 Tele-psychiatry and Tele-psychotherapy: Provision of tele-psychiatry and tele-psychotherapy services may be ensured for continuity of mental health services for patients who are accessible through telephone or internet-based communication free of cost in government hospitals and at a regulated cost in private hospitals. It is necessary to expand tele-psychiatry services so that they can be accessed by people throughout the country, particularly in underserved areas. The Guidelines for tele counselling services version 1.0, released on 14th April 2020 by NIMHANS Bangalore, must be followed by all mental health professionals while conducting tele-counselling.

5.3 Substance Abuse- Prevention and Intervention: Existing community-based substance abuse prevention and intervention services should be strengthened as there has been a growing problem of substance use during the pandemic and associated mental health problems.

5.4 Counselling for Patients Recovered from Covid-19: All recovered patients of COVID-19 should have access to counselling, in the language of their choice, either in person or over telephone, regarding issues like apprehensions, fear, anxiety, stress, or any other. The families and caregivers of the deceased persons should also be provided with counselling services to control the probability of occurrence of mental health issues such as depression, post-traumatic stress disorder (PTSD) and development of suicidal tendencies.

6. Support for Special Groups:

6.1 Mental Health Support for Frontline Workers: Services of psychologists and other mental health professionals should be provided in each district specifically to provide mental health support for frontline workers like medical professionals, police personnel as well as other workers in high pressure jobs like ambulance drivers and crematoria staff to deal with mental health issues during the period of Covid-19.

6.2 Homeless Persons with Mental Illness: Policy should be made for testing and treatment of homeless/ destitute persons with mental illness. If a Photo ID of such a person is not available, it may not be insisted upon. Mental healthcare for homeless PMIs should be ensured by taking the local Police authority into loop.

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6.3 Other vulnerable groups: Mental health support must be ensured considering the specific needs of other vulnerable groups like the elderly, pregnant women, migrant workers, PWDs as well as children who have lost their parents or have been victims of abuse.

6.4 Child Care Institutions: All childcare institutions including those for children with disabilities, juvenile homes, child welfare homes, rehabilitation centres, etc, must ensure covid-safety, physical and mental health infrastructure and human resources to cater to the mental health needs of children.

7. Suicide Prevention:

7.1 Steps for Prevention of Suicides: Urgent steps for prevention of suicide, including helplines, counselling, mental health first-aid, identification of risks for vulnerable groups and mental health support for such individuals should be ensured.

7.2 Presumption of Severe Stress in Cases of Attempt to Commit Suicide: Notwithstanding anything contained in section 309 of the Indian Penal Code, any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code as per provision contained under Section 115 of the Mental Healthcare Act, 2017.

8. Health Insurance: Insurance Companies of the private/ public sector should make provision for medical insurance for treatment of mental illness on the same basis as is available for treatment of physical illness, keeping in mind the rising cases of mental illness during Covid-19 period. Government may operationalise and implement insurance for mental health as part of "Ayushman Bharat".

9. Media Sensitivity in Reporting about the Pandemic and Greater Attention to Mental Health: The media must be sensitive to the mental health impact of news shared on various platforms and ensure that while reporting, the facts required to be placed before the public are not sensationalized causing panic, as well as also ensure awareness building about Covid-related precautions, treatment and recovery, addressing mental health problems and improving resilience.

10. Promoting Research: The Government(s) may encourage key research in the area of mental health impact of Covid-19 in general and PWDs and PMIs in particular.

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ANNEXURE IV

Guidelines of NHRC on “Prevention of Suicide in Prison”

