

Kaunas University of Technology
Faculty of Social Sciences, Arts and Humanities

An evaluation of mental health stigma policies in India under United Nations and World Health Organization frameworks

Master's Final Degree Project

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Summary

Mental health stigma is a negative perspective of people with a mental illness. It involves stereotyping and prejudices towards the person who has a mental illness. Commonly, people believe that mental health stigma is associated with how people treat a person with a mental health condition in a society, and considering them inferior is the only form of stigma that comes under the realm of public or social stigma. With the structural development in society, mental health stigma has spread widely in other spheres as well, such as in workplaces and even strongly embedded in legislation. Awareness alone cannot help to control mental health stigma and its outcome. There is a need for the introduction of reforms at every level to influence people in treating people with mental illness with equality and empathy, rather than considering them dangerous. Internationally, the United Nations (UN) and World Health Organization (WHO) have introduced such policy documents and frameworks, which provide a rights-based approach to dealing with people with mental health conditions. At the national level, member states of the UN are also gradually introducing such reforms. India is a country that is not only a member state but also a signatory to the Convention on the Rights of Persons with Disabilities (CRPD) since 2007. So, there is a major shift in the development, introduction, and implementation of laws and policies regarding mental health in India. With a population of 1.45 billion currently, the rate of people affected by mental disorders is also high. Along with it, mental health stigma in all forms is also very deeply rooted in society at many different levels. In recent years, the Indian government has introduced a series of policies such as the National Mental Health Policy 2014 (NMHP), the Indian Mental Healthcare Act 2017 (IMHA), and the Rights of Persons with Disabilities Act 2016 (RPwD). This study aims to evaluate how much these policies align with standards and values set by the UN and WHO frameworks concerning mental health stigma. For this, the strengths and weaknesses of the policy documents will be measured. The final task is to identify gaps in policy to introduce more effective designs in the future. To achieve this aim, a normative policy analysis approach is being adopted through which an evaluation criterion has been developed, derived from the UN and WHO frameworks, such as community inclusion, anti-stigma awareness, and free and informed will. For the analysis, the deductive content analysis method is used, which assessed the Indian mental health stigma policy documents under target questions set according to the above-mentioned criteria. This master's thesis consists of a table of contents, a list of abbreviations, a list of tables, a summary in English and Lithuanian, an introduction, a chapter regarding theoretical aspects of mental health stigma, a methodology section, an evaluation of Mental Health Policy documents of India under UN and WHO frameworks, a conclusion, recommendations, references, and appendices.

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Santrauka

Psichikos sveikatos stigma – tai neigiamas požiūris į žmones, turinčius psichikos sutrikimų. Ji apima stereotipizavimą ir išankstinius nusistatymus prieš asmenį, turintį psichikos sutrikimų. Įprastai žmonės mano, kad psichikos sveikatos stigma yra susijusi su tuo, kaip visuomenėje elgiamasi su asmeniu, turinčiu psichikos sutrikimų, ir kad jo laikymas prastesniu yra vienintelė stigmatos forma, patenkanti į viešosios ar socialinės stigmatos sritį. Vystantis visuomenės struktūroms, psichikos sveikatos stigma plačiai išplito ir kitose srityse, pavyzdžiui, darbo vietose, ir netgi tvirtai įsitvirtino įstatymuose. Vien tik sąmoningumas negali padėti kontroliuoti psichikos sveikatos stigmatos ir jos pasekmių. Reikia įgyvendinti reformas visais lygmenimis, kad žmonės galėtų elgtis su asmeniu, turinčiu psichikos sutrikimų, lygiavertiškai ir empatiškai, o ne laikyti jį pavojingu. Tarptautiniu lygmeniu Jungtinės Tautos (JT) ir Pasaulio sveikatos organizacija (PSO) yra pristatiusios tokius politikos dokumentus ir sistemas, kurios suteikia teisėmis pagrįstą požiūrį į žmonių, turinčių psichikos sutrikimų ir negalią, darbą. Nacionaliniu lygmeniu JT valstybės narės taip pat palaipsniui diegia tokias reformas. Indija yra viena iš tokių šalių, kuri yra ne tik valstybės narė, bet ir Neįgaliųjų teisių konvencijos (CRPD) signatarė nuo 2007 m. Taigi, Indijoje įvyko didelių pokyčių kuriant, diegiant ir įgyvendinant psichikos sveikatos įstatymus ir politiką. Šiuo metu šalyje gyvena 1,45 milijardo žmonių, todėl psichikos sutrikimų turinčių žmonių skaičius taip pat yra didelis. Be to, visų formų psichikos sveikatos stigma yra labai giliai įsišaknijusi visuomenėje įvairiais lygmenimis. Pastaraisiais metais Indijos vyriausybė pristatė keletą politikos kryptų, tokių kaip 2014 m. Nacionalinė psichikos sveikatos politika (NMHP), 2017 m. Indijos psichikos sveikatos priežiūros įstatymas (IMHA) ir 2016 m. Neįgaliųjų teisių įstatymas (RPwD). Šio tyrimo tikslas – įvertinti, kiek ši politika atitinka JT ir PSO nustatytus standartus ir vertybes dėl psichikos sveikatos stigmatos. Tuo tikslu bus įvertinti politikos dokumentų stipriosios ir silpnosios pusės. Paskutinė užduotis – nustatyti politikos spragas, kad ateityje būtų galima įdiegti veiksmingesnius modelius. Šiam tikslui pasiekti taikomas normatyvinis politikos analizės metodas, pagal kurį sukurtas vertinimo kriterijus, pagrįstas JT ir PSO struktūromis, tokiomis kaip bendruomenės įtrauktis, kovos su stigma sąmoningumas ir laisva bei informuota valia. Analizei naudojamas dedukcinės turinio analizės metodas, kuriuo Indijos psichikos sveikatos stigmatos politikos dokumentai buvo įvertinti pagal tikslinius klausimus, nustatytus pagal minėtus kriterijus. Magistro darbą sudaro turinys, santrumpų sąrašas, lentelių sąrašas, santrauka anglų ir lietuvių kalbomis, įvadas, skyrius apie teorinius psichikos sveikatos stigmatos aspektus, metodologijos skyrius, Indijos psichikos sveikatos politikos dokumentų vertinimas pagal JT ir PSO struktūras, išvados, rekomendacijos, literatūros sąrašas, priedai.

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List of abbreviations and terms

Abbreviations:

UN. – United Nations;

WHO. – World Health Organization;

CRPD. – Convention on the Rights of Persons with Disabilities.

MHAP. – Mental Health Action Plan 2013–2030.

NMHP 2014. – National Mental Health Policy 2014.

MHCA 2017. – Mental Healthcare Act 2017.

NMHS. – National Mental Health Survey 2015-16

RPwD 2016. – Rights of Persons with Disabilities Act 2016.

WHO-OHCHR Guidance. – Mental health, human rights and legislation: guidance and practice.

ECT. – Electroconvulsive Therapy.

PMHC. – Person with a mental health condition

NGO. – Non-governmental organization

Terms:

Mental illness – A medically diagnosable health condition that affects a person's thinking, mood, behaviour, or ability to function in daily life.

Stigma policy – The negative stereotyping and prejudices directed at a person who faces a mental health condition.

Psychosocial disability – The functional impact of a severe mental health condition on a person's daily life.

People with lived experience – People who have experienced or are experiencing mental illness.

People with disabilities – People with long-term mental, intellectual, or psychosocial impairment that limit major life activities.

People with mental health conditions – Individuals who experience clinically significant disturbances in emotional regulation, thinking, or behaviour. This includes everything from diagnoses of medical conditions and mental disorders.

Bio-medical model – A model that views mental disorder as physical brain diseases or biological abnormalities.

Rights-based approach – It is a conceptual approach that places human rights, such as dignity and autonomy, at the core of mental health care and policy-making.

Legal capacity – The ability to hold rights and exercise those rights.

Substitute decision-making – A process where a designated third party makes health care, financial, and personal care decisions on behalf of an individual who has been assessed as lacking the mental capacity.

Support decision-making – It is a system that comprises various support options that allow a person to exercise legal capacity and make decisions with support.

Anganwadi worker – A frontline community health and childhood educator in India.

Introduction

Relevance of topic

Stigma around mental illness and disorders is widespread across India. According to the WHO regional Committee for South East Asia report, which is related to addressing mental health in India, stigma is a major challenge to the success and better implementation of mental health policies in India. (Organization, 2023). There is a lack of knowledge among people about mental health, and substance use disorders are conditions that require action (Organization, 2023).

Stigma related to mental health in India is deeply rooted in people's cultural beliefs. India is a country with vast geographical land and a large, diverse population. They have diverse philosophies. (Choudhary et al., 2024). These philosophies recognize mental illness in their own distinct ways, which impact a person with mental health conditions who faces stigma starting initially from his own family, society, and then leads to structural stigma in educational institutions, workplaces, and even in mental health institutions. (Choudhary et al., 2024). Stigma around mental illness can create barriers to accessing adequate and quality healthcare services in India. (Meena, 2015). An Individual might hesitate to request help because of fear of judgment and discrimination from mental health professionals. (Meena, 2015). Due to this, many people with mental illness cannot receive basic support, leading to severe conditions. Recently, India has made advances in introducing mental health reforms and legislation. The Mental Health Care Act 2017 was introduced for safeguarding the rights of people with lived experience of a mental illness and promoting a rights-based approach. (Meena, 2015). Still, there is a huge gap in the effective implementation of such policies and plans. There are barriers like low budget allocation for mental health care and insufficient medical staff to meet mental health needs. (Paul, 2018). There is a problem of lack of funds for mental healthcare in India, and less than 1% of the country's health budget is spent on mental health care. (Paul, 2018).

