

Ensuring Psychosocial Interventions Align with Rights-Based Mental Healthcare in India

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ABSTRACT (10 PT)

The Mental Healthcare Act (MHCA), 2017 marked a paradigm shift in India's mental health landscape by reframing mental illness through the lens of rights, dignity, and person-centered care. While the Act enshrines psychosocial interventions as an essential component of treatment, implementation remains uneven, hindered by workforce shortages, systemic biomedical bias, financial inaccessibility, and weak ethical oversight. This viewpoint critically examines the interface between MHCA 2017 and psychosocial care, highlighting gaps in service delivery, the persistence of harmful practices such as conversion therapy, and the neglect of adverse outcomes in psychotherapy. It argues that without structural reforms including integration of the National Commission for Allied and Healthcare Professions Act, 2021, expanded insurance coverage, stronger accountability mechanisms, and recognition of allied professionals psychosocial interventions risk remaining marginalized. The article emphasizes the urgent need for rights-based, culturally sensitive, and ethically sound practices to realize the transformative vision of MHCA 2017. Strengthening psychosocial care is not ancillary but central to building a mental health system grounded in equity, recovery, and human dignity.



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INTRODUCTION

The National Mental Health Survey (NMHS) of India reveals that 13.7% of the population are likely to experience mental health challenges at some point in their lives, and 10.6% are currently living with mental illness (BE, 2001). These statistics are more than just numbers, they represent individuals going through complex emotional distress, frequently without proper support and social awareness. The scale of this mental health burden necessitates systemic transformation of care delivery and not just changes in the policy. In recognition of this urgency, the Government of India enacted the Mental Healthcare Act, 2017 (MHCA 2017), marking a historic pivot toward a rights-based, person-centric mental health system (Government of India, 2017).

The Government of India introduced the Mental Healthcare Act (MHCA) in 2017 a measure that reconceptualized mental health as not merely a medical treatment but as a question of individual rights and social integration. The MHCA signaled a departure from earlier custodial or illness-centered perspectives, foregrounding principles of autonomy, personhood, and legal protection. The Act sets forth a legal guarantee for every citizen to receive mental healthcare that is accessible, affordable, and of high quality, thereby establishing a clear state responsibility for inclusive care. In addition, it empowers individuals through provisions for informed consent, advance directives, and a statutory right to dignity and nondiscrimination.

The Mental Healthcare Act, 2017 (MHCA) signifies more than statutory reform; it embodies a moral and constitutional commitment to dignity, accessibility, and equity in mental health care. Anchored in a rights-based framework, it resonates with global standards such as the World Health Organization's Comprehensive Mental Health Action Plan, which emphasizes community-based interventions and the integration of psychosocial support into holistic care. Yet, in practice, psychosocial interventions in India remain underutilized and under-supported, undermining the Act's transformative ethos. This commentary critically analyzes the interface between MHCA 2017 and

psychosocial care in India, highlighting regulatory opportunities, ethical imperatives, and the need for strategic reform to fulfill the Act's transformative potential.

RESULTS AND DISCUSSION

Psychosocial Interventions Under MHCA 2017

Under Section 18 of the MHCA 2017 guarantees every citizen's right to mental healthcare, including services provided by state-funded institutions (Government of India, 2017). This right is not only limited to pharmacological treatment but allows access to multidisciplinary, evidence-based care. Psychosocial interventions such as psychotherapy, rehabilitation, cognitive remediation, and vocational support are thus enshrined.

These interventions are fundamentally designed to restore autonomy, reduce disability, and supporting community integration. Although the MHCA 2017 promotes person-centered care, it appears that the systematic orientation remains largely biomedical in many institutions. However, there are major obstacles to this implementation. Public mental health infrastructure suffers from lack of trained professionals, including clinical psychologists, psychiatric social workers, and rehabilitation specialists (Patel et al., 2018). Despite having great resources, the private sector's high costs and urban concentration prevent many people from getting these services. Moreover, psychosocial therapies are rarely covered under insurance schemes, further exacerbating inequity in access. Evidence from national surveys such as the NMHS (2016) and WHO reports indicates that mere availability of services does not guarantee utilization, as cultural restrictions, perceived stigma, and family pressures often discourage individuals from seeking such care. For instance, composite case vignettes from semi-urban India demonstrate how individuals may decline counseling despite availability, fearing community stigma (Patel et al., 2018; Government of India, Ministry of Law and Justice, 2021). There are several other cases that restricts people from visiting psychologist and seek counseling, that slowly affects their mental health if not treated earlier and may lead to serious psychological disorder in the near future.