1. A comprehensive suicide prevention programme must be introduced in all prisons by the State/UT Government, involving training of staff involved in correctional home services, health care and mental health of prisoners. The staff should be fully aware and proficient in initiating emergency response to a suicide attempt along with keeping vigil and adopting measures for prevention also. Periodic mock drills/rehearsal should be carried out to sensitize the stake holders and to reduce reaction time in assessment and providing professional assistance.
2. The State Prison Directorate should ensure enhancement of constructive and supportive relationships between prison staff and inmates. Particular emphasis should be placed upon improvement in regimes, staff training and rostering arrangements to enhance these relationships to suit all needs.
3. The newly admitted prisoners should be interviewed by a trained medical officer along with a qualified Psychologist for identification of inmates who appear to be psychologically abnormal and who could be prone to suicidal tendencies. The key to identifying potentially suicidal behaviour in inmates is through careful inquiry/interview and assessment during initial screening of the inmates. The pre-entry/initial health screening report of the prisoner must be filled up in detail and signed by both medical officer and Psychologist after filling all the mandatory information. Initial health assessment must be followed by regular follow up assessment as well.
4. CCTVs should be installed at the reception area and monitored 24x7 through a control room for monitoring effective initial screening.
5. The bandwidth of opportunities for inmates to interact with the outside world may be expanded through provision of news papers, television and movies in addition to periodic meetings with family and friends to maintain their social contacts. The prison environment could also be made less stressful by introduction of Yoga programmes and providing soothing music through speakers installed at appropriate places in consultation with prisoners.
6. Each prisoner/inmate should be provided with the opportunities to participate in constructive activities such as employment, education and skill development programs that build competence levels and address cure depressive

tendencies while simultaneously preventing aggressive behavior. Introduction of outdoor and group activities would bring positive attitude and group bonhomie among the inmates.

7. All aspects of prison operations and programs must be designed to cater to the diversity of the prison population in terms of culture, ethnicity, gender and sentencing status.
8. Priority should be given to provide comprehensive mental health services to prisoners, including:
 - a) Regular multidisciplinary screening and assessment of the mental health of the prisoners. Post of regular medical officers at central prison and weekly visit of a Psychiatrist/doctor to the District jails must be ensured.
 - b) Adequate mental health treatment and management, resources and systems should be made available within the prison including a qualified psychologist so that dependence on external agencies is minimized to extreme cases only.
 - c) Acute mentally ill prisoners must be shifted to Mental Hospital u/s 29 of the Mental Health Act, 1987, and
 - d) Provision should be there in prisons for continued mental care facilities even after specialist management and treatment of a mentally ill prisoner is over so that regular follow up is maintained even after the prisoner returns back into the prison environment, and gets reintegrated into the community.
9. Following points may be covered by suicide awareness training provided to prison officers and staff:
 - a) How to identify inmates with signs of suicidal tendencies and rate them according to the level of their problems.
 - b) Precautions to be taken by the staff monitoring these inmates.
 - c) Basic understanding of human behavior and ability to identify psychosomatic illnesses by observing prisoner's sudden change in behavior.
 - d) Basic training in medical emergency response to all jail officials to respond and provide immediate medical first aid



like cardio-pulmonary resuscitation (CPR) in cases of suicide attempts and other such emergencies till professional help is sought.

e) Identification of good Samaritans among the jail inmates who can keep an eye on prisoners and warn the staff to preempt suicides.

- 10. Conduct a thorough audit of the jail premises to find out the probable places/areas and items that are prone to be used while committing suicide. This should help in identifying and re-designing 'suicide resistant cells' with the intention of replacing potential hanging and anchoring points.**
 - 11 It is also important to strengthen the grievance redressal system in prisons and get regular feedback on quality of food, entertainment and other facilities from prisoners. It is imperative to engage prisoners in positive and constructive activities and also in socially useful productive work, religious activities and motivational therapy through discourses. A complaint box inside the prison could be a useful tool for redressal of complaints and to obtain feedback of inmates. Integration of the records of all the prisoners should be done so that if an under-trial prisoner had been previously incarcerated in a different jail then information about his background, behaviour and treatment records could be obtained from there and the same will be useful to the jail officials in his screening and assessment.**
 - 12. There should be rigorous review and intensive follow up of each suicide case to find out and alleviate the particular reasons behind the suicide and the steps to be taken so that such an occurrence in future is prevented.**
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ANNEXURE V

देवेन्द्र कुमार सिंह, मा.प्र.से.
महासचिव
Devendra Kumar Singh, IAS
Secretary General



राष्ट्रीय मानव अधिकार आयोग
मानव अधिकार भवन, सी-ब्लॉक,
जीपीओ कम्प्लेक्स आईएनए, नई दिल्ली-110 023 भारत
NATIONAL HUMAN RIGHTS COMMISSION
Manav Adhikar Bhawan, C-Block,
GPO Complex, INA, New Delhi-110023 India

D.No R-14/6/2022-PRPP (RU-4)

19th June, 2023

Subject: Advisory to mitigate Deliberate Self Harm and Suicide attempts by prisoners

Dear Sir / Madam

The National Human Rights Commission, NHRC is mandated by the protection of Human Rights Act, 1993, to protect and promote the human rights of all the citizens in the country.