To assess the effectiveness and implementation of these mental health policies relevant to human rights, the UN and WHO rights-based standards and frameworks are the best analytical tools. They can provide a broad set of indicators to assess the progress of policy and governance mechanisms regarding mental health stigma in India. These frameworks are internationally recognised standards for what states should include in mental health policy, especially regarding dignity, equality, non-discrimination, and participation, especially the CRPD, which calls for policy reform that promotes legal capacity, non-coercive practices, participation, and community inclusion, making it directly applicable as an assessment framework for national policy design. (Organization, 2021).

Novelty of research

This research study can contribute by evaluating India's mental health stigma-related policy documents in a structured way, rather than focusing only on why stigma exists or how widespread it is in India. The existing research work includes mostly literature review or review of the National Mental Health Survey (2016-2015) of India, which focuses on collecting evidence about the presence of mental health stigma on different levels in India. Even though relevant, this method cannot fully analyse the effectiveness and strengths of stigma policies and where the gaps exist. The difference in this research study is that it uses UN and WHO rights-based frameworks and their guidance criterion (such as non-discrimination and legal protections, participation of persons with lived experience, community-based support, safeguards against coercion, and accountability) as a foundation for assessing the effectiveness of anti-stigma mental health policy (Organization, 2025a).

Using these criteria, the study systematically develops a set of indicators relevant to mental health stigma. These indicators can be observed as themes along with rating criteria, which help to examine key instruments connecting to mental health stigma within policy documents such as the MHCA 2017, the NMHP 2014, and the RPwD 2016. This can contribute to making amendments and developments in mental health stigma policy designs in the future. The research also highlights governance and implementation challenges that can weaken real-world impact, even when policies include strong commitments on paper. Overall, the novelty lies in offering an international standard-based assessment that links stigma theory to concrete policy design features and implementation barriers in India.

Research Problem

India is among those countries that have worked to introduce legal and policy instruments to reduce mental health stigma and strengthen rights-based mental health governance. However, the extent to which India's stigma-related mental health legislations and implementation mechanisms align with international UN and WHO rights-based standards remains vague and is not consistently evident in existing research. Most of the literature in this regard is a literature review connected to the existence of mental health stigma or its specific types of mental health stigma in India until now. The problem is that it is difficult to identify whether India's policy structure provides the foundational elements emphasised in international frameworks like the CRPD and Mental Health, human rights and legislation: guidance and practice 2023 about obligatory legal protection, non-discrimination, participation of people with mental illness or disorder in designing policy and decision making, safeguards against coercion, and a shift toward community-based care. These international frameworks, like the UN and the WHO, not only provide guidelines about how to plan, design, and implement mental health policies but also lay out a set of assessment criteria that can aid member states in evaluating their mental health policy documents. This qualitative document analysis gives detail interpretation about the scope of legislation, challenges, and gaps in implementation, and how further amendments can be made to develop them according to international standards. This research study addresses this scope, challenges, and gaps through a structured, criteria-based evaluation of India's key policies using UN and WHO frameworks as benchmarks.

Research object

India's mental health policy documents.

Research aim

To evaluate the extent to which India's mental health stigma policies align with the frameworks of the UN and WHO.

Research Objectives

1. To identify the most relevant UN and WHO rights-based criteria for evaluating stigma-related mental health policy of India.
2. To assess India's key mental health policy documents against these criteria, including the National Mental Health Policy 2014 and Mental Healthcare Act 2017(MHCA 2017), focusing on policy design elements such as legal protections, non-discrimination, participation, community-

based care, and safeguards against coercion.

3. To analyse the major policy gaps and implementation barriers that emerge from this assessment when India's policies are compared with the selected UN and WHO-based criteria.

Research questions

1. Which UN and WHO framework criteria are most relevant for evaluating anti-stigma mental health policy?
2. To what extent do India's key mental health stigma policies reflect these criteria in their policy structure?
3. What are the main gaps and implementation barriers for the Indian mental health stigma policy when assessed against these criteria?

Research method

The study design applied in this research study is normative policy analysis. UN and WHO frameworks are used to obtain a policy evaluation criterion. These evaluation criteria are based on the UN and WHO rights-based approach for mental health reforms. It includes the right to free and informed, stigma awareness, and legal capacity. The method implemented to evaluate the Indian mental health stigma policies is deductive content analysis under this design. With this method, the broader evaluation criteria were converted into targeted questions, and these were used to code the Indian mental health policy documents. The document consists of – pages, 5 tables, 2 figures, 1 appendix, and – sources.

1. Theoretical aspects of Mental Health Stigma and related policies:

This section provides an insight into how the legal and policy frameworks of the UN and WHO can be used as measuring scales for analysing the mental health stigma policies implemented in India. This analysis of Indian policies will help to know how national policies align with international standards and guidelines provided for states. The first step is to understand fundamental concepts of mental health, mental illness, the mental health policy, and the concept of mental health stigma to understand what this study is about and what is being evaluated. Stigma itself is a very broad concept, and understanding its impact on mental health and people with mental health disability and psychosocial disabilities is important. This provides support to understand why it is necessary to evaluate mental health stigma policies specifically. These concepts are not mere descriptive information about what they are, but also connect us to an understanding of mental health stigma principles of the WHO and UN, which provide guidelines for states to construct their own mental health policies. As the research is particularly about mental health stigma policies, the theoretical foundation of stigma can help understand how it can affect different aspects of a person's life who is affected by mental illness. This foundation includes both classical theories, such as Goffman's theory of spoiled identity, and contemporary theories of stigma, such as Link and Phelan's Conceptualization of Stigma, which explain how societies identify and make mental health stigma a norm that later becomes part of day-to-day life, economic, and political environment. The part related to the implication of mental health stigma policies creates a bridge for understanding the evaluation criteria for assessing India's mental health stigma policies. Altogether, the fundamental concepts, theoretical base of mental health stigma, and international policy frameworks, such as those of the UN and WHO, create an analytical mirror that helps us to evaluate the Indian mental health stigma policies in their reflection.

1.1. Concepts of Mental Health, Mental Illness, and Mental Health Policy:

Mental health is a significant part of well-being. The WHO defines mental health as a condition of well-being that lets people deal with life's stressors, use their skills, study and work productively, and give back to their communities organization (2025c). According to the WHO, health is not just the absence of illness; it is also a condition of complete physical, mental, and social well-being. (Organization, 2025d). This means that mental health is not just the absence of mental illness.

Across this definition, three theoretical principles constantly emerge. Firstly, mental health is an inherent part of health, which influences how individuals think, feel, and act. Secondly, mental health is not a double condition, but a gradual change from well-being to extreme psychological damage. Thirdly, mental health is formed by complicated interactions among biological, social, cultural, and environmental factors. (Gautam et al., 2024).

While mental health refers to a positive state of emotional and cognitive well-being, mental illness represents troubles in these very fields. (Organization, 2025b). According to the WHO, mental illness involves clinically significant disturbances in an individual's cognition, emotional regulation, or behaviour which reflect dysfunction in psychological, biological, or developmental processes and lead to distress or impaired functioning. (Organization, 2025b).

Recent scholars reinforce this understanding. A 2024 review in Behavioural Sciences visualizes mental illness as a range of diagnosable psychological conditions that are identified as continuous disturbances in thoughts that obstruct an individual's work, interpersonal relations, and creative

arrangement with society (Vacca et al., 2025). This underlines that mental illness or disability is not fully the presence of some signs but the point at which these signs begin to damage well-being and the everyday working capability of the person. These concepts emphasize the importance of developing mental health action plans and policies at national and regional levels in countries, so they help to cater to the needs of such people and provide them with not only safeguards against stigma and discrimination but also introduce preventative measures to reduce the burden of mental disorders for the future. A better understanding of mental health policy can help us to map the idea for analysing India's mental health stigma reforms.

According to the definition of the WHO, a mental health policy is an official declaration of a government that provides insight into how elaborate the vision, values, principles, and objectives are concerning mental health (Funk & Drew, 2015). The key elements of such a policy reform include a vision statement, clear objectives, and the area of action (Organization, 2025a). Mental health policy and plan are important tools to help decide which mental health legislation or provision can best support its goals. Similarly, the laws also provide a backbone to achieve the goals and objectives of the policy (Organization, 2025a). The mental health legislation provides a framework for the protection of the rights of people with mental health conditions. (Funk & Drew, 2015). While formulating such laws or legislation, it is important to consider which UN and human rights treaties have been ratified by the governments of state parties. It is important to keep in view what obligations such treaties place on the signatory country, which they need to take into account while making mental health reforms.

The question arises as to why national governments are responsible for making mental health policy. One way in which we can understand it is that mental health is influenced by social and structural determinants present in a country. These determinants include stigma, discrimination at various levels, gender inequality, unemployment, inequality in the legal system, and lack of accountability (Losito, 2024). These factors cause great stress, which leads to a high rate of depression and many other mental health diseases. Further, due to mental illness, people with lived experience also face discrimination and disability in the presence of social barriers (Pandey & Singh, 2024). This is why mental health policy requires an approach or system that is not solely based on the biomedical model, but contains a rights-based approach (Organization, 2025a).

The biomedical model focuses on neurological factors of disease, and treatments include hospitalization and medication (Funk & Drew, 2015). A rights-based approach, on the other hand, includes equality, non-coercion, participation, and community inclusion (Organization, 2021). This requires providing services and support at a multi-sectoral level. In this way, multiple sectors connect and collaborate (Organization, 2025a). This includes many public and private sectors. This makes it essential for governments to take full responsibility for making, presenting, and implementing mental health policy.

