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MENTAL HEALTHCARE ACT, 2017: A HOLLOW PROMISE? EVALUATING IMPLEMENTATION GAPS IN RURAL INDIA

AUTHORED BY - RISHABH SHARMA & MANI YADAV

Abstract

The Mental Healthcare Act (MHA) 2017 is a landmark legislation in India, which envisions right based mental health care, and decriminalization of suicide. But in rural India, there are challenges to its implementation and the socially disadvantaged continue to fall through the cracks. This article examines the deficiencies in MHA 2017 on the ground in its intended rural setting, discussing barriers to effective implementation at the systems level (eg. Infrastructure gaps, workforce shortages, cultural stigma, and lack of funding). Based on mixed-method research which included literature reviews, National Mental Health Survey data, and case studies across Gadchiroli (Maharashtra), the report documents how these gaps contribute to the perpetuation of human rights violations, socioeconomic loss, and intergenerational trauma. The paper concludes with pragmatic policy considerations such as scaling up infrastructure with telepsychiatry and mobile health units, improving community engagement through bottom-up campaigns and school-based programs, and optimizing funding and accountability structures. By responding to these obstacles, India may narrow the treatment gap and deliver fair mental health care to its rural population, translating normative into action and rhetoric into results.

Keywords: Mental Healthcare Act 2017, rural India, implementation gaps, mental health stigma, telepsychiatry, policy recommendations.

In Jharkhand's distant villages, a family faces a silent crisis. A middle-aged farmer, who was the mainstay of his family, is now suffering from chronic depression and cannot work or take care of his family. His wife, weighted down by farm work and housework, tries to feed their children while dealing with her husband's declining mental health. Limited access to health care facilities and stigma associated with mental illness leads the family to traditional healers, where they hope to find solace through rituals and remedies but finds little comfort. This is far from an isolated example, but rather a jarring microcosm of unfolding mental health related

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death in rural India — a testament to how legislative promises do not always equate with meaningful support.

Despite its economic progress, India still has a significant burden of mental health. According to WHO, with 18% of the world population, India contributes with 2,443 disability-adjusted life years (DALYs) per 10,000 of the population due to mental health issues.[1] The overall age-adjusted suicide rate is a disturbing 21.1 per 100,000 population, and the economic burden attributable to mental health disorder from 2012 to 2030 is estimated to be USD 1.03 trillion.[2] Awareness regarding this issue can be traced back to the mental healthcare legislation in 1987[3], and its failing, and subsequently, the enactment of the Mental Healthcare Act by the Indian government in 2017.[4] A much-needed attention to mental health care was bridged by the 2017 Mental Healthcare Act (MHA 2017) that made suicide non-punishable and enabled rights-based care of the individuals with mental illness in accordance with the framework of the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[5] The Act focuses on the human rights, legal capacity, equality, and dignity of persons with mental illness (PMI), promoting community-based treatment for PMI, and protecting them from human rights violations, stigma, and discrimination.[6]

Though the MHA 2017 is meant as a progressive step, its implementation remains a near-impossible task in the rural parts of India. Globally, it has been observed that nearly 15% of India's adult population suffer from mental health issues which require treatment; however, there remains a treatment gap wherein 70% to 92% of the affected population do not seek treatment.[7] This discrepancy is even greater in rural regions, where psychiatric institutions are limited, poorly equipped, and frequently uncomfortable to use. According to the National Mental Health Survey (NMHS) 2015-16, urban metro regions (13.5%) showed higher prevalence of mental disorders in comparison to rural areas (6.9%), which hints towards higher underreporting or lack of awareness in rural settings.[8] In addition, India only has 0.75

[1] World Health Organization, Mental Health – India, WHO, https://www.who.int/india/health-topics/mental-health (last visited Apr. 24, 2025).
[2] Id.
[3] *Mental Health Act*, No. 14 of 1987, Acts of Parliament, 1987 (India).
[4] *Mental Healthcare Act*, No. 10 of 2017, Acts of Parliament, 2017 (India).
[5] Id. Sec. 115.
[6] Rakesh K. Chadda, Influence of the New Mental Health Legislation in India, 17 BJPsych Int'l 20 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8277537/.
[7] National Institute of Mental Health and Neurosciences, *National Mental Health Survey of India, 2015–16: Summary*, at 2–3 (2016), https://indianmhs.nimhans.ac.in/phase1/Docs/Summary.pdf.
[8] Id at 15.

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psychiatrists per 100,000 people, which is significantly below the WHO-recommended number of at least 3 per 100,000, further aggravating the workforce shortage, especially in rural areas.[9] The chronic implementation gaps were also attributed to the shortage of mental health providers, a socio-cultural barrier including stigma, lack of awareness about treatment options as well as continued reliance on traditional healers.

