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Mental Health Policies and Laws in India: A Critical Review of Historical Evolution, Legislative Frameworks, Policy Architecture, and Programmatic Responses

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Abstract

Mental health policy in India has experienced an extensive and uneven shift from asylum-centric governance and custodial management to a rights-based, community-oriented framework that aims to integrate mental healthcare within public health services. In order to analyse India's mental health trajectory from colonial-era lunatic laws to current legislation and programs, this review study synthesises secondary literature and reliable online sources, such as peer-reviewed papers, official policy documents, and statutory texts. The research highlights (i) the political and historical foundations of mental health legislation; (ii) the institutional and conceptual changes brought about by the Mental Healthcare Act (2017), the National Mental Health Programme (1982), and the National Mental Health Policy (2014);
and (iii) the emergence of instructional psychosocial programs and tele-mental health in the post-COVID era. Although India's recent reforms—especially the Mental Healthcare Act, 2017—reflect a strong normative commitment to dignity, autonomy, non-discrimination, and access, the paper contends that implementation is still hampered by underfunding, workforce disparities, uneven federal capacity, fragmented governance, and enduring stigma. A policy agenda centred on bolstering community mental health systems, guaranteeing enforceable funding and accountability, integrating promotion and prevention across sectors (education, labour, social welfare), and developing strong monitoring frameworks to convert rights "on paper" into lived entitlements is presented at the end of the review.

Keywords: Mental health law, Mental Healthcare Act 2017, National Mental Health Programme, National Mental Health Policy 2014, DMHP, Tele-MANAS, India, mental health promotion, human rights.

I. Introduction:

Why Mental Health Policy and Law Matter in India

Mental health is increasingly being recognised as a public health, development, and human rights priority rather than just a therapeutic field. In India, poverty, gendered limitations, educational expectations, unstable work, displacement, and social isolation all have a significant impact on the burden of mental diseases. Because of these connections, mental health governance is no longer solely a biological endeavour but rather a social and political one. However, there has long been a persistent treatment gap, unequal access to care, and high levels of stigma associated with mental health services in India, all of which influence patterns of help-seeking and service access (Gururaj et al., 2016; Shidhaye& Kermode, 2013).

The absence of policy texts is not the primary problem. India currently has an advanced rights-based law, a national mental health program, and a specific mental health strategy. However, the more important question is whether these tools work together to effectively promoting mental health and provide accessible care, particularly for underprivileged groups. If state resources, spending, and service delivery do not align with legal obligations, rights may continue to be symbolic. As a result, this assessment takes a critical stance, questioning how laws and policies have changed over time, what institutional presumptions they incorporate, and what obstacles to execution still exist.

Objectives of the review:

1. To trace the historical evolution of mental health laws in India from colonial regulation to contemporary reforms.
2. To examine the architecture of mental health policy and programmes—especially NMHP, DMHP, and the 2014 policy.
3. To analyse the Mental Healthcare Act, 2017, as a rights-based shift and evaluate its implementation challenges.

4. To map modern initiatives (Tele-MANAS, KIRAN, Manodarpan, school health and wellness) in the context of promotion and prevention.
5. To identify structural gaps and propose policy directions grounded in evidence and human rights.

II. Methodology:

Secondary Data–Based Review Design

This paper is a secondary data–based narrative and critical review. Sources were selected from:

- **Peer-reviewed review articles and empirical studies** available online (PubMed/PMC and publisher sites);
- **Official Government of India websites** (MoHFW/NHM/DGHS, portals for Tele-MANAS and education initiatives);
- **National surveys/reports** (National Mental Health Survey 2015–16);
- **Statutory legal texts and bills** supplied by the user (Mental Healthcare Act, 2017; Mental Healthcare (Amendment) Bill, 2023; and a human rights–oriented chapter on Indian mental health legislation).

Instead of doing a systematic review of clinical results, the evaluation prioritises thematic synthesis and institutional analysis, concentrating on rights, governance structures, finance commitments, staff capability, program rationale, and implementation constraints.

The Mental Healthcare Act, 2017 A2017-10 and the Mental Healthcare (Amendment) Bill, 2023 _BillsTexts_RSBillTexts_Asintro are two important legal papers that were employed. Peer-reviewed evaluations of India's legal reforms are added to the review, which also draws upon a thorough Indian viewpoint on mental health legislation and human rights. Mental-HealthCare-and-Human-Rig.