A structural barrier lies in the resistance to acknowledge non-psychiatric professionals like psychologists and social workers as independent therapeutic providers. Professional turf wars and unclear rules hinders the collaboration envisioned by the Act, reinforcing a medicalized model that marginalizes psychosocial approaches.

Regulatory Reforms

To improve the psychosocial workforce, the National Commission for Allied and Healthcare Professions Act, 2021 (NCAHP) offers a promising framework to strengthen the psychosocial workforce (Government of India, Ministry of Law and Justice, 2021). By prioritizing standardized qualifications, ethical codes, and creation of centralized registry with mandatory periodic updates, clear supervision protocols, and sanction mechanisms for ethical violations, the NCAHP Act enables the formal recognition and deployment of social workers, counselors, and therapists. However, the maintenance of care quality is crucial to the success of these task sharing models and is still problematic in the absence of training and standards for supervision.

More importantly, the NCAHP supports task-sharing models essential in a country with limited mental health resources (Maulik et al., 2017). Especially in underserved and rural areas, the Act has the potential to greatly increase access to psychosocial care when combined with insurance reforms and digital health initiatives. For instance, India currently has fewer than 0.07 psychologists per 100,000 population, compared to the WHO-recommended minimum of 3 per 100,000. Setting measurable coverage targets (e.g., halving this gap within 5 years) and expanding insurance coverage for psychosocial care can make implementation more accountable. Institutional responsibilities must also be clarified: the Ministry of Health should set policy direction and financing priorities; the NCAHP Council should maintain registries, enforce ethical standards, and monitor training; and state governments should ensure on-ground deployment and integration into public health systems. Integrating NCAHP and MHCA implementation could thus catalyze a scalable, decentralized, and ethically grounded mental health system.

Table 1 presents structural barriers to equitable mental healthcare in India and recommended Interventions

Dimension	Challenge	Recommended Action
Workforce	Shortage of trained professionals	Implement NCAHP to certify and deploy providers; set measurable targets (e.g., doubling workforce in 5 years); Ministry of Health to finance, NCAHP Council to maintain registry and accreditation, State governments to ensure deployment.
Financial Accessibility	Lack of insurance for non-pharmacological care	Expand coverage under Ayushman Bharat and state health schemes to include psychosocial interventions; aim for at least 50% of insured plans to cover counseling and rehabilitation within 3 years.
Ethical Oversight	Occurrence of unethical practices and violations	Enforce MHCA Section 20 through regular audits; NCAHP Council to establish disciplinary boards; State Mental Health Authorities to receive and act on complaints; measurable indicator: annual reporting of complaints and sanctions.
Rural-Urban Disparity	Services concentrated in urban centers	Promote task-sharing and tele-mental health strategies with defined coverage benchmarks (e.g., ensure availability of at least one tele-mental health hub per district by 2027); State governments to operationalize outreach models.

Rights Violations in Psychosocial Interventions

An Unaddressed Crisis While psychosocial care aims to heal, unethical or pseudoscientific practices can cause serious harm. It is extremely concerning that conversion therapy and aversive conditioning have been documented in India, with the Madras High Court (2020) explicitly banning such practices and UNHRC reports confirming their persistence (United Nations Human Rights Council, 2020; Mahdanian et al. , 2023). These practices aimed at altering sexual orientation or suppressing behaviors through punitive techniques are internationally recognized as forms of psychological torture (Council on Minority Mental Health and Health Disparities, 2024).

While Section 20 of the MHCA explicitly forbids inhuman or degrading treatment (Government of India, 2017). Yet, enforcement remains weak, especially when it comes to unregulated and informal service providers. Concrete enforcement pathways are needed, including mandatory licensing of all mental health service providers, creation of complaint mechanisms under State Mental Health Authorities, periodic inspections, and clear sanctions such as suspension of licenses or criminal liability in cases of violation. The ongoing use of such harmful interventions highlights a critical failure to integrate ethical accountability into the mental health systems. It is essential to strengthen oversight, enforce licensing and provide survivors legal remedies in order to protect individuals.