This study aims to critically assess the application of the MHA 2017 in rural India, analysing the gaps between legislative intent and the lived reality of rural vulnerable populations. It seeks to address the following key research questions:

- What are the key barriers to implementing the MHA 2017 in rural India?
- How do these gaps affect vulnerable populations, particularly women, marginalized communities, and those living in poverty?
- What policy measures can address these challenges and ensure equitable access to quality mental healthcare in rural India?

To answer these questions fully, a mixed-methods approach will be used in this study. Thus, the proposed solution entails a comprehensive literature review regarding mental health policy and implementation in India, conducting in-depth analysis of the National Mental Health Survey (NMHS) data for trend and disparity analysis of mental health outcomes, and stakeholder data of rural healthcare workers to get a primary account on enablers and barriers related to MHA 2017 implementation. The purpose of this study is to combine these multiple sources of evidence to gain a better understanding of the implementation gap and establish evidence-based policy recommendations to resolve the mismatch of promises made by the legislature that are not being realized within rural India.

The MHA 2017: Key Provisions and Promises

In spite of advancements in medical science, India is burdened with high mental health burden that affects the personal, social and economic lives of individuals, Identifying this challenge and echoing the UN Convention on the Rights of Persons with Disabilities, the Indian government passed the Mental Healthcare Act (MHA) in 2017 replacing the Mental Health Act of 1987. Likewise, the MHA 2017 was heralded as a gamechanger in the realm of mental healthcare, focused on a rights-based approach and incorporating mental health services within the mainstream of healthcare.[10] This chapter explores the main provisions and promises of the

[9] Id at 32.
[10] Supra note 6.

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MHA 2017 in the evidential context against the anticipated transformational impact on mental healthcare in rural India which faces acute challenges.

Rights-Based Framework

Since the MHA 2017 advances a rights based framework - it advocates for the respect and rights of individuals with mental illness. This framework is based on several central provisions:

- **Decriminalization of Suicide (Section 115):** One of the landmark provisions in the MHA 2017 is in relation to the decriminalization of suicide attempts.[11] Acknowledging that persons who are committing suicide are often in a state of significant stress, the Act provides that such persons are presumed to need care, treatment and rehabilitation, rather than punishment. Section 115 requires the government to offer this (recurrence-reducing) care.[12] This change is meant to challenge the stigma surrounding suicide and encourage individuals to seek help. But abetment of suicide is still an offence punishable offense[13], highlighting the complex legal landscape surrounding suicide attempts.
- **Access to Affordable Care (Section 18):** The Act highlights the right to access affordable, good quality and geographically accessible mental healthcare services without discrimination.[14] It requires the government to offer a variety of services such as outpatient and inpatient treatment, rehabilitation in halfway homes, and community-based rehabilitation.[15] Treatment and services should be provided free of cost for those living below the poverty line or living in destituteness or homeless.[16] The Act also requires insurers to offer coverage for mental illness at the same level as coverage for physical illnesses which addresses a major barrier to access.[17]
- **Advance Directives and Nominated Representatives (Sections 5–6):** There are provisions in the MHA 2017 for advance directives, allowing individuals to make advance directives outlining their wishes regarding their treatment even when they

[11] Supra note 4 at Sec. 115.
[12] Laxmi Naresh Vadlamani & Mahesh Gowda, Practical Implications of Mental Healthcare Act 2017: Suicide and Suicide Attempt, 61 Indian J. Psychiatry 220 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6482674/.
[13] Bharatiya Nyaya Sanhita, Sec. 108, No. 45 of 2023, Acts of Parliament, 2023 (India).
[14] Supra note 4 at Sec. 18(2).
[15] Supra note 4 at Sec. 18(4)
[16] Supra note 4 at Sec 18(5).
[17] Supra note 4 at Sec. 21(4)

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may be unable to do so due to a lack of capacity.[18] These directives may specify preferred and/or nonpreferred care and may designate a named proxy to make decisions for the patient. This clause is meant to preserve the autonomy of individuals even when they are unable to communicate their will. These advance directives may be contested in the Mental Health Review Board (MHRB) to mitigate abuse.[19] The nominated representatives have to take into account the wishes, life history, values, and best interest of the individual when making decisions.