III. Historical Evolution:

From Custodial Regulation to Rights Discourse

3.1 Colonial roots and the custodial paradigm

The colonial endeavour of classification and control is permanently linked to the history of mental health law in India. The structural requirements of the colonial state, in particular the management of asylums and the confinement of those considered "lunatics," influenced early regulation. The Indian Lunacy Act (ILA), 1912, which is regarded as a fundamental piece of legislation managing mental health in colonial India, was a significant consolidation of such frameworks (Firdosi, 2016).

Custodial presumptions predominated in this early legal framework, which prioritised administrative administration and public order while framing mental illness as a condition necessitating incarceration. It was implied that people with mental illnesses were subjects to be managed through institutionalisation rather than rights-bearing citizens entitled to care.

3.2 Post-independence attempts: Mental Health Act 1987

India progressively worked to modernise colonial laws after attaining independence. The colonial lunacy legislation was superseded by the Mental Health Act of 1987, which also established mental health agencies and regulations for nursing homes and psychiatric hospitals. However, critical research points out that the Act continued to be mostly institution-centric, with little focus on social inclusion, consent, rehabilitation, and community-based care. A thorough human rights-focused analysis of Indian mental health laws highlights the fact that early mental health laws around the world were initially created to shield the public from "dangerous" patients, and that a paradigm shift toward community care only later took hold as a result of treatment advancements and human rights movements (Math &Nagaraja, 2010). Human Rights and Mental Health Care.

3.3 The reform moment: Mental Health Care Bill and the road to MHCA 2017

During the Mental Health Care Bill phase, discussions surrounding India's proposed reforms became more heated, leading to the Mental Healthcare Act, 2017. This legislative activity is monitored by academics as part of a larger endeavour to harmonise domestic law with human rights frameworks and international standards (Firdosi, 2016).

IV. System and Epidemiological Context:

The Need for Reform

The realities of prevalence, service access, and treatment gaps must be taken into consideration when reviewing mental health laws and policies. A key source of information is still the National Mental Health Survey (NMHS) 2015–16, which was conducted by NIMHANS with government assistance. According to Gururaj et al. (2016), the survey offers nationally applicable insights about prevalence patterns, care-seeking behaviours, and system constraints.

The NMHS also highlights systemic constraints, such as insufficient integration of mental healthcare

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into regular public health delivery, a lack of qualified caregivers, and under-availability of services at the district and primary levels. These circumstances establish the context for the assessment of rights-based legislation. The reasoning is simple: if services are lacking or inaccessible, legal rights to access and nondiscrimination become vulnerable.

Stigma exacerbates the issue of access. According to a widely recognised assessment by Shidhaye and Kermode (2013), stigma and prejudice are major obstacles to the use of mental health services in India, influencing not just whether individuals seek care but also how families and communities react to mental distress.

V. Policy Architecture:

National Programmes and the 2014 Mental Health Policy

5.1 National Mental Health Programme 1982: ambitions and structural constraints

The **National Mental Health Programme (NMHP)**, launched in 1982, is largely acknowledged as an early and ambitious endeavour to increase access outside of specialised hospitals and incorporate mental health into general health services. The goals of NMHP are outlined on official government portals in terms of integrating services into larger health systems and providing universal and equitable access to high-quality mental healthcare (DGHS/MoHFW).

However, NMHP's history also highlights the contrast between vision and implementation. According to recent academic studies, NMHP's development was impacted by early Indian community psychiatry initiatives and global health innovations like Alma-Ata, but it continued to experience difficulties with service delivery and scale-up (Gangadhar, 2023).

5.2 District Mental Health Programme (DMHP): community reach and uneven roll-out

The **District Mental Health Programme (DMHP)** has become a crucial tool for operationalising NMHP through services provided at the district level. However, the efficacy and reach of DMHP have differed greatly amongst states. The availability of experts, administrative dedication, and financial stability are frequently critical factors in implementation. In reality, many DMHPs have struggled to maintain community participation, rehabilitation, and psychosocial interventions—exactly the categories required for mental health promotion—while focusing on outpatient services and pharmaceutical availability.

5.3 National Mental Health Policy 2014: conceptual shift to rights and promotion

The **National Mental Health Policy of India (2014)**is a crucial text because it clearly views mental health from the perspectives of rights, equity, justice, participation, and quality. Reducing the treatment gap and disability burden is emphasised in the policy text, which also highlights the importance of prevention and promotion in the national response.

The 2014 policy is strongly aligned with rights-based approaches and aims to integrate mental health care into a socially integrative, destigmatising framework, according to academic evaluations (Gupta, 2021).