1.2. Theories of Stigma

To understand why anti-stigma laws are needed, it is important to understand the conception of stigma and how this can damage people with mental health conditions. The stigma theories examined provide us with an analytical framework to understand how stigma is deeply connected to mental health. According to Erving Goffman, who presented one of the most organised analyses of this concept in his 1963 book *Stigma: Notes on the Management of Spoiled Identity*, society categorises

people or places them into “boxes,” each associated with specific expected attributes (Goffman, 2009). Despite being subjective, the attributes stigmatized by the audience can have objective consequences for targets (Aranda et al., 2023). They may be perceived as dangerous, weak, or morally flawed. When a person possesses some attributes that are less desirable in society, people see him as a tainted one (Hector & Khey, 2018). According to this idea, stigma is an attribute and becomes a core feature of the everyday life of such a person (Zavyalova & Younger, 2026).

These definitions provide a solid base to understand the mental health stigma. People with mental health conditions do not meet society’s expectations most often of “normal” behaviour. As a result, they may be labelled “dangerous,” “unpredictable,” or “unreliable.” (Hector & Khey, 2018). This is mental health stigma, which not only affects the physical and emotional well-being of a person with mental illness but also their social life and legal capacity.

Goffman presented two different types of stigmas: the discredited and the discreditable. Individuals whose differences are visible, such as unusual behaviour which can be taken as a sign of illness, are discredited. Those whose stigma is not immediately seen or visible are discreditable and may choose to hide their condition so they can avoid judgment from society (Goffman, 2009). Mental illness is, at times, considered a discreditable stigma as it can be hidden. Many individuals hide symptoms due to fear of discrimination. This means perceived stigma or self-stigma, where people with mental illness start to internalize the perceived discrimination and feel shame (Hector & Khey, 2018) which can become a barrier in seeking help or gaining access to mental health care services. This turns it into a visible problem in treatment (Corrigan, 2004). Therefore, this thesis will evaluate different policy measures such as geographically accessible mental health treatment plans, respecting the privacy of persons with mental illness, and integrating mental health with primary health services within the criteria of quality health services.

Consistent with Goffman’s view, there is a general agreement among stigma scholars that stigma is a social construct (Major et al., 2018). An attitude that can be seen as normal in one culture might be stigmatising in another one. An individual is stigmatized in a community, and this is explained by their belief that she has deviated from some social norm or standard (Allison, 2024). In many situations, stigma is used against a person with a mental illness to justify discrimination. Stigmatised individuals may gradually be viewed as “less than fully human,” which Goffman notes often leads to discriminatory practices rationalised as deserved (Goffman, 2009). This can be termed as social stigma, where discriminatory behaviour can be directed towards individuals with mental health problems because of the psychiatric label they have been given (Hector & Khey, 2018).

According to (Corrigan, 2004; Corrigan & Watson, 2002) the difference between public stigma and self-stigma (internalized stigma) suggests that laws must repeatedly address external hurdles and internal psychological results. Public stigma can be decreased through contact-based interventions, public education, school curriculum, and anti-discrimination laws (Kreiner, 2025). Educational intervention can provide evidence-based information about those mental health conditions that are stigmatized, and this helps to correct false information. This can positively affect stigma and social avoidance (Rodrigues et al., 2025). Medical education can equip healthcare professionals with the necessary knowledge to understand and respect their patients' cultural backgrounds and experiences (Ahad et al., 2023). This provides the basis for assessing whether the national governments include such intervention plans while formulating mental health stigma policies.

While it provided the classical foundation for understanding the concept of stigma as a “deeply discrediting” attribute (Link & Phelan, 2001), it significantly expanded this concept by proposing a more systematic, sociological model. Link and Phelan’s framework says that stigma is not a single act or attitude but a multidimensional social process involving five interrelated components, which are labelling, stereotyping, separation, status loss, and discrimination, all operating within power structures that allow these processes to unfold (Link & Phelan, 2001). This modern concept, which includes all these elements, is very relevant to mental health stigma. It captures not only internal prejudices but also the structural and institutional stigma that develops the negative situation for individuals with mental illness. These dimensions significantly impact an individual’s health, social interaction, and willingness to seek help (Rodrigues et al., 2025).

The first component of stigma includes labelling human differences (Link & Phelan, 2001) highlighting that societies do not usually observe natural differences among people. They select specific differences as socially important and ignore others. Once a difference is labelled by society, it becomes treated as natural and as no one can question it. This is why it is safe to say that stigma is less about inherent or unchangeable physical quality or an objective attitude, but rather more about subjective judgments that are socially made by observers (Kreiner, 2025). It gives it immense social power. Every day life becomes centred around these labels. For example, mental illness is not stigmatized simply because disease symptoms are there, but because society has socially decided that they are threatening, shameful, or morally weak. In this way, labelling becomes the basis for mental health stigma. These two keep adding to each other, cutting people off from normal opportunities and pushing them towards social exclusion (Hector & Khey, 2018).

Once a label is used, the second element of stigma appears. It associates labelled distinctions with negative attributes or stereotypes. This is the point at which Goffman’s ideas interrelate with Link and Phelan’s framework. Stereotyping includes attaching a set of socially shared beliefs to a labelled group (Link & Phelan, 2001). When people of the community stigmatize people with mental illness, stereotypes often become a main part, such as “mentally ill = dangerous”, “People with schizophrenia cannot work.”(Link & Phelan, 2001; Rodrigues et al., 2025). These ideas and perspectives lead to fear and avoidance. When stereotypes are automatically widespread, these started to shape institutional norms and public behaviour. This leads to structural stigma, which is embedded in institutional settings, laws, and policies, causing discriminatory behaviour and barriers to opportunities (Hector & Khey, 2018). Structural stigma requires a multilevel approach, as it is deep-seated in systems such as healthcare, education, and the legislative system. This includes policy reforms, public education campaigns, and anti-discrimination measures (Rodrigues et al., 2025).

Structural Stigma, as described by (Link & Phelan, 2001) provides a clear justification for changing policy from narrow clinical interferences toward broader human rights-based mental health governance. Stigma harms are the most powerful when these social positions are backed by institutions and systems with the authority to enforce them. This theoretical understanding has clear implications for mental health policy. As individuals and groups come together, their collective influence becomes more powerful, especially to combat structural stigma. For example, they could work toward policy changes not only in their own practice, but also in state licensing boards and professional associations (Kreiner, 2025). The relevance of this concept lies in the identification of policy measures that allow and encourage the participation of persons with lived experience in public decision-making and inclusion in educational and employment sectors.

They also set the stage for the next stage, which is the separation of “us” from “them.” Culture, religion, customs, and social norms deeply inspire this “us versus them” division. Mental health stigma is different across societies, and it is due to the culture of these societies, which decides about differences that are threatening or unacceptable. As a result, stigmatized individuals experience status loss, a reduction in social standing, and discrimination across multiple domains of life (Link & Phelan, 2001). Culture shapes stigma differently in different social groups, and cultural adoption of interventions following the concept of “what matters most” may help people (Javed et al., 2021). This can improve patient-provider communication and reduce perceived stigma (Ahad et al., 2023). Other methods include capacity building of the mental health workforce and improved access to care through integration with primary healthcare (Javed et al., 2021). Corrigan’s claim that stigma reduces efforts to seek help and interferes with treatment arrangements further indicates the need for rights-based, private, community-based, and non-coercive services (Corrigan, 2004).

A major element of Link and Phelan’s paradigm is the emphasis on power. Stigma only happens when a group has enough social, economic, or political power to put labels on people, enforce stereotypes, create isolation, and act on prejudice. Without power, labels and stereotypes do not become stigma (Link & Phelan, 2001). Focus on power affairs determines that stigma continues when organizations own the authority to execute and enforce negative measures. Therefore, stigma reduction requires system-level reforms, such as anti-discrimination laws, comprehensive service design, improved resource division, and equal access to mental healthcare (Shahwan et al., 2022).



Fig. 1. Link and Phelan’s Stigma Theory elements

These theoretical perspectives of stigma segregate the concept of stigma into three different types. Internalized or self-stigma, public stigma, and structural stigma (Rodrigues et al., 2025). These types are derived from the two main aspects of a person’s life, which are briefly discussed earlier: social and structural aspects. Social aspects are related to the everyday social life of a person, which includes cultural beliefs, community norms, and interactions with friends and family members. This factor can be considered as a leading cause of public and self-stigma (Kreiner, 2025).

Public stigma is how most people keep a negative attitude about a person with a mental illness (Kreiner, 2025). These responses then manifest as discrimination, examples include refusal to offer housing, social opportunities, or fair treatment in everyday life (Corrigan PW, 2002). This is the base for imposing harmful and discriminatory social sanctions on PMHC (Aranda et al., 2023). Research shows that even highly trained mental health professionals often hold stereotypical views of persons with mental illness, endorsing ideas such as fear (“they are dangerous”), authoritarianism (“they cannot make decisions”), and benevolence (“they are childlike and need care”)(Corrigan PW, 2002).

Stigma also operates internally, connecting it directly to Goffman’s earlier insight that stigma damages a person’s “social identity” and shapes how they see themselves (Goffman, 2009). (Link & Phelan, 2001) develop their ideas based on this by showing how cultural stereotypes become internalized over time. As stereotypes become part of a person’s upbringing, individuals with mental illness begin to expect rejection and devaluation (Farina et al., 1968). Research demonstrates that people form expectations about whether society will accept them as friends, coworkers, neighbours, or romantic partners (Kreiner, 2025). Once they believe that others will reject them, they internalize these beliefs, leading to self-doubt, avoidance, and defensive behaviour. Individuals also avoid seeking treatment because of the fear of receiving a mental illness diagnosis; such fear is driven by the stigma (Kreiner, 2025).

Stigmatized individuals might expect to be treated normally, but society often fails to do so. They begin to judge themselves according to socially decided values. The main problem is a lack of recognition from those they interact with. Such people think that stigmatisers might deny them respect, and gradually these individuals come to believe that this rejection is justified (Shahwan et al., 2022).