Institutional Mechanisms

To operationalise the rights-based framework, the MHA 2017 sets up institutional mechanisms for implementation and oversight:

- **Mental Health Review Boards (MHRBs):** MHRBs are quasi-judicial institutions constituted at the state level to safeguard the rights of persons with mental illness and monitor the appropriate implementation of the Act.[20] MHRBs are headed by a District Judge and include representatives from the District Collector's office, psychiatrists, medical practitioners and NGOs.[21] They review advance directives, appoint suggested representatives, and make final decisions on complaints involving service deficiencies and rights violations. MHRBs also render the views of experts to the courts on issues concerning mental illness.
- **Integration with Primary Healthcare (Ayushman Bharat):** Realizing that the mental healthcare needed to be decentralized and access in rural areas was lacking, the MHA 2017 resonates with the Ayushman Bharat program.[22] This initiative aims to integrate mental health services with the primary health care in Health and Wellness Centres (HWCs). Accredited Social Health Activists (ASHAs) are trained in the identification of individuals with mental health issues, to provide basic supports and referral.[23] The integration aims to utilise the existing primary healthcare infrastructure and workforce to address the treatment gap in rural India.

MHA is one of the milestone in the journey to ensuring rights and well-being of people with

[18] Supra note 4 at Sec. 5.
[19] Supra note 4 at Sec. 5(3)
[20] Supra note 4 at Sec. 73.
[21] Supra note 4 at Sec. 74.
[22] Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PM-JAY), About PM-JAY, Nat'l Health Auth., https://nha.gov.in/PM-JAY (last visited Apr. 24, 2025).
[23] National Health Systems Resource Centre (NHSRC), MNS Care Training Manual for ASHA 42 (2021), https://nhsrcindia.org/sites/default/files/2021-12/MNS%20Care%20Training%20Manual%20for%20ASHA.pdf.

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mental illness in India. Its rights-based structure and institutional apparatus have the potential to revolutionise mental healthcare, especially in neglected rural regions. The Act aims to establish a more humane and equitable system of mental healthcare by decriminalizing suicide, making access to affordable care a right, and empowering people to make their own choices as to their own care. But the MHA 2017 will be successful only if implemented effectively — a systemic challenge involving resource and workforce deficiencies, and societal stigma and discrimination. In the following chapters, we will focus on these implementation gaps and examine to what degree the promises of the MHA 2017 are being realized in rural India.

Implementation Gaps in Rural India

The Mental Healthcare Act (MHA), 2017 was enacted with a lofty aim of enabling access to quality mental healthcare and protecting the rights of persons with mental illness (PMI). It included forward-looking elements such as advanced directives and appointed agents. However, the promise of the MHA has the potential to become an empty promise particularly, in rural India, where systemic challenges block its effective implementation. Despite accounting for 68.8% of the population previously estimated as 1.3 billion (Census of India 2011), rural India carries a disproportionate burden of mental illness along with unique barriers to care.[24] This chapter explores the key implementation gaps that can undermine the aims of the MHA in rural India like infrastructure deficits, awareness and stigma and resource allocation, as well as a qualitative case study analysis tying all these challenges together.

Infrastructure Deficits

Rural India already has a huge deficit in mental health infrastructure, which is a major barrier to the effective implementation of MHA. It has a stark shortage of mental health professionals. Indeed, where the World Health Organisation (WHO) recommends a minimum of 3 psychiatrists per 100,000, India has only 0.75, but the situation in the rural areas is even more dire with a correspondent ratio of 1/200,000.[25] This shortage drastically hampers access to specialized care, leaving many without treatment. Additionally, although the government has approved 25 Centres of Excellence to prepare more postgraduate students for mental health and 47 PG Departments in mental health in government medical colleges were upgraded,[26] The

[24] Swarthout M.D. et al., Perceptions of ASHA workers in the HOPE collaborative care mental health intervention in rural South India: a qualitative analysis, 11 BMC Health Serv. Res. 1311 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8573636/ (last visited Apr. 24, 2025).
[25] Supra note 7.
[26] Ministry of Health & Family Welfare, Measures taken to Improve Mental Healthcare,

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number of new posts in rural areas is encouraging but it's hope for rural impact remains to be seen.

In addition to a shortage of professionals, the non-functioning of MHRBs and rehabilitation centers worsens the situation.[27] The MHA mandates the formation of MHRBs, which aim to protect the rights of the patients, at the district level, however, their operationalization has been slow. In the same vein, because of the lack of rehabilitation centers, patients with chronic mental illness do not have the needed help for recovery and reintegration into the society.