Critical gap: However, policy documents are not always enforceable. Policies may serve as aspirational declarations rather than practical roadmaps in the absence of statutory force, goals, and funding sources. When contrasted with the more stringent legal requirements established by the MHCA 2017, this becomes quite important.

VI. The Mental Healthcare Act, 2017:

Rights-Based Legislation and Its Implications

The **Mental Healthcare Act, 2017 (MHCA)** is the most significant contemporary legal development in India's mental health governance. The Act's declared purpose is to provide mental healthcare and services and to "protect, promote and fulfil the rights" of persons with mental illness. A2017-10

6.1 Central rights and entitlements under MHCA 2017

A defining feature of MHCA is its explicit articulation of rights:

- **Right to access mental healthcare** (including affordability, quality, and availability without discrimination). A2017-10
- **Right to community living** and protection against segregation solely due to lack of family or community facilities. A2017-10
- **Right to protection from cruel, inhuman, and degrading treatment**; and **rights to dignity, privacy, confidentiality**, and access to information. A2017-10
- **Insurance parity**: The Act requires insurers to provide for mental illness treatment on the same basis as physical illness. A2017-10

As a result, the law incorporates a normative change: mental illness is now viewed as a basis for

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rights and safeguards rather than as a primary reason for incarceration. According to legal and human rights literature, this represents the wider global shift from custodial care to rights-based governance (Math &Nagaraja, 2010). Human Rights and Mental Health Care

6.2 Advance directives, nominated representatives, and supported decision-making

In order to institutionalise autonomy and facilitate decision-making, MHCA introduces prior directives and designated representatives. These represent a political and ethical position that acknowledges people with mental illness as decision-capable subjects in need of support rather than agency substitution; they are not only procedural advances. A2017-10

6.3 Institutional architecture: Authorities and Review Boards

In order to monitor rights abuses, establish accountability mechanisms, and regulate institutions, the Act creates Central and State Mental Health Authorities and Mental Health Review Boards. 2017–10

6.4 Scholarly interpretation: strength and controversy

Duffy and Kelly (2019) highlight MHCA as an unusually expansive legal commitment—granting a legally binding right to mental healthcare to a massive population—while also noting the political and practical difficulties of implementing such rights in resource-limited settings.

6.5 Implementation challenges: rights without services?

The central critique that emerges across scholarship is that rights may become symbolic if systems cannot deliver services. Implementation demands:

- workforce expansion and training;
- district-level service availability;
- financing adequate to ensure free care for eligible groups;
- functional Review Boards and grievance mechanisms;
- Coordination with police, prisons, and social welfare institutions.

According to NMHS studies and program reviews, these are exactly the areas where India's health system limitations are still evident (Gururaj et al., 2016; Gangadhar, 2023).

VII. Mental Health Prevention and Promotion: From Institutional Practice to Rhetoric

Though its institutionalisation is unequal, mental health promotion is often mentioned in policy discourse. Promotion necessitates going beyond therapy to address social determinants such as education, employment, gender violence, and social exclusion, as well as protective factors and community resilience.

7.1 MHCA's explicit duties to governments

MHCA 2017 includes a chapter on duties of the appropriate government; these duties include promoting mental health, preventive programs, reducing stigma, raising awareness, and developing human resources. 2017–10

Promotion and prevention are portrayed as legislative obligations rather than as discretionary public messaging, which is a significant legal recognition.

7.2 Education sector turn: Mental Healthcare (Amendment) Bill, 2023

The amendment bill is important because it reflects a newer policy imagination where mental health is linked directly to student wellbeing and institutional responsibility within educational settings.

While the details require careful interpretation within the bill's text, its broad direction aligns with a growing post-COVID policy emphasis on adolescent and youth mental health.

7.3 Stigma reduction as promotion: what literature shows

Promotion efforts cannot succeed if stigma continues to block help-seeking. Shidhaye and Kermode's (2013) review is especially useful here because it frames stigma not simply as "lack of awareness," but as a structural barrier embedded in social relations, community narratives, and discriminatory practices.

VIII. Programmes in the Modern Scenario: Digital and Community Innovations

8.1 Tele-MANAS: national tele-mental health infrastructure

The post-pandemic period has seen a major expansion of tele-mental health services. The Government of India's **Tele-MANAS portal** positions the initiative as free 24/7 mental health support with multilingual availability and a national helpline (14416 / 1800-891-4416).

Policy communication from government sources also describes Tele-MANAS as organised through a tiered structure (state cells with trained counsellors and referral mechanisms).