2. Towards the fulfillment of the above mandate, NHRC has been working towards preventing avoidable loss of life, especially in custody. Since the incidence of suicides in prisons have not come down and considering the legislative changes and recent trends in number of suicidal deaths, the NHRC issues an Advisory, dated 19th June, 2023, to mitigate Deliberate Self Harm and Suicide attempts by prisoners. A copy of the same is enclosed for necessary follow-up action. This Advisory may be read and implemented in conjunction with similar Advisory issued by the Commission in 2014. Copy of the same is also enclosed for ready reference (**Annexure X**).

3. All concerned authorities are requested to advise their concerned departments to implement the recommendations given in the said advisory and to furnish an 'Action Taken Report' on the same within three months for information and perusal of the Commission.


(Devendra Kumar Singh)

Encl.:

1. **Advisory dated 19th June, 2023 (8 pages) containing Annexure I (1 Page), Annexure II (5 Pages), Annexure III (1 Page)**
2. **Annexure X (3 pages)**

To:

The Chief Secretaries of all States/UTs

Copy to:

1. DG, BPRD
2. DG of all Prisons
3. DS (PR & ATC), MHA





National Human Rights Commission
RU-4 PRPP Division
F.NO. R-14/6/2022-PRPP (RU-4)

NHRC/Adv./01/2023-24

Dated: 19th June, 2023

Advisory to mitigate deliberate self harm and suicide attempts by prisoners

Prisons in India have seen a significant number of deaths through suicide in recent years. Suicide in prisons is multifactorial, which includes medical and mental health issues, particularly the stress of adjusting to imprisonment as well as those involving family, lack of purposeful activity and certain conditions present in the prison environment.

A number of unnatural deaths are taking place in Indian Prisons. More than 80% of these deaths take place due to suicide. The predominant mode of committing suicide is by hanging (93%) followed by poisoning, self-inflicted injury, drug overdose and others.

Prisons authorities are responsible for protecting the health and safety of the inmates and the continuing suicides constitutes gross violation of human rights. Therefore, making adequate provision for suicide prevention would be beneficial for improving the living conditions in the Prison.

National Human Rights Commission (NHRC) has been working towards preventing avoidable loss of life by exploring various measures to save lives. Detailed guidelines on "Prevention of Suicide in Prison", were issued by NHRC in 2014. However, since the incidence of suicides in the prisons has not come down, and considering the legislative changes and recent trends in number of suicidal

deaths, the NHRC is issuing the following Advisory to mitigate deliberate self harm and attempts at suicide by prisoners.

1. Filling up the Vacancies & Augmenting the staff strength

- a) Existing vacancies of Prison staff should be filled up particularly those of Prison Welfare Officers, Probation Officers, Psychologists and Medical Staff.
- b) The strength should be suitably augmented to include Mental Health professionals.
- c) Government should review the sanctioned strength of the Prison staff every five years.

2. Training of Prison staff

- a) A component of mental health literacy must be included in the basic training of Prison staff. This needs to be supplemented with refresher training every three years. A suitable supervisory officer to be designated as the Mental Health Officer and assigned to ensure such training.
- b) The curriculum of such a component of mental health literacy in the basic and refresher training of Prison staff must be prepared at the State level in collaboration with a government mental health institution & other experts.
- c) The Prison staff be trained for administering PFA (Psychological First Aid). PFA is a training program to identify, understand and respond to signs of mental illnesses and substance abuse disorders to enable trainees to develop "the skills to reach out and provide initial help and support to an inmate developing a mental health or substance use problem or experiencing a crisis".
- d) Selected Prison staff in each Prison barrack be trained in providing Cardiopulmonary Resuscitation & First Aid (CPR), particularly for handling



attempted hanging, bleeding through self inflicted cuts or on ingesting toxic substances.

- e) They also be trained to inform the trained medical staff immediately and to shift the patient to the closest medical facility.

3. Screening at admission stage

- a) Mental health screening be included in the initial health screening report of every prisoner.
- b) Where a mental health professional is not available, the available medical staff be provided training by mental health professionals in conducting screening of prisoners
- c) If the preliminary screening identifies signs and symptoms of mental health disorder, a mental health professional should be consulted.