The reliance on government facilities for healthcare in rural areas underscores the need for better infrastructure. A survey indicated that 55% of rural residents depend on government secondary-level facilities, and 43% use government primary healthcare facilities for minor ailments.[28] For critical illnesses, 60% rely on government secondary-level facilities.[29] However, these facilities are often ill-equipped to handle mental health issues. Telemedicine, while promising, remains underutilized, with only 9% of rural residents having accessed such services.[30] Moreover, 83% of facilities in the North region lack telemedicine services, highlighting regional disparities.[31] Although the government has upgraded over 1.73 lakh Sub Health Centres (SHCs) and Primary Health Centres (PHCs) to Ayushman Arogya Mandirs and added mental health services under Comprehensive Primary Health Care,[32] The effectiveness of these measures requires further evaluation. Migration for better healthcare facilities is common, with 58% of rural residents reporting this trend in their communities, especially in the Northeastern states (84%),[33] indicating the inadequacy of local infrastructure.

https://mohfw.gov.in/?q=pressrelease-200 (last visited Apr. 24, 2025).

[27] Mishra G.C. & Das S., Is the Mental Healthcare Act 2017 fully implementable in the Indian context?, 13 Odisha J. Psychiatry 7 (2022), https://journals.lww.com/odjp/fulltext/2022/07000/is_the_mental_healthcare_act_2017_fully.3.aspx (last visited Apr. 24, 2025).

[28] Tribal Health Resource Network, State of Health in Rural India, at 7 (May 2024), https://www.trif.in/wp-content/uploads/2024/05/State-of-health-in-Rural-India.pdf (last visited Apr. 24, 2025).

[29] Id. at 21.

[30] Id. at 17.

[31] Id.

[32] Press Info. Bureau, Union Minister Dr. Mansukh Mandaviya chairs the 16th Central Council of Health and Family Welfare (CCHFW), https://pib.gov.in/PressReleasePage.aspx?PRID=2100706 (Jan. 19, 2025) (last visited Apr. 24, 2025).

[33] Supra note 28 at 13.

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Awareness and Stigma

Low awareness of legal rights and persistent stigma surrounding mental illness are formidable barriers to the MHA's effective implementation in rural India.[34] Many rural residents are unaware of the rights and protections afforded to them under the MHA, hindering their ability to seek redress for violations. Stigma, deeply entrenched in cultural beliefs, further deters help-seeking behavior.

Traditional beliefs often attribute mental illness to supernatural causes or past sins,[35] leading families to seek help from traditional healers rather than mental health professionals. In fact, 70-80% of the rural population with mental illness initially consult traditional healers.[36] This preference for traditional medicine, while culturally relevant, can delay access to evidence-based treatments. Even when PHCs offer treatment for mental and physical abuse, awareness remains low, with only 28% of respondents aware of such provisions.[37]

Studies have shown that ASHA workers, who are crucial in bridging the healthcare gap in rural areas, often hold stereotyped beliefs about people with mental illness and have limited understanding of clinical depression.[38] However, interventions like the HOPE study have demonstrated that training can improve ASHA workers' understanding of mental illness and reduce stigma.[39] Prior to the HOPE study, many ASHA workers believed that mental illness was caused by evil spirits and that patients do not improve.[40] Post-intervention, most understood that mental illness is a treatable condition. The National Suicide Prevention Strategy (NSPS), launched in 2022, aims to reduce suicide mortality by 10% by 2030 through screenings, helplines, and awareness programs.[41] However, its reach and impact in rural areas remain to be seen.

[34] Supra note 27.
[35] Khorgade G., *Mental health and the tribal perspective*, 12 Indian J. Psychol. Med. 1191, 1193 (2020), https://ijip.in/wp-content/uploads/2020/09/18.01.124.20200803.pdf (last visited Apr. 24, 2025).
[36] Id. at 1191.
[37] Supra note 28, at 25.
[38] Swarthout M.D. et al., Perceptions of ASHA workers in the HOPE collaborative care mental health intervention in rural South India: a qualitative analysis, 11 BMC Health Serv. Res. 1311 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC8573636/ (last visited Apr. 24, 2025).
[39] Id.
[40] Supra note 28, at 1191.
[41] Supra note 32.

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Resource Allocation

This will significantly impact MHA's rural India implementation, as in India resource allocation against MHA is abysmally low and leads to significant under-utilization. Mental health programs are poorly funded, constituting only 0.05% percent of the health budget for mental healthcare.[42] In India, the economic loss from mental illnesses from 2012 to 2030 is estimated to be USD 1.03 trillion, highlighting the need for increased investment in mental healthcare.[43]

The situation is only made worse by a lack of proper training of ASHA workers in mental health. Although ASHA workers are ideally placed to identify and refer people with mental health problems, they often lack adequate training and support.[44] Previous studies have also established the efficacy of training ASHA workers to carry out mental health assessments.[45] A pilot study conducted in rural Maharashtra reported a significant enhancement in the ASHA workers' mental health knowledge and assessment scores post-training.[46] Community-led intervention Atmiyata project fills this gap by building the capacity of community volunteers to identify and offer primary support to individuals with common mental disorders.[47]

While, 85% of the respondents know about the Ayushman Bharat Health Account (ABHA) card, only 23% of the respondents possess an ABHA and only 30% used health care services under it through its use.[48] This highlights a disconnect between knowledge and usage of government health programs. Moreover, 51.6% of households in India spent less than INR 25000 and around 25% between INR 25001–50000, on migration for treatment out of pocket.[49] In addition, the financial burden of healthcare payments makes access to care for vulnerable populations even more limited.