Critical evaluation: Tele-mental health can reduce barriers related to distance and stigma, but it also raises concerns about (i) digital exclusion for those without stable phone access; (ii) continuity of care after counselling; (iii) referral bottlenecks in districts with limited clinical services; and (iv) confidentiality and data governance. These concerns are not arguments against tele-mental health; they are reminders that tele platforms are not substitutes for strong local services.

8.2 KIRAN helpline and crisis support

In 2020, the **KIRAN** national mental health rehabilitation helpline was launched by the Ministry of Social Justice and Empowerment (PIB release).
Peer-reviewed discussion of the helpline during COVID-19 highlights KIRAN as a national multilingual, toll-free service aimed at mental health support and suicide prevention (Ransing et al., 2020).

8.3 Manodarpan: psychosocial support for students

The **Manodarpan initiative**, hosted by the Ministry of Education, explicitly addresses psychosocial support for student mental health during and beyond COVID-19, providing resources and counselling linkages.

8.4 School Health & Wellness Programme under Ayushman Bharat

Mental health promotion is also embedded in broader school health planning under Ayushman Bharat's Health and Wellness component. The NHM portal describes the School Health & Wellness Programme as incorporating school-based health promotion activities, implemented in government and aided schools.
This is crucial because it signals institutional mainstreaming: mental health and emotional well-being are treated as part of a broader health and wellness curriculum rather than a narrow clinical add-on.

8.5 Primary care integration: Health & Wellness Centres / AyushmanArogyaMandir

India's comprehensive primary healthcare strategy aims to strengthen service delivery through Health & Wellness Centres, supported by operational guidelines.
Although primary care integration is often described as a cornerstone of mental healthcare reform, implementation depends on trained personnel, medicine availability, referral pathways, and community engagement—exactly the domains in which DMHP has historically struggled.

IX. Evidence from Research: What Works, What Scales, What Fails

9.1 Community-based care and task-sharing: COPSI trial

A landmark randomised controlled trial—**Chatterjee et al. (2014)**—evaluated a collaborative community-based intervention for people with schizophrenia in India (the COPSI trial). The study provides evidence that community health workers supervised by specialists can deliver meaningful care and reduce disability compared to facility-based care alone.
Why this matters for policy: it demonstrates that India's reliance on scarce specialists is not the only feasible model. Task-sharing and community approaches can be designed in ways consistent with rights and community living provisions under MHCA 2017.

9.2 Stigma and service utilisation

As noted, stigma is not merely an attitudinal problem but a practical barrier to service use and social inclusion (Shidhaye& Kermode, 2013).
This suggests promotion strategies must include sustained social interventions—school-based normalisation, workplace programmes, community campaigns, and legal literacy—rather than sporadic awareness events.

9.3 Policy assessment and critique

Gupta (2021) provides a structured discussion of India's 2014 policy and its alignment with rights-based principles and equity, while also drawing attention to the need for stronger implementation mechanisms.
Gangadhar (2023) offers a contemporary review of NMHP's trajectory, framing it as a programme whose promise has expanded but whose delivery remains constrained by structural challenges.

X. Cross-Cutting Implementation Challenges

10.1 Financing and prioritisation

A persistent theme across mental health governance in India is that commitments outpace budgets. Laws such as MHCA explicitly speak of adequate and equitable budgetary provisions for effective implementation, including access to essential medicines. A2017-10
Yet evidence from surveys and programme experiences suggests underfunding remains one of the most serious constraints.

10.2 Human resource deficits and training

Workforce shortages are widely acknowledged: psychiatrists, clinical psychologists, psychiatric social workers, mental health nurses, counsellors, and community-level staff are insufficient relative to population needs. MHCA requires governments to take measures for human resource development and training. A2017-10

Without scaling training pipelines and supervision structures, service availability and promotion activities cannot be sustained.

10.3 Governance fragmentation and federal variation

Health is substantially a state responsibility in India's federal structure. This produces wide inter-state variation: some states establish functional authorities and programmes, while others lag in implementation. Rights under MHCA require institutional mechanisms like Review Boards; uneven roll-out directly undermines equal citizenship entitlements.

10.4 Continuity of care and rehabilitation

Even earlier legal critiques emphasised that rehabilitation and aftercare were often neglected, leading to long-term institutionalisation and "dumping grounds" dynamics (Math &Nagaraja, 2010). Mental-HealthCare-and-Human-Rig…

MHCA's right to community living and obligations for community-based facilities make rehabilitation central, but implementation requires inter-sectoral coordination with social welfare, housing, disability services, and employment schemes.