4. Supervision and monitoring of at-risk prisoners

State should have two levels of monitoring by Mental Health/trained Medical Staff assisted by Prison staff as detailed below:

- a) Relevant information of at risk prisoners should be appropriately shared with concerned Prison staff, particularly with reference to the following:
 - i. Does the prisoner have any medical/mental health condition?
 - ii. Is the prisoner taking any medication?
 - iii. History of substance abuse?
 - iv. The previous background of the prisoner, which may trigger or exacerbate his existing mental health conditions?
- b) **Observation of inmates:**
 - i. Assessment and treatment by trained mental health professionals.

- ii. Regular observation by Prison staff and assignment of a prisoner 'buddy', trained in psychological first aid.
- iii. Susceptible prisoners not to be employed in works which involve the use of sharp or heavy instruments. The custody of knives, agricultural sharp or pointed objects should be carefully counted and managed post use.
- iv. Telephone contact with friends or family of the prisoner to be ensured, in accordance with relevant regulations. Further, adequate number of telephones to be installed in the prisons considering the number of prisoners.

(c) **Suicide Watch:**

- i. In order to provide supportive service and treatment to prisoners at the risk of deliberate self-harm or those expressing suicidal thought, they be referred to the appropriate mental health officer/expert.
- ii. High-risk prisoners be shifted to premises that enable 24x7 monitoring with the help of CCTV cameras.
- iii. Access to material which can be used for suicide by hanging or inflicting self injury by sharp edged implements or toxic material must be prevented in such cases.
- iv. Family members of the at-risk inmates must be contacted to give them the required assurance, counseling and mental support.
- v. Priority be assigned to shifting the injured to a medical facility without delay. If this is not possible, life-saving efforts should be initiated and continued until the arrival of trained medical staff.
- vi. Prison staff should secure the location of the attempted suicide and preserve the spot for subsequent investigation

5. **Training of prisoners**

- a) Selected prisoners in each Prison barrack to be trained in providing Cardiopulmonary resuscitation and First Aid, particularly for handling attempted hanging, bleeding through self-inflicted cuts or ingesting toxic substances.
- b) All prisoners be made aware of fellow prisoners trained in Cardiopulmonary resuscitation and first aid.
- c) **Gatekeeper Model:** (devised by the World Health Organization, WHO), to strengthen mental health care in Prisons be implemented for training of carefully selected inmates to identify prisoners at risk of suicide:
- d) It be ensured that fellow prisoners do not mistreat prisoners with mental health issues.
- e) Programmes on mental health be organized to sensitize prisoners.

6. Collaborative Framework for mitigation

The Prison Administration, in collaboration with local Mental Health Institutions, should:

- a) Appoint a nodal expert to assist with risk assessment and treatment.
- b) Connect with community based initiatives, like the District Mental Health Programme, and
- c) Engage with willing private mental health care professionals/NGOs working in the field of mental health.

7. Addiction among prisoners

- a) Measures to tackle the issue of addiction among prisoners be undertaken by regular visits of mental health care professionals and de-addiction experts.
- b) The issue to be seen as a health and rehabilitation issue rather than that of security.

8. Compliance with relevant statutory provision

Appropriate governments and Prison administration to ensure compliance with the extant legal provisions including the following:-

- a) Section 103 of The Mental Healthcare Act, 2017; related to treatment facilities for prisoners with mental health issues (**Annexure I**).
- b) Rule 7 & 10-11 of The Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018 related to free legal aid, modalities of transfer, minimum standards, etc., in custodial institutions (**Annexure II**).
- c) The State/UT to identify one prison for setting up mental health establishment under Section 103(6) of the Act and Rule 11 (**Annexure III**)

9. Prison House Keeping

- a) Abrasive and corrosive chemicals, such as phenyls, acids, etc., used for cleaning toilets and surfaces, to be beyond the reach of prisoners.
- b) Tools used for building maintenance, such as ropes, glass, wooden ladders, pipes, etc., to be kept in safe custody of the concerned Prison staff. Carelessness tends to lead to unforeseen eventuality.
- c) Regular check and vigil on bed sheets and blankets of inmates be exercised to ensure that these are not used to make ropes, etc., to attempt suicide.
- d) The place/area in Prison prone to such acts be identified and corrective actions, including installations of CCTVs, to be ensured.