[42] Supra note 27.
[43] Supra note 32.
[44] Supra note 24.
[45] John S. et al., Assessing the Efficacy of Mental Health Assessment Training for Accredited Social Health Activists Workers in Rural India: A Pilot Study, 14 BMC Health Serv. Res. 511 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC10199160/ (last visited Apr. 24, 2025).
[46] Id.
[47] MHIN, ATMIYATA: A community-led intervention in rural India, https://www.mhinnovation.net/innovations/atmiyata-community-led-intervention-rural-india (last visited Apr. 24, 2025).
[48] Tribal Health Resource Network, State of Health in Rural India, at 22 (May 2024), https://www.trif.in/wp-content/uploads/2024/05/State-of-health-in-Rural-India.pdf
[49] Id. at 15.

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Case Study: Gadchiroli, Maharashtra

Maharashtra's Gadchiroli, a predominantly tribal district, showcases difficulties in the implementation of the MHA in rural India. In a study conducted among tribes of the tribal block Gadchiroli, reported low mental health literacy and low treatment seeking behaviour was found among tribal. The lack of access to care is compounded by geographical isolation and socioeconomic status.[50]

The study emphasized the dominance of a cultural belief regarding mental illness, where traditional healers were the first source of treatment. There are PHCs in every village, however, there are no mental health treatment facilities available.[51] Contrary to the stigma associated, most families do care for such individuals; however, out of influential beliefs, they engage in harmful practices.[52]

But the study does shed light on ways to fix the problem. Collaboration with traditional healers, giving them basic mental health training, and involving them in referral systems are vital strategies to address mental health problems in the tribal community.[53] Other recommended strategies include community-based facilities, training of ASHA workers and community health workers, and assigning more mental health teams for work within the tribal population.

MHA gives hope for the future of mental healthcare in India. Its implementation in rural areas, however, is hampered by infrastructure gaps, lack of awareness, and limited resource allocation. Filling these gaps will require making resources available, raising awareness and access to culturally sensitive interventions, reducing stigma, and empowering community health workers, such as ASHA workers, through a comprehensive training approach. Another reason is these interventions were very much local context specific, and massively engaging with traditional healers, as the case study of Gadchiroli illustrates. If integrated in this manner, MHA can help promote equitable, affordable, quality mental health care for all regardless of where they live, only if concerted action is taken.

[50] Supra note 38.
[51] Supra note 35
[52] Supra note 35
[53] Supra note 47.

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Consequences of Implementation Failures

The 2017 Mental Healthcare Act (MHA) was supposed to be transformative policy aimed to safeguard rights of people living with mental illness and grant them their right to access care of appropriate quality. But ground reality, particularly in rural India, paints a very different picture. The domino effect of these implementation gaps has eroded the principles the Act was meant to restore. This chapter explores the legal consequences of these failings in the forms of human rights violations, socio-economic impacts, and intergenerational trauma.

Human Rights Violations

The continued violation of the rights of persons with mental illness (PMI) due to the failure in implementing the MHA is one of the most disconcerting outcomes of the Act at present. Tthe Act clearly seeks to protect PMIs from cruel, inhuman and degrading treatment. However, unregulated providers and unethical practices remain in common practice in many rural areas mainly due to ineffective monitoring and enforcement mechanisms.

The National Human Rights Commission (NHRC) has already undertaken this exercise of monitoring mental health systems, especially the so-called "mental hospitals" and has provided benchmarks for implementation.[54] Well, 7 years in to the enactment of MHA, the basic tenets for effective administration and oversight remain unaddressed due to a plethora of programmatic and societal barriers. The constitutional right of PMIs is one that is too often compromised, as many states do not have State Mental Health Authorities (SMHAs), and Mental Health Review Boards (MHRBs) that should ensure the rights of PMIs are too often either non-existent or defunct.[55]

Lack of these important oversight entities are directly leading to the continued use of unregulated locations where PMIs are at-risk of inhumane conditions such as overcrowding, no privacy, and undesirable housing units.[56] Furthermore, it has highlighted the inhumane

[54] Kumar A. et al., Mental Health and Psychosocial Problems in Tribal Population: A Narrative Review, 13 Indian J. Community Med. 18, 18-24 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC7923507/pdf/13063_2021_Article_5136.pdf (last visited Apr. 24, 2025).
[55] Mathur C. et al., Community-Based Mental Health Services in India: Current Status and Roadmap for the Future, 16 Indian J. Psychol. Med. 101 (2024), https://pmc.ncbi.nlm.nih.gov/articles/PMC11262246/ (last visited Apr. 24, 2025).
[56] Tripathi A. et al., National Tele-Mental Health Program in India: A step towards mental health care for all?, 15 Indian J. Psychol. Med. 187 (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC9045352/ (last visited Apr. 24, 2025).