10.5 Police, prisons, and custodial settings

Mental illness within prisons and custodial institutions raises complex ethical and legal issues. Earlier analyses highlight the need for systematic mental health assessment and standards in prisons (Math &Nagaraja, 2010). Mental-HealthCare-and-Human-Rig…

MHCA includes duties for other agencies (police, prisons), but operational clarity and enforcement depend on administrative training and resources.

The most significant implementation gaps persist despite the Mental Healthcare Act of 2017's positive improvements. Because there are no clear operational rules, police and hospitals frequently pursue criminal procedures, creating ambiguity in the decriminalization of suicide due to the continuous existence of Section 309 of the IPC (Mishra &Galhotra, 2018; Pathare et al., 2021).

Additionally, livelihood insecurity—a significant factor in psychological distress among farmers, migrant workers, and informal labourers—is not adequately addressed by mental health policies, particularly in the post-COVID era characterized by job loss and stress related to debt (Kumar et al., 2021; Deshpande&Arora, 2022).

Although access to digital mental health services like Tele-MANAS has improved recently, worries about data privacy, consent, and continuity of care still exist, especially in light of the Digital Personal Data Protection Act, 2023 (Mehta & Bhatia, 2024).

Furthermore, new issues including older adults' mental health, caregiver stress, and psychosocial stress connected to climate change and disasters are still poorly included into current frameworks for mental health governance (Patel et al., 2023; Charlson et al., 2021).

XI. Discussion:

Interpreting India's Mental Health Governance Trajectory

India's mental health policy evolution can be read as a slow shift across three overlapping paradigms:

1. **Custodial-administrative paradigm** (colonial laws; early postcolonial institutional care): mental illness as threat and object of confinement.
2. **Public health integration paradigm** (NMHP/DMHP): mental health as part of general health systems, though often limited by specialist dependence and uneven implementation.
3. **Rights-based and community living paradigm** (MHCA 2017; policy 2014; post-COVID digital and school initiatives): mental health as citizenship entitlement, autonomy, non-discrimination, and social inclusion.

However, the shift is incomplete. Rights-based law sets high standards, but if district and primary services remain weak, people may have enforceable rights in principle but not in practice. Tele-mental health and school-based initiatives represent a significant modernisation, yet they must connect to robust on-ground services to avoid becoming "front doors" without functioning rooms behind them.

12. Recommendations: Toward Implementable Rights and Effective Promotion

Based on the reviewed evidence, a realistic policy agenda would include:

1. **Make MHCA implementation measurable:** publish state-wise dashboards tracking Review Board formation, service availability, complaint redressed, and community facilities.
2. **Ring-fence mental health financing:** link budget allocations to NMHP/DMHP indicators and MHCA obligations,

including essential medicines and free services for vulnerable groups. A2017-10

3. **Scale task-sharing with supervision:** use models supported by evidence, such as COPSI-style community interventions (Chatterjee et al., 2014).
4. **Strengthen promotion beyond awareness days:** embed stigma reduction and mental health literacy across schools, workplaces, panchayats, and community institutions (Shidhaye& Kermode, 2013).
5. **Integrate tele-mental health with local care pathways:** Tele-MANAS should have clear district referral protocols, follow-up systems, and coordination with DMHP.
6. **Institutionalise student wellbeing:** align the 2023 amendment directions with Manodarpan and School Health & Wellness Programme implementation, including trained counsellors and referral systems. _BillsTexts_RSBillTexts_Asintro…
7.
8. **Develop community rehabilitation infrastructure:** halfway homes, supported housing, vocational rehabilitation, and family support services in collaboration with social welfare departments—key to realising the right to community living. A2017-10

XII. Conclusion

India's mental health governance has moved decisively away from colonial custodial models toward an ambitious rights-based and community-oriented framework. The National Mental Health Policy (2014) and the Mental Healthcare Act (2017) articulate a vision of equity, dignity, autonomy, and social inclusion, while newer initiatives such as Tele-MANAS, KIRAN, Manodarpan, and school wellness programmes reflect policy modernisation and a stronger emphasis on promotion and prevention.

Yet the fundamental challenge remains implementation. Rights cannot function as lived entitlements without service infrastructure, workforce capacity, budgets, and accountable governance. The next phase of reform must therefore focus less on expanding the normative horizon—which India has already done impressively—and more on building the institutional and financial architecture needed to deliver mental health promotion and care close to where people live, study, and work.

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