- e) Barracks to be kept free of objects which can be used for hanging, e.g., Iron Rods/Grills, Fans, Hooks, or similar objects.
- f) Since most suicides take place in Prison toilets, there should be no iron rod, ventilation grill, fan or hook in the toilet which can be used for hanging.
- g) Further, the door of the toilet should be designed in such a way that strict vigil can be kept to avoid possible risk of suicide attempts while maintaining the privacy of the users.

10. Strengthening visitor system

- a) The Prison administration should encourage visits by family members to provide emotional support for prisoners.
- b) Prison staff should reduce, to the extent possible, waiting time of visitors.
- c) E-Mulakat and the National Prisons Information Portal enabling relatives/friends/ advocates of prisoners to book prior appointments for meeting prisoners be used.
- d) In addition, to cover gaps of poor cyber literacy or language issues, easy ways be worked out by arranging visits of relatives in the Prison.
- e) Prison rules relating to searches need be strictly followed.
- f) Visitors should be treated with courtesy at all times, and the conduct of the Prison officials should be exemplary.

11. Prison Environment

- (a) **Recreational facilities:** Prisoners must be provided with life skill-based education and activities like yoga, sports, crafts, drama, music, dance and suitable spiritual and optional religious instructions to channelize their energies positively and occupy their time. This can be done with help of reputed NGOs, if required.



(b) **Vocational Training:** the facilities for up-skilling, vocational guidance and means for financial independence to be increased. Long terms skilled prisoners may be linked with government schemes for entrepreneurship.

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Annexure I

Extracts from Mental Healthcare Act, 2017

Sec. 103 : **Prisoners with mental illness.**- (1) An order under section 30 of the Prisoners Act, 1900 or under section 144 of the Air Force Act, 1950, or under section 145 of the Army Act, 1950, or under section 143 or section 144 of the Navy Act, 1957, or under section 330 or section 335 of the Code of Criminal Procedure, 1973, directing the admission of a prisoner with mental illness into any suitable mental health establishment, shall be sufficient authority for the admission of such person in such establishment to which such person may be lawfully transferred for care and treatment therein:

Provided that transfer of a prisoner with mental illness to the psychiatric ward in the medical wing of the prison shall be sufficient to meet the requirements under this section:

Provided further that where there is no provision for a psychiatric ward in the medical wing, the prisoner may be transferred to a mental health establishment with prior permission of the Board.

(2) The method, modalities and procedure by which the transfer of a prisoner under this section is to be effected shall be such as may be prescribed.

(3) The medical officer of a prison or jail shall send a quarterly report to the concerned Board certifying therein that there are no prisoners with mental illness in the prison or jail.

(4) The Board may visit the prison or jail and ask the medical officer as to why the prisoner with mental illness, if any, has been kept in the prison or jail and not transferred for treatment to a mental health establishment.

(5) The medical officer in-charge of a mental health establishment wherein any person referred to in sub-section (1) is detained, shall once in every six months, make a special report regarding the mental and physical condition of such person to the authority under whose order such person is detained.

(6) The appropriate Government shall setup mental health establishment in the medical wing of at least one prison in each State and Union territory and prisoners with mental illness may ordinarily be referred to and cared for in the said mental health establishment.

(7) The mental health establishment setup under sub-section (5) shall be registered under this Act with the Central or State Mental Health Authority, as the case may be, and shall conform to such standards and procedures as may be prescribed.



Annexure II

Extracts from Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018

Rule 7 : Custodial institutions —The person in charge of custodial institution, including prison, police station, beggars homes, orphanages, women's protection homes, old age homes and any other institution run by Government, local authority, trust, whether private or public, corporation, cooperative society, organisation or any other entity or person, where any individual resident is in the custody of such person, and such individual resident is not permitted to leave without the consent of such person, shall display signage board in a prominent place in English, Hindi and local language, for the information of such individual or any person with mental illness residing in such institution or his nominated representative informing that such person is entitled to free legal services under the Legal Services Authorities Act, 1987 or other relevant laws or under any order of the court if so ordered and shall also provide the contact details of the availability of services.