Stigma is a key barrier to participating in mental health treatment, and people avoid treatment for two primary reasons: the fear of losing self-esteem by accepting the stigmatised label, and the fear of public exposure, being known as mentally ill. As a result, stigma interferes with the entire process of seeking care, beginning with acknowledging symptoms and continuing through the process of initiating therapy and remaining in treatment (Hector & Khey, 2018). When stigmatised people interact with one another, they experience comfort and confidence. It feels as if belonging to a community of people with a similar experience (Kreiner, 2025). This happens through peer groups or support networks and can be liberating. This type of collective coping mechanism can improve the well-being of individuals (Corrigan et al., 2012). Therefore, the analysis examines whether the selected policy documents include concrete measures such as government-supported peer networks and community programmes that play a significant part in reducing mental health stigma at an institutional stage.

Structural stigma refers to the means by which social institutions, policies, and environments create barriers for people who face mental illness, even when no individual consciously discriminates against them (Link & Phelan, 2001; Rodrigues et al., 2025). Structural or institutional stigma is reflected in regulations, laws, and policies at many levels of society, e.g., national, state, and local governments; criminal justice systems; workplaces; school districts; and universities (Kreiner, 2025). These patterns demonstrate that stigma is embedded in social and legal systems. Discrimination starts not just from direct aggression but also from the methods institutions use to handle stigmatized groups.

Thus, it can best be defined as institutionalized policies and practices that, without a reasonable or objective foundation, address people with mental illnesses in ways that reduce their opportunities and access to resources and may tend to put them generally at an unequal position in society (Voldby et al., 2022). (Page number) This happens in different sectors such as healthcare, criminal justice, media, government policy making, and public participation (Link & Phelan, 2001). People with mental illness receive inferior treatment to people with no mental illness. In the employment sector, having a mental illness can reduce opportunities, laws remain discriminatory in the justice and legal system, and there is negative coverage on most media portals (Voldby et al., 2022).

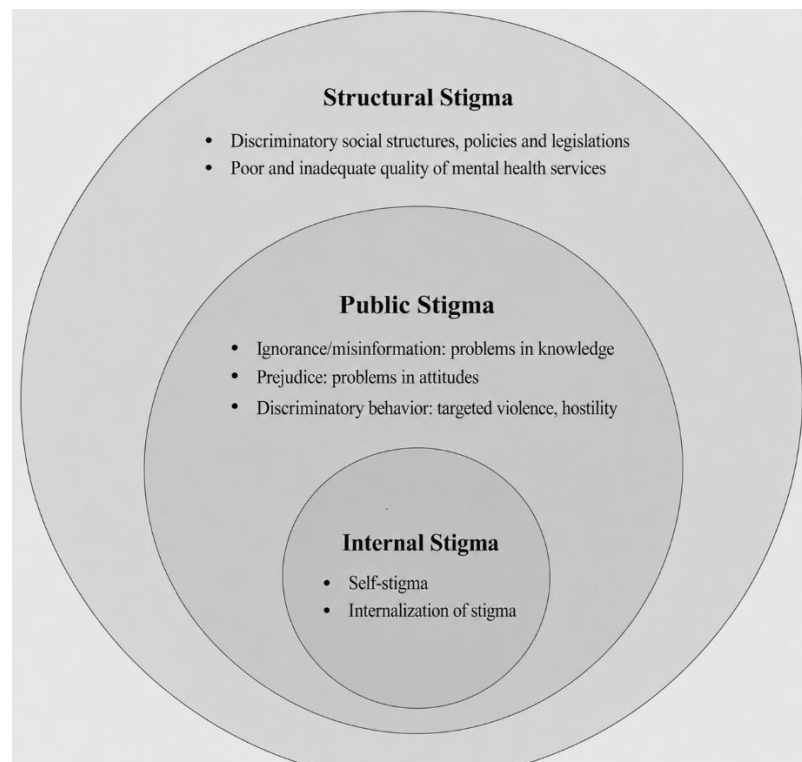


Fig. 2. Types of Mental Health Stigma

Even though all these types are different from one another in their domain and how they affect the person with mental illness, in reality, there is a chain of action that connects all three of them. The process of stigma sometimes initiates with public stigma, which is the adverse reaction that members of a community or society can have towards people with mental illness (Shahwan et al., 2022). It relates to the discriminatory treatment applied by the population, which, in general, adheres to the concept of stereotyping (Rodrigues et al., 2025). It includes naming or labelling a person with a mental illness (Link & Phelan, 2001), social exclusion by friends and family, considering them inferior even in healthcare settings at the hands of professionals. This leads to structural stigma, which is embedded in institutional settings, laws, and policies, causing discriminatory behaviour and barriers to opportunities (Hector & Khey, 2018). Structural stigma is deeply rooted in sectors such as healthcare, education, and the legal system, and requires a multilevel approach, including policy reforms, public education campaigns, and anti-discrimination measures (Rodrigues et al., 2025).

The impact caused by public and structural stigma can sometimes be harder to deal with than mental illness as such. A person with a mental health issue might internalize prejudiced views, which impact self-confidence and potentially lead to avoiding treatment, social withdrawal, substance abuse, or show suicidal tendencies (Choudhary et al., 2024). This is known as self-stigma. So, to reverse the

process of mental health stigma, addressing structural stigma first and foremost is important, as it involves reforming the laws, policies, and institutional practices. Policy can set standards and improve access to rights-based services, which can change behavioural norms and attitudes towards people with mental illness (Rodrigues et al., 2025).

These policy implications closely align with the international mental health governance agenda, particularly the WHO and UN frameworks that conceptualise stigma as a barrier to human rights, social inclusion, and access to care (Assembly, 2006; Organization, 2021). The next section builds on these connections by examining how international organisations translate stigma theory into global policy standards. The theories of Goffman, Link and Phelan, and Corrigan converge on a view of stigma as a process that violates dignity, restricts rights, and limits participation. This theoretical understanding aligns directly with how the WHO and the UN conceptualise mental health in global policy frameworks.

The WHO's Comprehensive Mental Health Action Plan 2013-2030 identifies stigma and discrimination as basic hurdles to mental health care and recovery (Organization, 2021). The action plan highlights that governments and administrations should implement policies that encourage human rights, integrate mental health into the community environment, and ensure that discrimination is avoided. It provides people with mental illness fair opportunities in education, employment, and social life (Link & Phelan, 2001). These values reflect Link and Phelan's emphasis on reducing structural Stigma through systemic reforms.

The WHO's Quality Rights document shows stigma as a violation of human rights and discriminatory, while asking for the transformation of mental health and social care services and structures toward liberation, legal capacity, and supported decision-making (Organization, 2022). This perspective mainly corresponds to (Goffman, 2009) argument that organizations often emphasize shunned identities, and to (Corrigan, 2004) finding that strong or separated services intensify both public and self-stigma.

This rights-based approach resonates strongly with Corrigan's argument that stigma limits autonomy and participation, and with Link and Phelan's emphasis on the role of social power in excluding people with mental illness. Therefore, the theoretical perspectives reviewed earlier provide a conceptual basis for interpreting what the WHO and the UN expect from national mental health policies. These models outline the mechanisms through which stigma operates, while the international framework offers the normative and legal standards against which national policies can be evaluated.

1.3. UN and WHO Frameworks to evaluate Mental Health Stigma Policies of India

This section examines the UN and WHO mental health frameworks as a baseline and foundation for evaluating the Indian Mental Health Stigma-related policy documents. The theoretical models of Goffman, Link and Phelan, and Corrigan have increased awareness and realization regarding stigma surrounding mental illness and how it adversely affects the life of a person. So, there is a need to reform mental health systems and create meaningful national policies and practices according to a human rights approach (Funk et al., 2025). Many national governments have pledged progress through UN resolutions, international conventions, and WHO action plans. These provide guidance, strategies, concrete actions, time frames, targets, and indicators (Organization, 2025a) to support the development of national mental health policies in line with international human rights standards (Funk et al., 2025).

These frameworks not only provide guidelines for policy development and implementation, but also offer very solid and tangible evaluation criteria (OHCHR, 2023) which can help to assess and review national mental health policies systematically, identify gaps, tailor policy reforms to the local context, and design person-centered directives (Funk et al., 2025). This can promote autonomy, community inclusion, and equality (Assembly, 2006) which are vital to reduce mental health stigma.

The normative policy evaluation UN and WHO frameworks include the CRPD Guide, General Comments Nos. 1, 5, and 6, the Comprehensive Mental Health Action Plan (2013-2030), Mental health, human rights and legislation: guidance and practice, and the WHO Quality Rights Toolkit on mental health policy and strategic action plan. Mental health is framed not only as a component of health but as a fundamental human right and as part of the public good. This means a shift from the biomedical model to a more person-centered, recovery-oriented, and rights-based approach (Ragins & Sunkel, 2024). States are considered largely responsible for ensuring that people with mental illness and disabilities enjoy liberty, dignity, and respect legally (Assembly, 2006). These documents are suitable evaluation benchmarks because they are built upon international human rights principles such as equality, non-discrimination, and freedom for participation, which are derived from the Universal Declaration of Human Rights, International Covenant on Economic, Social, and Cultural Rights (Cardoso et al., 2025) so, these can be instruments in assessing the extent to which human rights are being respected and upheld (Karanikolas et al., 2026).

The CRPD guide is the main foundational document which provide comprehensive, legally binding principles for evaluating mental health policy. Later, other UN and WHO guidance documents and action plans were introduced, aligned with the CRPD principles. These translated the principles into policy designs, implementation techniques, and set the assessment targets. Therefore, these documents combine to present a normative evaluation framework that can help to derive criteria (such as free and informed consent and elimination of coercive practices, equal recognition before law, stigma awareness and elimination of stereotypes, community inclusion and provision of mental health services) against which national mental health stigma-related policy documents of India can be evaluated.