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conditions inside institutions and the government's failure to initiate long-term measures for transferring individuals to community air.[57] This is often with a particular emphasis on the notion of individual autonomy and right to refuse treatment which is often overlooked, especially regarding issues where family or caregivers might be making illegal decisions for the individual that lack sufficient legal safeguards over the control of the individual.[58]

Moreover, the provision of advance directives to express the desire for future treatment under the Act is primarily nonexistent because of a shortage of mental healthcare facilities, an overloaded judiciary and practical difficulties in maintaining records.[59] Such policies undermine the right of informed consent and open the door to non-consensual and potentially harmful interventions.

Although integration of General Hospital Psychiatry Units (GHPUs) under the Act has been aimed at improving access, it has unintentionally been linked to increased length of stay and fewer active beds, with the subsequent possibility of overcrowding and sub-optimal care.[60] On the ground, MHA could have retained a provision permitting family members to remain with patients when they were admitted for hospitalization (where it is possible), as it has been in GHPUs and even in some psychiatric hospitals.

Socio Economic Impact

The implementation failures of the MHA 2017 have far-reaching socioeconomic consequences, exacerbating the vulnerabilities of individuals with mental illness and their families, particularly in rural India. Untreated mental illness places a significant economic burden on families, pushing them further into poverty. The National Mental Health Survey (NMHS) 2016 estimated that families spend ₹1,000-1,500 per month on treatment and travel.[61] The 75th Round of the National Sample Survey (NSS) (2017-18) found the average hospitalization cost for psychiatric and neurological ailments was ₹26,843, with public hospitals costing ₹7,235

[57] Id.
[58] Knowledge Ridge, Digital Healthcare in Rural India, https://www.knowledgeridge.com/expert-views/digital-healthcare-in-rural-india (last visited Apr. 24, 2025).
[59] Sharma R. et al., A brief analysis of challenges in implementing telehealth in a rural setting, 14 Indian J. Community Med. 278 (2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC9014233/ (last visited Apr. 24, 2025).
[60] Nat'l Health Sys. Res. Ctr., Public-Private Partnerships in Health Care under the National Health Mission in India: A Review (2022), https://nhsrcindia.org/sites/default/files/2022-09/PPP%20BOOK%2027.05.2022_0.pdf (last visited Apr. 24, 2025).
[61] Sagar R. et al., Prevalence, patterns and correlates of common mental disorders in India: findings from the National Mental Health Survey, 2015-16, 59 Indian J. Psychiatry 21, 25 (2017).

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and private hospitals ₹41,239.[62]

The cost of medicines and travel are two large direct costs. Indirect costs are significant and a burdensome component of the total cost.[63] A 2018 study by the Public Health Foundation of India (PHFI) found that out-of-pocket (OOP) health expenses drove 55 million Indians into poverty in 2017, with 69% (38 million) impoverished by medicine costs alone.[64] Furthermore, estimates showed 59.5% and 32.4% of households had catastrophic healthcare expenditure on mental illness, exceeding 10% and 20% of monthly household consumption expenditure, respectively.[65]

Policy Recommendations

The prevalence of mental disorders in India is approximately 15% of the population,[66] which makes India a step away from a serious mental health crisis. Approximately 197.3 million people will require treatment for one of the common mental disorders but there remains a huge treatment gap, particularly in rural areas.[67] This discrepancy highlights the critical need for pragmatic policy measures that reconcile the differences between statutory law and real world practice. The MHA, enacted in 2017, was meant to transform mental healthcare in India—with a focus on rights, inclusion and community-based services. Redressing these gaps and ensuring that the promise of the MHA 2017 flies off the paper and is made real for everyone, but particularly for those in the most neglected regions of our country is the sum of the comprehensive policy recommendations contained in this chapter. From risk mitigation and begin with a groundwork, the recommendations direct themselves towards better organization,