Rule 10 : Method, modalities and procedure for transfer of prisoners with mental illness —Transfer of a prisoner with mental illness to the psychiatric ward of the medical wing of the prison or to a mental health establishment set up under sub-section (6) of Section 103 or to any other mental health establishments within or outside the State shall be in accordance with the instructions issued by the Central Government or State Government, as the case may be.

Rule 11 : Standards and procedures of mental health services in prison — The mental health establishment referred to in sub-section (7) of Section 103 shall conform to the minimum standards and procedures as specified in Schedule.

Schedule

(See rule 11)

Minimum standards and procedures for mental health care services in prisons**Minimum Standard for Mental Health care in Prison**

1. Prompt and proper identification of persons with mental health problems should be done.
2. Screening of all inmates during the time of entry to prison including the following:
 3. Mandatory physical and mental status examination
 4. Questionnaire screening for substance use
 5. Urine testing for common drugs of abuse
 2. Periodic random urine drug testing
3. Identification of persons with serious mental illness and proper treatment and follow-up for this group.
4. Ensuring the availability of minimum psychiatric medication in the prison to facilitate prompt treatment (Antipsychotic medication, antidepressant medication, anxiolytic medication, mood stabilizers, anticonvulsant medication, etc).
5. Availability of psycho-social interventions for prisoners with a range of mental health problems.
6. Protocols for dealing with prisoners with suicidal risk, with behavioural problems and crises related to mental illnesses as well as to prison life.



7. Suitable rehabilitation services for prisoners with mental illness. Specific attention to the aftercare needs of prisoners with mental illness including providing medication after release, education of family members, steps to ensure treatment compliance and follow up, vocational arrangements, and for those without families, arrangements for shelter.
8. Implementing of National Mental Health Program inside the central prisons
9. Dealing with the psychological stress of prison life
10. Counseling for stress needs to be provided to all prisoners in both individual and group settings.
11. Prisoners must be encouraged to proactively seek help for any emotional problems, substance use problems or physical health problems.
12. Training the prison staff in simple counseling skills. Empowering some of the sensitive, motivated convicted prisoners to be effective peer counselors.
13. One to one counseling upon entry, during periods of crises and upon need or request.
14. Addressing substance use problems
15. Identification of substance use problems through questionnaires, behavioral observation and urine drug screening.
16. Detoxification services and making suitable pharmacotherapy available for detoxification.
17. For persons with dependence, making available long-term medication as well as motivational and relapse prevention counseling.

18. Specific interventions to be made available include the following:

19. Tobacco cessation services (behavioral counseling, nicotine replacement therapy, other long-term tobacco cessation pharmacotherapy).

20. Alcohol - benzodiazepines for detoxification, vitamin supplementation for associated nutritional problems, counseling and long-term medication.

iii. For Opiates - buprenorphine or clonidine detoxification, long-term medication including opioid substitution (methadone/buprenorphine; opioid antagonists like naltrexone).

1. All drug users need to be evaluated for injecting use, for HIV/STI (including Hepatitis B and C screening) and appropriately treated.

2. There is a need for urgent human resource enhancement.

3. Professional Human Resources in the Prison. [All central prisons must ensure the presence of at least]:

4. 1 doctor for every 500 patients. In addition, every prison must have one each of the following specialists providing care - physician, psychiatrist, dermatologist, gynecologist and surgeon.

5. 2 nurses for every 500 prisoners

iii. 4 counselors for every 500 prisoners. These trained counselors (with a degree in any social sciences/any recognized degree with counseling experience (medical counseling/legal counseling/ psychosocial counseling/rehabilitation/education) can carry out the following tasks

1. Assessment

2. Counseling



3. Crisis intervention (family crisis, bail rejection, verdict pronouncement, interpersonal difficulties, life events, serious physical or psychiatric illness)
4. Legal counseling, pre-discharge counseling
5. Rehabilitation counseling
6. Substance use counseling
7. Training prison staff and peer counselors
8. Inpatient services
9. At least a 20-bedded psychiatric facility for every 500 prisoners
1. Prison aftercare services
2. All prisoners should have pre-discharge counselling on coping strategies, healthy life style practices and support systems they can access
3. For persons with mental illness they shall be referred to any mental health establishment for after care in community
4. Documentation
5. Computerized data base and tracking system for all prisoners
6. Surveillance of health conditions on a regular basis with adequate emphasis on confidentiality and proper information regarding these procedures to the prisoners
7. Health records for prisoners with basic health information, pre-existing health problems, health problems that develop during imprisonment, details of evaluation and treatment, hospitalization details, health status and advice at release