The UN CRPD is a legally binding international treaty that was adopted by member states in 2006. It can be considered as the first chapter for human rights discussion in subsequent years (Cardoso et al., 2025). It was aimed to confront violations of human rights against people who experience mental illness, including those for whom psychosocial distress is an impairment (Gordon et al., 2026). The UN CRPD has reconceptualized laws (Xue & Chen, 2026). It is important to notice that the CRPD does not provide new provisions; instead, it formulates the rights already enshrined in other UN documents (Gordon et al., 2026). All countries that signed the UN CRPD have obligations to align their national laws and policies with it. It requires those who have signed and ratified it to amend their domestic law and public policies to conform with the CRPD (Gordon et al., 2026).

Since then, many states have reviewed, revised, and replaced their laws and engaged in reforming mental health policy and practices (Karanikolas et al., 2026). This is why the CRPD is used as a foundational rights-based standard for evaluating mental health stigma-related policies. Although there are 50 articles included in the treaty, this study focuses on particular legally binding principles that can evaluate mental health stigma policies. The first principles in this regard are Articles 5 and 8, which deal with equality, non-discrimination, and awareness raising (Assembly, 2006). Such

articles provide key indicators that helped to create the criteria for evaluating how states deal with stigma awareness and the elimination of stereotypes, such as in their policy domain.

Furthermore, Article 12 of the CRPD is about equal recognition before the law (Assembly, 2006), which is especially significant for evaluating mental health stigma-related policies. This ensures that people with mental illness have legal rights on an equal basis and are dealt with respect and dignity in legal capacity. It rejects restrictions for persons with mental illness based on disability as a matter of principle. In this trend, mental health is no longer approached solely as a medical or welfare concern, but increasingly appears as a site of rights, citizenship, and social justice (Xue & Chen, 2026). This constitutes a shift away from traditional institutional and medical models to a rights-based approach and requires countries to address organizations that spread exclusion and discrimination. (Cardoso et al., 2025). The other articles, such as Article 13, access to justice, Article 15 freedom from torture or cruel, inhuman or degrading treatment or punishment, Article 16 freedom from exploitation, violence and abuse, Article 17 protecting the integrity of the person, Article 21 freedom of expression and opinion, and access to information, Article 24 education, Article 25 health, and Article 27 work and employment, are all interconnected with Article 12. Integrated as one, all these articles form the fundamental backbone for evaluating national mental health stigma-related policies implemented by countries. Many indicators presented by these articles overlap with broader efforts to respect, protect, and fulfill human rights for persons with mental illness and disabilities (Karanikolas et al., 2026).

In addition, Article 19 provides a clause about living with freedom and a chance of becoming part of the community again. It is built on the idea that is against institutionalisation. It connects with Article 14 regarding the liberty and security of a person. Together, these two provide support for the evaluation criteria of community inclusion included in the study. The CRPD provisions form the first layer for the evaluation criteria, but being very broad human rights principles, further detail, organization, and instructions for better understanding are needed. For this, the CRPD General Comments provide the indication and understanding.

The CRPD Committee produces general comments, which are documents that aid the interpretation of the treaty. These comments elaborate and clarify policy provisions mentioned in the CRPD. The comments are non-binding in international law, but provide an accurate interpretation of the particular convention (Lewis & Richardson, 2020). For this evaluation criterion, General Comment No. 1 related to Article 12 equal recognition before law, No. 5 related to Article 19 community inclusion, and No. 6 related to Article 5 equality and non-discrimination are especially relevant. Together, the aforementioned articles provide guiding pointers that can assess mental health stigma-related policies.

The CRPD General Comment No.1, based on Article 12, deals with equal recognition before law, which requires operationalizing systems and practices that can bring support decision-making rather than substitute decision-making (No, 2014). This article provides an understanding of supported decision-making, where people are provided with support to make their own decisions based on their own choice and preferences. The concept of supported decision-making contradicts that of substitute decision-making. This occurs when others make decisions on behalf of individuals, often based on what they consider to be in the best interests of those individuals (Gordon et al., 2026). This is a very challenging aspect as it deals with most mental health legislations that empower the legal systems, judiciary, mental health professionals, and even family members to decide on behalf of a person with mental illness who is identified as incapable of making decisions soundly. This equips the evaluation

criteria with indicators such as legal capacity, free and informed consent, and safeguards from coercive decision-making.

Similarly, General Comment No.5 is linked to Article 19 of CRPD, which contains the right to live independently and be included in the community (CRPD, 2017). It was created to combat the paradox of institutionalization in health care settings and to make efforts towards the gradual removal of these institutions (Karanikolas et al., 2026). There is a myth that sustains this stigma PMHC are not competent enough to make decisions about their lives (Karanikolas et al., 2026). The idea to live independently while achieving a meaningful life in community lies in the heart of Article 19, and this set the stage for evaluation criteria to assess whether states introduce effective legislation for persons with mental illness to accomplish these goals.

The Mental health, human rights, and legislation: guidance and practice 2023 is a comprehensive guide on how to design, develop, and implement good practices in mental health care. It identifies the challenges associated with current mental health policies and highlights the need for reforms that are consistent with the international human rights framework (Cardoso et al., 2025). This guidance document, in line with the CRPD and international human rights laws, addresses mental health stigma, discrimination, and violation of rights experienced by people with mental illness. It means coercive practices and institutionalization must end (OHCHR, 2023). The guidance includes a checklist to be used by countries to assess and evaluate legislation regarding mental health, and whether they have adopted a rights-based approach or not. (Gordon et al., 2026). Even though the 2023 Guidance is non-binding in nature, it marks a substantial advancement from the CRPD 2006, from a framework that justified coercive intervention through procedural safeguards to a more person-centered and human rights-centered approach (Xue & Chen, 2026). It shows two decades evolution in the WHO mental health guidance frameworks from 2006 to 2023. The document provides clear normative principles that can be operationalized into evaluation criteria for assessing mental health stigma-related policies. This includes equal access to quality mental health services, legal capacity which ensures that prohibiting substitute decision making and planning are binding.

Moreover, the WHO Comprehensive Mental Health Action Plan 2013-2030 and the WHO guidance on Mental Health Policy 2025 revolve around four key objectives, which can provide bases for states to analyse their national mental health plans effectively through such set standards (Organization, 2021). The first objective emphasizes effective and strong governance for mental health. The will of leadership is important in this context. The second objective is to ensure the provision of all-inclusive, integrated mental health care services with no segregation in mental health facilities and general care in a community-based setting. The third objective demands mental health promotion, highlighting the influence of equal opportunities for people with mental illness related to social factors like poverty, violence, education, employment, and housing on mental health (Organization, 2021). These objectives help set concise targets, such as the integration of mental health care into primary health care, and more community-based health facilities (Singh, 2021) universal health coverage regardless of age, sex, and socio-economic status. The targets related to the multisectoral approach, empowerment of persons with mental illness, and stakeholders' collaboration specifically led to building the criteria of all-inclusive participation in public decision-making. This shows stigma cannot be reduced only through legal reforms and awareness campaigns, but it requires an absolutely trained administrative and governance system to carry out these reforms and campaigns. That is why this framework provides a solid theoretical foundation for evaluating India's mental health stigma-related policies.

The WHO Quality Rights Toolkit is also used in this thesis as an international normative evaluation framework. It is because this toolkit comprehends broad rights-based principles of the CRPD into concrete criteria for assessing mental health systems. This toolkit identifies main human-rights-based themes such as the fair right to quality health care, respect before law as legal person, community inclusion, independence, and liberty to live life. These are connected and related to mental health stigma policy evaluation. The evaluation criteria for this policy analysis study are derived by detecting the rights and standards most relevant to stigma reduction in Indian mental health laws and policies, especially access to quality mental health care, free and informed consent, community inclusion, and stigma awareness. The WHO Quality Rights Toolkit also helps bridge policy evaluation and stigma theory by showing how mental health stigma-related harm, such as discrimination, social exclusion, and coercive measures, can be assessed by right-based set standards.

Table 1. Evaluation criteria derived from the UN and WHO frameworks

Evaluation criteria	The main frameworks of the UN and the WHO as sources	What these criteria evaluate
1. Free and informed consent and elimination of coercive practices.	CRPD Guide, General Comments No. 1, Guidance 2023, MHAP, Quality Toolkits.	Whether the policy protects consent, refusal of treatment, withdrawal of consent, and safeguards against forced treatment, restraint, seclusion, and other coercive practices
2. Equal recognition before law.	CRPD Article-12, CRPD/GC No. 1, WHO/OHCHR Guidance 2023.	Whether the policy recognises persons with mental illness as rights-bearing individuals with legal capacity, decision-making rights, and access to complaint mechanisms. Right to education, health, and employment.
3. Provision of mental health services.	CRPD Article-25, WHO/OHCHR Guidance 2023, MHAP	Whether policy ensures accessible, affordable, culturally appropriate, community-based, and rights-based mental health services, such as less funding for asylums, and mental health insurance.
4. Stigma awareness and elimination of stereotypes.	CRPD Article-5 and 8, General Comment No.6, WHO/OHCHR Guidance 2023, MHAP, Quality toolkits	Whether the policy includes awareness, education, training, and institutional measures to reduce stereotypes, prejudice, and discrimination.
5. Community inclusion	CRPD Article 19, General Comment No.5, WHO/OHCHR Guidance 2023, MHAP, Quality toolkits	Whether the policy supports community-based care, independent living, peer support, primary-care integration, and reduction of institutionalisation.
6. All-inclusive participation in Public decision-making.	CRPD Article 19, General Comment No.5, WHO/OHCHR Guidance 2023, MHAP, Quality toolkits	Whether persons with lived experience are included in policy-making, implementation, monitoring, and evaluation

This table shows six evaluation criteria, which are derived from the UN and WHO mental health frameworks, and what they will assess regarding mental health stigma in Indian Mental health policy documents. These are not just separate themes but combine to form an analytical normative framework. Each criterion is further functionalized into target questions (included as appendix-1), which form a matrix for evaluating mental health stigma-related policies.