[62] Nat'l Sample Survey Office, Key Indicators of Social Consumption in India: Health, NSS 75th Round (July 2017 - June 2018), at 93, Table 5.1.1, https://www.mospi.gov.in/sites/default/files/publication_reports/KI_Health_75th_Final.pdf (last visited Apr. 24, 2025).
[63] Kitenge R. et al., Integrating Mental Health Services into Primary Care Settings: A Multiple Case Study of Congolese Experiences Testing the Feasibility of the WHO's Mental Health Gap Action Programme, 22 Int. J. Environ. Res. Public Health 457 (2025), https://www.mdpi.com/1660-4601/22/3/457 (last visited Apr. 24, 2025).
[64] Salve P., Health Expenses Pushed 55 Million Indians Into Poverty In 2011-12, IndiaSpend (July 18, 2018), https://www.indiaspend.com/health-expenses-pushed-55-million-indians-into-poverty-in-2017-2017 (last visited Apr. 24, 2025).
[65] Garg C.C. & Karan A.K., Catastrophic Health Expenditure and Impoverishment Due to Out-of-pocket Payment for Healthcare in India: A Re-examination, 42 Health Policy and Planning 1187, 1193 (2017).
[66] AVPN, India Needs Impact Finance to Scale Innovative Mental Healthcare Models, https://avpn.asia/resources/blog/india-needs-impact-finance-to-scale-innovative-mental-healthcare-models/ (last visited Apr. 24, 2025).
[67] Daniel M. et al., An integrated community and primary healthcare worker intervention to reduce stigma and improve management of common mental disorders in rural India: protocol for the SMART Mental Health programme, 22 Trials 179 (2021), https://pmc.ncbi.nlm.nih.gov/articles/PMC7923507/pdf/13063_2021_Article_5136.pdf (last visited Apr. 24, 2025).

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creating circuits of engagement, creating better line of accountability and ensuring financial accountability, while duly recognizing the ethos of rural India for the culture to dominate in situation.

Strengthening Infrastructure

A strong and accessible infrastructure is the foundation of delivering effective mental healthcare. This meant devising practical solutions in rural India where geographical isolation and the lack of resources make such models challenging.

Telepsychiatry Initiatives and Mobile Mental Health Units

Telepsychiatry and mobile mental health units: These are great ways to provide mental healthcare services to inaccessible areas. To this end, initiative such as the National Tele-Mental Health Program (NTMHP),[68] including the T-MANAS initiative, are landmark steps in this direction. But its success depends on overcoming a few key challenges.

- **Infrastructure Development:** Focus on investment of uninterrupted internet connectivity and electricity in rural areas. Consider clean energy sources for our telepsychiatry equipment so we can run that equipment to ensure we provide consistent services.
- **Digital Literacy:** To promote empowerment of rural community to fully equipped with telemedicine services. These campaigns must be accompanied by language and cultural contraception through multilingual support and culturally sensitive content.
- **Data Security and Privacy:** To protect patient data, it is essential to strictly comply with the provisions delineated in the Digital Personal Data Protection Act (DPDPA) of 2023. Ensure telepsychiatry services are HIPAA-compliant: Hardware and software.
- **Integration with Existing Systems:** Seamlessly integrate tele-mental health services with existing health schemes like Ayushman Bharat Digital Mission and e-Sanjeevani.
- **Mobile Medical Units (MMUs):** Deploy MMUs integrated with primary diagnostic and treatment facilities staffed by trained mental health professionals. These units may perform outreach camps, on-spot consultations, and referrals.
- **Training and Support:** Ensure continued education and monitoring of primary care providers and CHWs relevant to telepsychiatry platforms and MMUs.

[68] Supra note 56.

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Mandatory Mental Health Training for Primary Care Providers

It is important to integrate mental health care with primary care settings for early detection and treatment. This means providing primary care providers with training to treat prevalent mental health conditions.

- **Curriculum Development:** Do include a comprehensive mental health portion in the UG studies of medical and paramedical. Such training should include the identification, diagnosis, and management of the most prevalent mental disorders and when and how to refer patients.
- **mhGAP Training:** WHO's Mental Health Gap Action Programme (mhGAP-IG) for training of mental health for physicians and nurses.[69] The program offers an evidence-based approach for managing mental health conditions in settings with limited resources.
- **Continuing Professional Development (CPD):** Reinforce mental health training through on-the-job training, supervision, and continued professional development (CPD) courses.[70]
- **Task-Sharing:** Implement task-sharing strategies, where trained nurses, medical assistants, and CHWs assist primary care physicians in delivering mental healthcare services.
- **Cultural Competence Training:** Ensure cultural competence training is included in all mental health programs for healthcare providers. This training needs to address the cultural attitudes, knowledge, and skills and discrimination and prejudice.
- **Referral Systems:** Establish clear referral pathways between primary healthcare facilities and specialized mental health services. As a result, ensure adequate supervision of primary care staff by mental health specialists.