8. This information must be given to the prisoner to facilitate continuing health care after release.
9. All central prisons shall have dedicated tele-medicine services to provide health care
10. Following medicines shall be made available

Risperidone, Olanzapine, Clozapine, Haloperidol, Chlorpromazine, Trihexyphenidyl, Imipramine, Amitriptyline, Fluoxetine, Sertraline, Paroxetine, Valproate, Carbamazepine, Lithium, Clonidine, Atomoxetine, Lorezapam, Diazepam, Oxcarbazepine, Disulfiram, Naltrexone, Acamprosate, Nicotine Gums, Varenicline, InjFluphenazine Inj Haloperidol, InjFlupenthixol, InjLorezapam, Inj Diazepam, Inj Promethazine Inj Thiamine/Multivitamin.



Annexure III

shall forthwith report the fact to the Magistrate within the local limits of whose jurisdiction the person with mental illness resides.

(2) Any person who has reason to believe that a person has mental illness and is being ill-treated or neglected by any person having responsibility for care of such person, shall report the fact to the police officer in-charge of the police station within whose jurisdiction the person with mental illness resides.

(3) If the Magistrate has reason to believe based on the report of a police officer or otherwise, that any person with mental illness within the local limits of his jurisdiction is being ill-treated or neglected, the Magistrate may cause the person with mental illness to be produced before him and pass an order in accordance with the provisions of section 102.

102. Conveying or admitting person with mental illness to mental health establishment by Magistrate. (1) When any person with mental illness or who may have a mental illness appears or is brought before a Magistrate, the Magistrate may, order in writing

(a) that the person is conveyed to a public mental health establishment for assessment and treatment, if necessary and the mental health establishment shall deal with such person in accordance with the provisions of the Act; or

(b) to authorise the admission of the person with mental illness in a mental health establishment for such period not exceeding ten days to enable the medical officer or mental health professional in charge of the mental health establishment to carry out an assessment of the person and to plan for necessary treatment, if any.

(2) On completion of the period of assessment referred to in sub-section (1), the medical officer or mental health professional in charge of the mental health establishment shall submit a report to the Magistrate and the person shall be dealt with in accordance with the provisions of this Act.

103. Prisoners with mental illness. (1) An order under section 30 of the Prisoners Act, 1900 (3 of 1900) or under section 144 of the Air Force Act, 1950 (45 of 1950), or under section 145 of the Army Act, 1950 (46 of 1950), or under section 143 or section 144 of the Navy Act, 1957 (62 of 1957), or under section 330 or section 335 of the Code of Criminal Procedure, 1973 (2 of 1974), directing the admission of a prisoner with mental illness into any suitable mental health establishment, shall be sufficient authority for the admission of such person in such establishment to which such person may be lawfully transferred for care and treatment therein:

Provided that transfer of a prisoner with mental illness to the psychiatric ward in the medical wing of the prison shall be sufficient to meet the requirements under this section:

Provided further that where there is no provision for a psychiatric ward in the medical wing, the prisoner may be transferred to a mental health establishment with prior permission of the Board.

(2) The method, modalities and procedure by which the transfer of a prisoner under this section is to be effected shall be such as may be prescribed.

(3) The medical officer of a prison or jail shall send a quarterly report to the concerned Board certifying therein that there are no prisoners with mental illness in the prison or jail.

(4) The Board may visit the prison or jail and ask the medical officer as to why the prisoner with mental illness, if any, has been kept in the prison or jail and not transferred for treatment to a mental health establishment.

(5) The medical officer in-charge of a mental health establishment wherein any person referred to in sub-section (1) is detained, shall once in every six months, make a special report regarding the mental and physical condition of such person to the authority under whose order such person is detained.

(6) The appropriate Government shall setup mental health establishment in the medical wing of at least one prison in each State and Union territory and prisoners with mental illness may ordinarily be referred to and cared for in the said mental health establishment.