2. Methodology

This study examines how mental health stigma is addressed in selected Indian mental health policy and legal documents. The research focuses on evaluating specific policy designs and governance documents rather than examining public attitudes, empirical results, and outcomes. The focus is on formal public policy frameworks and action plans that reflect or mirror the international right-based (Singh, 2021) and mental health frameworks, which include instructions on how to follow or implement stigma-related principles. For this study, the UN and WHO mental health frameworks are best suited because they include indicators and global targets for countries, which we can use to analyze a country's national action plans and policies. The good thing is that these are elaborated with consultations of member states.

Mental health stigma is not only observed in social attitudes and prejudices in society, but also, more specifically, in how it is embedded at the institutional level. To combat it, state-level action plans, policies, and laws are required. This research investigates Indian policy documents that in which manner they address stigma. The use of words and language, the level of priority, safeguards, protection measures, and initiative. In this sense, stigma is understood both directly through references to discrimination, anti-stigma measures, and right-based protection, and indirectly through policy provisions related to respect, recovery, and community-based care. (OHCHR, 2023). So, the object of research is Indian mental health policy documents. More specifically, on these documents, the mental health stigma-related policies. The subject of research is how stigma-related principles are treated in these policies and whether they deal with discrimination, exclusion, and forced institutionalization ideas.

2.1. Research design

The following study works with a normative policy evaluation design. Normative policy evaluation criteria enable planners to distinguish 'good' from 'bad' and to answer the normative questions concerning what makes a plan/policy a good plan/policy, or how would we know a good plan/policy if we saw one? Without such normative criteria, policy analyses might be merely based on some subjective value judgements, and planners cannot properly justify and validate the outcomes of their evaluations (Shahab et al., 2019). The reason for using this policy evaluation design is that this study evaluates the Indian mental health stigma policy documents through a normative evaluation criterion. In this research, the normative evaluation criteria are derived from international human rights and mental health frameworks developed by organizations such as the WHO and the UN. These frameworks provide a set of principles, including non-discrimination, anti-stigma values, which serve as benchmarks for analysis.

This approach is different from conventional policy evaluation approaches. A conventional policy approach checks if the policy achieved its goals or not. It means checking what was planned earlier in the goals. It analyses the overall successes and failures of policy based on results. On the other hand, in normative design, we need standards and values to judge the policies. Under this normative design, the Indian written policy documents will be read, studied carefully, and the important ideas regarding mental health stigma will be identified and analysed. So, it evaluates the extent to which India's health policy aligns with these normative standards with the aim of identifying key gaps between international guidelines and national policy designs and implementations.

While conducting the evaluation during the study, a deductive content analysis approach was used. This approach consists of reading textual data and highlighting those parts of the text that, on first impression, appeared to be related to the predetermined codes. Next, the highlighted texts would be coded using the predetermined codes.(Assarroudi et al., 2018).

For the coding process, the first step was that the provisions presented in the UN and WHO frameworks are broad and overlapping, so they were organized into six evaluation criteria. These chosen criteria are directly or indirectly connected to mental health stigma. The selected criteria include 1. Equal recognition before law 2. Free and informal consent and elimination of coercive practices 3. Community inclusion 4. Quality mental health services 5. Effective participation in public decision making 6. Anti-stigma awareness and elimination of stereotypes.

For these criteria to work, they are further segregated into easily usable target questions. Each document was read systematically, and provisions relevant to each question were identified, extracted, and coded under the appropriate criteria. These questions under each criterion help to analyze the strengths and weaknesses of Indian mental health stigma policies. For example, the criteria of free and informed consent and elimination of coercive practices include questions related to the right to gain information about health assessment and treatment, and the use of force during treatment in mental health institutions. This will help to look at Indian mental health policy documents extensively and identify laws related to mental health stigma.

In this design, the method of qualitative document analysis uses documents as the main source. These documents provide research data, information, and insights that can be a valuable addition to a knowledge base (Bowen, 2009). This method is appropriate because the study is based on close reading and interpretation of official documents rather than on interviews, surveys, or statistical data.

According to this approach, the reading text included Indian mental health policy documents such as MHCA 2017, RPwD 2016, and NMHP 2014. The codes for this study are also predetermined by selecting synthesizing and selecting criteria specifically related to mental health stigma from the UN and WHO frameworks. The documents were read, and the parts of the policy document relevant and connected to these codes were highlighted. Each relevant part highlighted was then organized under its relevant code. The policy documents were also assessed on a qualitative basis of how strongly moderate or weak each criterion was reflected in them. This created a very organized comparative matrix. A strong rating indicates that the criteria are strongly embedded in the policy document and directly reflect the WHO and UN standards. It provides specific rights, duties, and safeguards that match the criteria. A moderate rating indicated that the document addresses the criteria partially or indirectly, but the provision is general, limited, vague, conditional, or lacks detailed implementation safeguards. Under weak alignment, the document does not address the criteria clearly, contradicts the statement, or leaves a major gap in protection. In the final step, these findings were interpreted to know about the strengths, limitations, and gaps in India's mental health stigma policy documents.

Scientific literature was also used for analyzing mental health stigma in India's real-life setting. It was also used to provide evidence and strengthen the analysis of Indian Mental health policy documents. Scientific articles are collected using SCOPUS, Google, ScienceDirect, PubMed, Sage Journals, ResearchGate, and Springer Nature links.

Further, the study consists of three main parts: theoretical frameworks, normative evaluation of Indian policy documents, and, thirdly, the conclusion. The theoretical section of this research discusses the

conceptual bases for the whole research. It consists of three key elements: the main concepts of mental health and mental health policy, theoretical frameworks of stigma and normative frameworks as evaluation criteria for Indian Mental health policy documents. Firstly, the fundamental concepts of mental health, mental illness, and mental health policy are added, which help to understand how stigma emerges in the health and governance system and connect to them. Secondly, classical and contemporary stigma theories explain stigma as a social and structural process that includes labelling, stereotyping, status loss, and discrimination. These theories prove that stigma not only develops at the individual level but is also deeply embedded at the societal and structural level. The theories added in this section are core theories by Erving Goffman, Bruce Link, and Jo Phelan. Thirdly, the theoretical section includes international normative frameworks developed by the UN and WHO organizations to evaluate mental health plans and policies.

2.2. UN and WHO frameworks as evaluation benchmarks

While establishing criteria for my normative evaluation of Indian mental policy documents, the frameworks of the UN and WHO regarding mental health policy were the most accurate choice. These international mental health policy frameworks are globally recognized standards for overall and especially state-led policy evaluation. These frameworks include the Conventions on the Rights of Persons with Disability (CRPD), CRPD General Comment No. 1, CRPD General Comments No. 5, CRPD General Comments No. 6, WHO-ONHCR Guidance 2023, and WHO Comprehensive Mental Health Action Plan 2013-2030.

The documents such as CRPD are legally binding if signed and satisfied by state parties. The status of India showed that it was ratified in 2007, which makes it a state party. It is itself a formal policy document that lists general principles of evaluation in the form of articles. This helps to easily use it as an analytical framework for another mental health policy document. For more guidance regarding specific mental health stigma-related articles of CRPD, Article 5, Article 12, and Article 19, the documents of general comments 6, 1, and 5 are used as they help us to dive deeper and interpret in detail these earlier-mentioned articles. They help to understand the vague language of the CRPD guide. The broad principles can be easily coded into usable categories for the evaluation of Indian mental health stigma policies.

Comprehensive Mental Health Action Plan 2013 and WHO-ONHCR Guidance 2023 were elaborated with the consultation of member states. These are involuntary and non-binding but provide resources and guidance for states that are thinking of adopting, implementing, or needing to access mental health legislation. These are closely linked frameworks that are also in line with principles from the CRPD guide. In light of widespread human rights violations and discrimination experienced by people with mental disorders, a human rights perspective is essential.

Before the evaluation of Indian Mental Health stigma policies, a brief analysis of Indian mental health stigma is included in the research.

2.3. Indian Mental Health Stigma Policy Documents

Before directly starting the normative evaluation of Indian Mental Health Policy documents, this study works its way up by adding the existing mental health stigma landscape to form a context ahead of the real evaluation. The analysis focuses on public stigma and structural stigma. This provides an empirical background that provides a better understanding of the Indian mental health

scenario overall. We can also clearly see the gap between lived realities about stigma in social and on a structural level, and policy designs.

The documents as the object of assessment I chose are the NMHP 2014, MHCA 2017, and the RPwD 2016. The National Mental Health Policy 2014 provides the vision and sets the policy objectives regarding nationwide mental health initiatives. It determines the goals and priorities of national health reforms. Both NMHP 2014 and MHCA 2017 are binding laws. MHCA 2017 enforces the rights of persons with mental illness and the responsibilities of the mental healthcare system. It is made in accordance with principles laid out in the CRPD Guide of the UN 2006, for which India is a signatory since 2007. MHCA 2017 seeks to impose a government duty to reduce stigma and spread awareness regarding mental health problems. RPwDA 2016 safeguards against discrimination. It includes mental illness as one disability category. It broadly focuses on the inclusion and entitlement of people with all kinds of disabilities. DMHP focuses on providing health services. It focuses on service delivery, training, and district administration. It works through health administration and the district public health system. Together, these four documents provide a detailed insight into the Indian policies and initiatives regarding Mental health stigma.