Boundary Violations in Psychotherapy

Therapists hold a powerful position in the therapeutic relationship, which places a strong ethical responsibility on them. Many clients are in vulnerable state when they attend therapy, depending on the professionals for safety, support, and direction. When a therapist crosses boundaries whether emotional, financial, or sexual it's a serious violation of trust (Beutler et al., 2005; Treuer, 2008; Hoffman, 2016). These actions not only harm the client but also damage the reputation and trust in the mental health professionals.

Laws like the Mental Healthcare Act (MHCA) 2017 and the National Commission for Allied and Healthcare Professions (NCAHP) Act 2021 must put into actions to enforce ethical training, institutional accountability, and grievance redressal mechanisms. Reports from professional bodies such as the Indian Psychiatric Society have acknowledged instances of ethical lapses, while international literature (e.g., APA case reviews) documents boundary violations with significant harm. Stronger disciplinary mechanisms are therefore needed, including mandatory reporting of violations, creation of independent ethics committees, and public disclosure of sanctions.. A robust, transparent disciplinary process that strengthens trust in the mental health professions and not only protects those who seek help.

Unacknowledged Adverse Effects in Psychotherapy

A Systemic Blind Spot Psychotherapy can be life-changing but like any other powerful invention, it carries potential risks. Research has identified negative outcomes such as emotional dependency, symptom exacerbation, and interpersonal disruptions (Epstein & Simon, 1990; Barlow, 2010; Lilienfeld, 2007). These effects, are well-documented globally, yet they often go unreported in Indian clinical context (Linden, 2013; MJ, 2016; Rozental et al., 2016), partly because we lack standard systems to identify them. Currently, there is almost no systematic Indian data on adverse effects, which underscores the urgency for national-level monitoring. The routine use of standardized tools such as the Negative Effects Questionnaire (NEQ) should be mandated across clinical settings, along with national audits and outcome monitoring systems to track adverse effects and ensure accountability (20).

To ensure informed consent and therapeutic safety, clinicians must incorporate adverse effect assessments into routine practice rather than showing it is universally beneficial and harmless (Bystedt et al., 2014; BE, 2001). Policymakers should mandate such practices through ethical guidelines and clinical audits and not by just ignoring the complexities of therapy risks which undermines the very principles of autonomy and dignity that MHCA seeks to protect.

CONCLUSION

The Mental Healthcare Act, 2017 is a progressive, rights-based charter that re-imagines mental health not merely as a medical issue but as a societal and ethical priority. However, laws alone cannot transform systems. The realization of MHCA's vision depends on how earnestly we reconfigure our institutions, empower our professionals, and center our interventions on human dignity.

Psychosocial care is not an adjunct to pharmacology, it is a cornerstone of comprehensive recovery. For too long, this domain has suffered from neglect, fragmentation, and ethical oversights. The gap between the progressive vision of the MHCA and the lived reality of those in distress remains wide, with access to care constrained by stigma, structural barriers, and insufficiently resourced psychosocial services. The NCAHP Act, though often overlooked, offers a strategic lever to correct these imbalances. If properly implemented, it can help foster a qualified, accountable, and compassionate workforce. India is poised at a juncture to either fulfil the promise of the MHCA or risk symbolic compliance without systemic reform.

The way forward requires a clear roadmap anchored in measurable indicators. Policymakers should set targets for reducing the treatment gap (e.g., from 70% to 50% within five years), expanding the psychosocial workforce (e.g., doubling the psychologist-to-population ratio), and mandating national reporting of adverse effects using standardized tools like the NEQ. Clinicians must ensure their interventions are person-centered and trauma-informed, while educators embed rights-based, community-oriented approaches in training curricula. State governments and the NCAHP Council must work in tandem to monitor implementation, ensure accountability, and enforce ethical standards. Only through such structured, multi-level action can India transition from symptom-focused care to systems that deliver recovery with competence, compassion, and unwavering respect.