Community Engagement

Community-based engagement is vital to reducing stigma, addressing mental health literacy, and creating a supportive environment for individuals with mental illness.

Grassroots Awareness Campaigns Leveraging Local Leaders

[69] World Health Organization, Mental Health Gap Action Programme (mhGAP), https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme (last visited Apr. 24, 2025).

[70] Patel V. et al., Integrating Mental Health in Primary Care in India, 5 World Psychiatry 59, 61 (2006), https://pmc.ncbi.nlm.nih.gov/articles/PMC2777555/pdf/MHFM-05-005.pdf (last visited Apr. 24, 2025).

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- **Engage Local Leaders:** Partner with the heads of villages, religion leaders, and other influential people to promote accurate information on mental health and refute stigmatizing beliefs.
- **Culturally Tailored Messaging:** Create awareness materials that are tailored to local cultural beliefs and practices around mental health. Maximize the reach and impact by leveraging native languages and communication channels.
- **Community Health Workers (CHWs):** Train community health workers, such as Accredited Social Health Activists (ASHAs), to recognize mental health problems, offer simple support, and connect people to services.
- **Integrating Traditional Healers:** Involve traditional healers, religious leaders, and practitioners of alternative systems of medicine to make them aware of the provision for professional diagnosis and treatment. Develop clear guidelines and oversight mechanisms for working together with traditional and biomedical practitioners.

School-Based Mental Health Programs

Schools offer a unique opportunity to promote the mental health and well-being of children and adolescents.

- **Appoint School Counselors:** The National Education Policy 2020 recommends appointing social workers and counselors in schools that would reach out to students in-person and virtually.[71]
- **Teacher Training:** Train teachers to identify students with mental health needs and connect them to appropriate care providers.
- **Curriculum Integration:** Include mental health topics in the school curriculum to raise awareness, reduce stigma, and teach coping skills.
- **Multi-Tiered Approach:** Implement a multi-tiered approach to school mental health, incorporating universal, selective, and indicated interventions.
- **Parental Involvement:** Engage parents and families in school-based mental health programs to create a supportive home environment.

[71] Ministry of Education, National Education Policy 2020, Sec. 6.19 (2020), https://www.education.gov.in/sites/upload_files/mhrd/files/NEP_2020.pdf (last visited Apr. 24, 2025).

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Funding and Accountability

Sufficient and transparent funding mechanisms are crucial to the sustainability and effectiveness of mental health initiatives.

Increase Budget Allocation and Enforce MHRB Establishment

- **Increase Investment:** Increase public spending on mental health to a minimum of 5 % of the total health budget, as per the recommendation of the Lancet Commission.[72]
- **Ring-Fenced Funding:** Make ring-fenced funding for mental health services.[73]
- **MHRB Establishment:** Establishment of Mental Health Review Boards (MHRBs) at the state level to ensure the protection of the rights of individuals with mental illness, and review the quality of care.
- **Innovative Financing Mechanisms:** Explore innovative financing mechanisms options like social impact bonds (SIBs) and blended finance to draw private capital and enhance funding efficiency.[74]
- **Incentivize Private Sector:** Engage the private sector in providing quality mental health services that provides benefit to society while generating a return on investment.

Public-Private Partnerships for Service Delivery

- **Leverage PPPs:** These partnerships combine their expertise, technology and resources for better mental healthcare delivery in rural areas.
- **PPP Models:** Develop PPPs in the area of telepsychiatry services, mobile medical units, diagnostic services, and rehabilitation programs.
- **Clear Agreements:** Establish formal agreements between the public and private partners, specifying roles, responsibilities, and accountability mechanisms.
- **Monitoring and Evaluation:** Implement strong monitoring and evaluation frameworks to measure the success of PPPs and ensure they serve community needs.
- **Community Involvement:** Invite several communities into the development and consideration of PPPs to make sure that these are culturally effective and aligned with local wants.

[72] The Lancet Comm'n on Global Mental Health & Sustainable Dev., The Lancet Commission on Global Mental Health and Sustainable Development, 392 Lancet 1553, 1586 (2018).
[73] Supra note 55.
[74] Supra note 66.

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Conclusion

A comprehensive strategy focusing on these areas is essential to address the current implementation challenges faced under the MHA 2017. The above-mentioned policy recommendations would help India to meet the promise of the MHA 2017 and ensure that quality access to mental healthcare will not be denied by geographical constraints and any socio economic standpoint of individuals. The answer may be in a persistent focus on innovation, collaboration, and a comprehensive understanding of the specific challenges and opportunities of rural India. Only when we do so can we effectively bridge the gap between policy and actual practice, create a changed mental health care landscape, and cultivate a society that values and supports the well-being of all its citizens.