2.4. Rigor and limitation

The rigor of this study can be seen as the systematic analytical approach adopted in Normative evaluation design. A predetermined coding mechanism and organized matrix with a transparent rating system are applied consistently in all the selected mental health policy documents. This shows that the analysis is not based on vague impressions. By corroborating evidence from other scientific literature back the analysis made during the study.

The limitations include that the study is based on analyses of documents. This cannot help us to fully measure how policy works in real life, and no empirical data has been collected to measure the actual outcomes. Another important aspect is that this study is limited to selected mental health policy documents. Which means analysis is only limited to these documents. It is not necessary that all legislation related to mental health stigma is contained in one standalone, single, corroborated document, but other policy documents as well, in an integrated way. So, this makes it challenging for all the findings and interpretations of these documents to provide a complete picture of India's mental health reduction effort.

3. Indian Mental Health Stigma Policy Evaluation

Globally, people with mental health conditions face serious challenges in gaining access to fundamental rights. They are subject to discrimination and poor-quality healthcare. The stigma associated with these conditions means that people experience exclusion and rejection in society (Organization, 2012). Mental health problems persist in India at an alarming rate. This statement can be verified by the findings of NMHS 2015-16, according to which the mental health morbidity rate is 10.6% for the adult population.(Mallik, 2025). 150 million Indians need active mental health intervention (Avula et al., 2025). According to The Lancet in Global Burden of Disease, by 2017, about 197 million people (14.3%) were affected by mental disorders. (Sagar et al., 2020). The trend in youth is specifically highlighted by the Mental State of India report, according to which over 50% youth scored in the “distressed or struggling” range on the Mental Health Quotient (MHQ) (Labs, 2023). The real issue is not that the problem emerges and exists, but that it continues to persist due to a lack of awareness and strong stigma around it.

While discussing the theories related to stigma, it was already mentioned that stigma is a situation or process in which a person is labelled negatively and then discriminated against at many different levels, which can damage the psychological and emotional state further, along with the credibility of the person as part of society. One important way to improve the lives of these people is through effective policies and legislative reforms. Since India ratified the UN CRPD in 2007, there has been a major shift in its mental health policies from a focus on medical treatment to a rights-based model. These acts include NMHP 2014, RPwD 2016, and MHCA 2017. These acts and policies aim to provide quality mental health care and emphasize reducing stigma around mental health. To know whether these policies and acts adhere to international standards, it is critical to assess and evaluate them. Evaluation of Indian mental health stigma policies through the lens of UN and WHO mental health frameworks helps to further amend existing ones, introduce and implement new reforms in India.

3.1. National Mental Health Policy 2014

The NMHP 2014 represents a significant shift in India’s mental health governance journey. It is a national framework that was developed in the Indian context to align Indian mental health policy with WHO mental health policy guidance and the CRPD. The policy highlights the cross-cutting issues such as stigma, rights-based approach, and community participation. The policy aims to promote mental health and mental illness and ensure the socio-economic inclusion of persons with mental health conditions. However, there is a need to critically assess the policy visions, aims, and suggestions to know how India’s policy framework addresses mental health stigma, rights protection, and legal capacity for PMHC.

Free and informal consent and elimination of coercive practices

The NMHP 2014 of India provides a very limited foundation for strength or partial alignment related to the criteria of free and informed consent and elimination of coercive practices. It broadly mentions that human rights and the dignity of persons with mental illness and disabilities should be respected and protected. The values of the document also promise to protect the autonomy and freedom of choice of a person with mental health conditions (Ministry of Health & Family Welfare, 2014). These values reflect the global target of the WHO Mental Health Action Plan 2013-2030, which proposes that countries implement national policies and regulations in line with international and regional

human rights instruments. This also links these values to the CRPD Article 14, which emphasizes member states to ensure the rights and liberty of people with mental health conditions. The right-based language challenges the stereotypes that PMHC are not capable of deciding on their own (Choudhary et al., 2024). However, these broad principles cannot provide a clear picture of how they establish mechanisms or detailed treatment rights, which include free and informed consent and protection from coercive practices.

The policy aligns at the conceptual level, but there are many weaknesses and gaps regarding the above-mentioned criteria. The NMHP 2014 does not clearly satisfy the targeted questions under this criterion. The policy refers to protecting autonomy and liberty (Gupta & Sagar, 2022), but it lacks clear policy commitments such as consent to agree or refuse treatment, withdrawal of consent, and the right to receive information about treatment, or alternative treatment in simple and understandable language. It remains vague about the mental health-related interventions that should be the basis for a person to be able to make decisions about their own treatment choices. It did not clearly prohibit forced treatment, use of coercive measures such as chemical restraints or use of ECT. This shows a significant gap when evaluating it in comparison to the WHO/OHCHR 2023 and the CRPD-based standards. WHO/OHCHR 2023 framework clearly mentions that ending coercive practices such as involuntary treatment, isolation, and restraints is imperative to respect the rights of people using mental healthcare services (OHCHR, 2023). It is the fundamental component of the right to health.

Equal recognition before the law

The strengths of NMHP 2014 in relation to the criteria of equal recognition are that there should be no discrimination and equal opportunities for people with mental illness and disabilities. This non-discrimination and equal opportunity principle is related to different sectors of life, such as education, employment, and housing facilities, and shows that the policy adopted some new features (Gupta, 2021). There should be facilities for education to improve employability, and in the employment sector, no discrimination in seeking and retaining employment through employment policies for people with mental illness and disability. It must not be difficult for them to take part in regular activities such as operating bank accounts, obtaining identity documents, obtaining a driving license, and writing a will (Ministry of Health & Family Welfare, 2014). Introducing such measures and making them part of national policy explicitly indicates that Indian policy is meant to reduce structural stigma, which in turn leads to reducing public and self-stigma. People with mental illness will not feel status loss and discrimination due to stereotypes such as being incapable (Ahad et al., 2023). This strongly aligns with MHAP implementation options to support the recovery plan with resources. It advocates social inclusion with sectors such as housing, employment, and education (Organization, 2021). CRPD Articles 18, 24, and 27 also conform to this principle, which prohibits discrimination based on disability (Assembly, 2006).

The policy alignment is moderate, as it suggests amending and replacing policies and laws that are a reason for discrimination against people with mental illness. It also requires removing regulations and policies that create discrimination and stigma for people with mental illness, and further lead to exclusion from the community and society (Ministry of Health & Family Welfare, 2014). Even though these are strong conceptual principles in terms of the criteria for equal recognition before law, there is no operational strength in these. It is not a comprehensive strategy that identifies the specific barriers that produce exclusion and status loss for people with mental illness. There is no system introduced to indicate or enforce these reforms (Gupta & Sagar, 2022). The policy also introduces

the value that service and service providers are accountable to the person with mental illness. This recognizes them as rights holders. It means the service provider must be answerable to those people who provide mental health services. However, this provision does not provide a roadmap for what the accountability procedure will be, which clearly does not align with WHO/OHCHR 2023, indicating that a standalone mental health policy must include provisions related to matters such as the rights of service users in mental healthcare services, their diagnostic criteria, voluntary and involuntary treatment options, treatment within the community, informed consent for treatment, such as the use of ECT (OHCHR, 2023). It also wants countries to determine the integration of accountability mechanisms in all aspects of mental healthcare policy through legislation.

Even though NMHP 2014 recognizes non-discrimination and equal opportunities (Ministry of Health & Family Welfare, 2014) based on the target questions within the criteria of equal recognition before the law, it remains weak. The weakness and gaps exist related to protection and safeguards around the right of marriage, family, parenthood, and reproduction. It also does not mention anything about the legal standing of a person with disabilities in terms of the right to own, buy, or sell property. It does not address any legal remedies to uphold the rights of a person with mental illness or access to legal aid. This is a clear limitation and gap in terms of CRPD/GC No.1, under which Article 12 affirms that a person's mental health status must never be a ground for denying legal capacity. CRPD/GC No.1 wants states to provide the right of supported decision making by replacing substitute decision making (No, 2014). The WHO Quality Rights Toolkit and WHO/OHCHR 2023 also adhere to the same standard. The policy document does not explain how a person with health conditions will be supported in making health care or treatment decisions. This right of a person with mental health conditions provides them with legal capacity to choose, amend, or replace the decisions to acquire a supported decision maker (Domański & Lackoroński, 2023). With this right, the person will remain in control of decision-making capacity regarding treatment, healthcare, and life decisions. NHMP 2014 completely ignored this side of legal capacity while making policy. It means that NHMP 2014 does not fully comply with the CRPD Guide.

Quality mental health services

NMHP 2014 values the importance of integrated and quality healthcare for people with mental illness and disability. It requires that **mental healthcare services should be integrated into primary healthcare**. For this purpose, it suggests strategies such as for **short-term treatment, mental healthcare must be available in general hospitals like district hospitals, teaching hospitals, and medical college hospitals. These include family-centric services, screening, early identification and treatment of illness, improved infrastructure, recognition of assisted living and mental health services in a multi-specialty government hospital.** (Ministry of Health & Family Welfare, 2014). Another example of integration into primary care is including early childhood mental health programs in broad quality care through Aanganwadi centres. They need to redesign in a manner that, rather than just providing for basic needs, they support emotional and mental well-being by making a strong mother-child link. This will help to detect and cater to any early symptoms of mental illness. The awareness at an early stage about illness and its impact can make the person with illness more confident in dealing with it, and build a support mechanism to deal with any kind of stigma (Girase et al., 2022). There is a strong emphasis on accessible, comprehensive, and universally available mental health services with international standards (Gupta, 2021). These provisions all show strong conceptual alignment with the principle of universal health coverage by MHAP. It aligns with targets such as integrated mental health into primary health by 2030, outpatient care in general hospitals, and facilitating the recovery

of people of all ages with mental illness (Organization, 2021). The provisions also align with Article 25 of CRPD, which states that members need to provide people with mental health conditions the same quality and standard of healthcare as provided to other people (Assembly, 2006).