REFERENCES

- Barlow DH. Negative effects from psychological treatments: a perspective. *Am Psychol*. 2010 Jan;65(1):13–20. doi:10.1037/a0015643. PMID: 20063906.
- Beutler LE, Consoli AJ, Lane G. Systematic treatment selection and prescriptive psychotherapy. In: Norcross JC, Goldfried MR, editors. *Handbook of psychotherapy integration*. 2nd ed. New York: Oxford University Press; 2005. p. 121–43.
- Bystedt S, Rozental A, Andersson G, Boettcher J, Carlbring P. Clinicians' perspectives on negative effects of psychological treatments. *Cogn Behav Ther*. 2014;43(4):319–31.
- Council on Minority Mental Health and Health Disparities. *Position statement on conversion therapy and LGBTQ+ patients*. Washington (DC): American Psychiatric Association; 2024 May–Jun.
- Crawford MJ, Thana L, Farquharson L, Palmer L, Hancock E, Bassett P, et al. Patient experience of negative effects of psychological treatment: results of a national survey. *Br J Psychiatry*. 2016 Mar;208(3):260–5. doi:10.1192/bjp.bp.114.162628. PMID: 26932486.
- Epstein RS, Simon RI. The exploitation index: an early warning indicator of boundary violations in psychotherapy. *Bull Menninger Clin*. 1990 Fall;54(4):450–65. PMID: 2268752.
- Government of India. *Mental Healthcare Act, 2017*. New Delhi: Ministry of Law and Justice; 2017.
- Government of India. *The National Commission for Allied and Healthcare Professions Act, 2021*. New Delhi: Ministry of Law and Justice; 2021. Gazette No. 14 of 2021.
- Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, et al. *National Mental Health Survey of India, 2015-16: prevalence, patterns and outcomes*. Bengaluru: National Institute of Mental Health and Neuro Sciences; 2016. (NIMHANS Publication No. 129).
- Hoffman L. Boundaries and boundary violations in psychoanalysis. 2nd ed. *Am J Psychiatry* [Internet]. 2016 Aug 1 [cited 2025 Aug 4];173(8):841–2. Available from: <https://doi.org/10.1176/appi.ajp.2016.16040417>
- Lilienfeld SO. Psychological treatments that cause harm. *Perspect Psychol Sci*. 2007 Mar;2(1):53–70. doi:10.1111/j.1745-6916.2007.00029.x. PMID: 26151919.
- Linden M. How to define, find and classify side effects in psychotherapy: from unwanted events to adverse treatment reactions. *Clin Psychol Psychother*. 2013 Jul–Aug;20(4):286–96. doi:10.1002/cpp.1765. PMID: 22253218.
- Mahdanian AA, Laporta M, Bold ND, Funk M, Puras D. Human rights in mental healthcare: a review of current global situation. *Int Rev Psychiatry*. 2023 Feb-Mar;35(2):150–62. doi:10.1080/09540261.2022.2027348. PMID: 37105153.
- Maulik PK, Kallakuri S, Devarapalli S, Vadlamani VK, Jha V, Patel A. Increasing use of mental health services in remote areas using mobile technology: a pre-post evaluation of the SMART Mental Health project in rural India. *J Glob Health*. 2017 Jun;7(1):010408.
- Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018 Oct 27;392(10157):1553–98.
- Rozental A, Kottorp A, Boettcher J, Andersson G, Carlbring P. Negative effects of psychological treatments: an exploratory factor analysis of the Negative Effects Questionnaire for monitoring and reporting adverse and unwanted events. *PLoS One*. 2016 Jun 3;11(6):e0157503. doi:10.1371/journal.pone.0157503.
- Treuer T. Ethics in psychotherapy and counseling: a practical guide. 3rd ed. *Prim Care Companion J Clin Psychiatry*. 2008;10(1):79. PMCID: PMC2249822.
- United Nations Human Rights Council. *Practices of so-called "conversion therapy"*. A/HRC/44/53. Geneva: UNHRC; 2020.
- Wampold BE. *The great psychotherapy debate: Models, methods, and findings*. Mahwah (NJ): Routledge; 2001.