Guidelines of NHRC on "Prevention of Suicide in Prison"

1. A comprehensive suicide prevention programme must be introduced in all prisons by the State/UT Government, involving training of staff involved in correctional home services, health care and mental health of prisoners. The staff should be fully aware and proficient in initiating emergency response to a suicide attempt along with keeping vigil and adopting measures for prevention also. Periodic mock drills/rehearsal should be carried out to sensitize the stake holders and to reduce reaction time in assessment and providing professional assistance.
2. The State Prison Directorate should ensure enhancement of constructive and supportive relationships between prison staff and inmates. Particular emphasis should be placed upon improvement in regimes, staff training and rostering arrangements to enhance these relationships to suit all needs.
3. The newly admitted prisoners should be interviewed by a trained medical officer along with a qualified Psychologist for identification of inmates who appear to be psychologically abnormal and who could be prone to suicidal tendencies. The key to identifying potentially suicidal behaviour in inmates is through careful inquiry/interview and assessment during initial screening of the inmates. The pre-entry/initial health screening report of the prisoner must be filled up in detail and signed by both medical officer and Psychologist after filling all the mandatory information. Initial health assessment must be followed by regular follow up assessment as well.
4. CCTVs should be installed at the reception area and monitored 24x7 through a control room for monitoring effective initial screening.
5. The bandwidth of opportunities for inmates to interact with the outside world may be expanded through provision of news papers, television and movies in addition to periodic meetings with family and friends to maintain their social contacts. The prison environment could also be made less stressful by introduction of Yoga programmes and providing soothing music through speakers installed at appropriate places in consultation with prisoners.
6. Each prisoner/inmate should be provided with the opportunities to participate in constructive activities such as employment, education and skill development programs that build competence levels and address cure depressive



tendencies while simultaneously preventing aggressive behavior. Introduction of outdoor and group activities would bring positive attitude and group bonhomie among the inmates.

7. All aspects of prison operations and programs must be designed to cater to the diversity of the prison population in terms of culture, ethnicity, gender and sentencing status.
8. Priority should be given to provide comprehensive mental health services to prisoners, including:
 - a) Regular multidisciplinary screening and assessment of the mental health of the prisoners. Post of regular medical officers at central prison and weekly visit of a Psychiatrist/doctor to the District jails must be ensured.
 - b) Adequate mental health treatment and management, resources and systems should be made available within the prison including a qualified psychologist so that dependence on external agencies is minimized to extreme cases only.
 - c) Acute mentally ill prisoners must be shifted to Mental Hospital u/s 29 of the Mental Health Act, 1987, and
 - d) Provision should be there in prisons for continued mental care facilities even after specialist management and treatment of a mentally ill prisoner is over so that regular follow up is maintained even after the prisoner returns back into the prison environment, and gets reintegrated into the community.
9. Following points may be covered by suicide awareness training provided to prison officers and staff:
 - a) How to identify inmates with signs of suicidal tendencies and rate them according to the level of their problems.
 - b) Precautions to be taken by the staff monitoring these inmates.
 - c) Basic understanding of human behavior and ability to identify psychosomatic illnesses by observing prisoner's sudden change in behavior.
 - d) Basic training in medical emergency response to all jail officials to respond and provide immediate medical first aid

like cardio-pulmonary resuscitation (CPR) in cases of suicide attempts and other such emergencies till professional help is sought.

e) Identification of good Samaritans among the jail inmates who can keep an eye on prisoners and warn the staff to preempt suicides.

10. Conduct a thorough audit of the jail premises to find out the probable places/areas and items that are prone to be used while committing suicide. This should help in identifying and re-designing 'suicide resistant cells' with the intention of replacing potential hanging and anchoring points.
11. It is also important to strengthen the grievance redressal system in prisons and get regular feedback on quality of food, entertainment and other facilities from prisoners. It is imperative to engage prisoners in positive and constructive activities and also in socially useful productive work, religious activities and motivational therapy through discourses. A complaint box inside the prison could be a useful tool for redressal of complaints and to obtain feedback of inmates. Integration of the records of all the prisoners should be done so that if an under-trial prisoner had been previously incarcerated in a different jail then information about his background, behaviour and treatment records could be obtained from there and the same will be useful to the jail officials in his screening and assessment.
12. There should be rigorous review and intensive follow up of each suicide case to find out and alleviate the particular reasons behind the suicide and the steps to be taken so that such an occurrence in future is prevented.



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