The policy document also links quality care with adequate, advanced, and inter-sectoral funding and financing. The policy is integrated in nature and reflects global thinking in addressing ground realities and conditions in relation to the Indian context. That is why it reflects significant areas for action, such as universal access to mental health care (Gupta, 2021). It calls for planning according to the measured needs of mental illness and mental health problems and then allocating the budget according to different sectors. It recommends, therefore, appropriate plans with budgetary provision under each sector, such as education, employment, housing, and social care (Ministry of Health & Family Welfare, 2014). These provisions comply with MHAP objectives, including universal healthcare and evidence-based financial protection (Organization, 2021). It also complies with CRPD's substantive equality concept and the WHO Quality Rights Toolkit, which supports the evaluation of quality mental health services by defining them in both clinical and human terms (Organization, 2012). This means that the services should be available to the person with mental illness, including skilled staff, counselling, access to medication, but also without any discrimination. This helps to reduce the structural stigma around people with mental illness and mental disorders.

The NMHP 2014 moderately adheres to the importance of geographically accessible mental health services for people who live in rural areas or vulnerable groups, including homeless people. It recognizes that there is a need to increase access to mental health services in remote areas and difficult geographical locations. It recommends setting up crisis intervention centers and helplines as part of a district mental health program, and that people should actually be able to utilize them (Ministry of Health & Family Welfare, 2014). These provisions are in line with the WHO and UN mental health frameworks, but only provide a broader perspective (Jyotika, 2026). They are moderate because they do not specify the operational mechanism, as mentioned in frameworks. It lacks a target outreach, service model, or a comprehensive plan including actions, targets, implementation, and a monitoring system. MHAP, in this regard, provides detailed options for implementation, such as remote delivery services, digital health solutions, and in-home services (Organization, 2021). If a person with a mental illness, especially those belonging to vulnerable groups, cannot timely access these mental healthcare facilities, it can increase not only the severity of the disease but also internalize stigma among people with mental illness.

The NMHP 2014 shows a very broad conceptual model related to funding and finance on mental illness and disabilities, but it missed many important themes that need to be captured and mentioned while talking about budgetary planning. One of these themes is about mental health insurance (Gupta & Sagar, 2022). The policy document generally recognizes how poverty and excessive spending on mental health can be burdensome and aggravate the stress of people with mental illness (Ministry of Health & Family Welfare, 2014), but clearly does not guarantee mental health insurance as part of policies in both the public and private sectors. There is a need to guarantee that mental health care is recognized as equal to physical health care (Bhatta et al., 2025). Such distinctions, if kept, can increase discrimination against people with mental health conditions. Not being able to access mental healthcare insurance as part of a common health insurance plan cannot become a barrier in gaining access to mental health care facilities, as PMHC can lead to chronic illness (Arahanthabailu et al., 2024). This is a clear example of structural stigma. WHO/OHCHR Guidance 2023 demands that

countries operationalize their commitment to international human rights instruments by prohibiting any form of discrimination and facilitating equal access to health insurance (OHCHR, 2023).

The second theme is also connected to the same idea, which is about cost-free mental healthcare. NMHP 2014 provides no binding budgetary targets related to free and affordable healthcare. This is important because the WHO Quality Rights Toolkit and MHAP state that mental health services should be available for everyone, regardless of their social and economic status (Organization, 2021). Article 25 of the CRPD also recommends providing free and affordable healthcare programs for people with mental illness and disabilities (Assembly, 2006). Therefore, the absence of clear binding targets related to free and affordable mental healthcare shows weakness and gaps in policy alignment with the UN and WHO frameworks.

Stigma reduction and elimination of stereotypes

The NMPH 2014 shows strong alignment with the criteria of stigma reduction and elimination of stereotypes, with the provisions about improving human resources to address mental health needs. It introduces key areas of action such as effective governance and accountability, promotion of mental health, and enhanced availability of human resources for mental health (Gupta, 2021). The policy suggests increasing trained mental health professionals such as psychiatrists, psychologists, and counselors. It also suggests introducing training programs while integrating mental health into other allied fields, strengthening psychiatric nursing by introducing Master's and Diploma courses, and upgrading the mental health skills of Auxiliary Nursing Midwives (Ministry of Health & Family Welfare, 2014). PMHC can also be an important resources who can support recovery and spread information about mental health (Guerrero et al., 2025). Most importantly, the policy recommends that psychosocial interventions should be incorporated across disciplines to decrease stigma. These provisions show strong compliance with the UN and WHO mental health frameworks because, to reduce mental health stigma, actions such as mental healthcare training for healthcare providers are mandatory (OHCHR, 2023). These provisions can also lead to reducing stigma in mental healthcare professionals towards people with mental health conditions and treating them with better care (Sukhera & Knaak, 2022).

Further, the policy also recommends that training Anganwadi workers and schoolteachers is to help parents and caregivers understand the needs of the children. (Ogundele, 2018). This type of education discusses issues like social exclusion, life skills, including emotional awareness, communication, decision making, confidence, empathy, and problem solving. This will become part of the child's early mental health promotion. As signs of mental illness emerge mostly during adolescence, this system will create barriers in an individual's development of internal stigma and provide power to fight back against public mental health stigma to reduce its negative effects on them. Due to this, these provisions are closely aligned with the WHO and UN mental health frameworks, which promote combating stereotypes, prejudices, and harmful practices relating to people with disabilities.

The NMHP 2014 shows moderate conformity with the criteria of stigma awareness and elimination of stereotypes. The policy suggests that reliable mental health information should be easily available through mass media events, contact programmes to meet people with lived experience, counseling sessions, helplines, and websites (Ministry of Health & Family Welfare, 2014). These suggestions are linked to the idea of stigma reduction through mental health stigma awareness, combating the lack of knowledge about mental illness. It reflects the principles of Article 18 of CRPD, which demands

raising awareness to combat labelling and stereotyping through responsible media portrayal (Assembly, 2006).

The policy also encourages creating awareness among policymakers, planners, and governments about how income disparity, poverty, and unequal economic opportunities are connected to a high rate of depression and anxiety. There is a need to deal with these issues as they cause structural-level stigma and discrimination, which can worsen the situation of mental health. However, these can be classified as moderate provisions as they don't specify media, including social and print guidance and regulations related to anti-stigma content. It requires details about the use of language and ethics while reporting.

The criteria of stigma awareness and elimination of stereotypes are given due importance in the NMHP 2014 document. However, minor weaknesses or gaps can be seen where the policy does not create binding rules for workplaces and professional setups about how to prevent public and structural mental health stigma. There are no suggestions about how workplace regulations should be planned and implemented to deal with any kind of labeling, stereotyping, or discrimination in an office or professional capacity or environment (Ministry of Health & Family Welfare, 2014). The CRPD Article 27 completely deals with regulations regarding work and employment. It requires member states to introduce legislation for protection from harassment, safe working environment (Assembly, 2006). A further weakness and gap is that the policy document provides no insight into the mechanisms for monitoring, complaint, and accountability in case of stigmatizing behaviour. It does not explain how discriminatory or stigmatizing conduct by mental health professionals, employers, teachers, or media actors will be reported or corrected. The WHO Quality Rights Toolkit very specifically mentions accountability and discusses independent commissions, NGOs, and assessment committees to assess human rights in mental health (Organization, 2012). Therefore, when evaluating NMHP 2014, under UN and WHO frameworks, weakness is not that policy ignores stigma, but it does not specify a procedure to monitor or measurable indicators in case of discrimination against a person with lived experience.

Community Inclusion

Under the criteria of community inclusion, the strength of NMHP 2014 is related to giving importance to the needs of vulnerable members of society, who also carry the burden of mental illness and disability. The act acknowledges the issues faced by different vulnerable groups, such as the poor, homeless, children, women, and internally displaced people. It suggests measures to help these people become independent to lead their lives while also feeling like a member of the community and society. The suggested measures include changing poor living conditions, such as homelessness, overcrowding, sanitation, toilets, adequate nutrition, and safe drinking water (Ministry of Health & Family Welfare, 2014). The absence of these social factors can cause slow and poor recovery. It also suggests facilitating education for people with mental illness to increase job prospects, increase the availability of a range of community services such as daycare centers and short stay facilities, and appropriate housing with necessary support. These provisions support the CRPD Article 19, which recognizes the equal rights of people with mental illness and disability to live in the community and have choices equal to others (CRPD, 2017). The same right is also recognised by other UN and WHO mental health frameworks. Another strength of the act is the emphasis on inter-school coordination. It promotes the idea that the needs of persons with mental illness cannot be met by the health sector alone and requires collaboration with other sectors, such

as education, employment, housing, and social care. This shows the understanding that recovery from illness cannot be dependent only on clinical treatment. The act recommends that related departments should introduce policies and regulations, funding provisions, and explain how they can increase participation of people with mental illness across these departments. This aligns with MHAP, which requires states to adopt a multisectoral approach through coordination and partnership with the public sector.

On the side of moderate provision, the act acknowledges the issues of all different vulnerable groups and mentions them in detail, but while mentioning suggesting important groups were completely ignored. One such important group was people inside custodial institutions. The act recognizes the challenges of layered stigma within the criminal justice system, as the label of “criminal” can be harsh, misinterpreted, and almost impossible to remove (Ministry of Health & Family Welfare, 2014). In the mental health realm, stigma can be just as harsh and limit or prevent an individual from seeking treatment (Ahad et al., 2023). Now, if we picture both together can cause harmful and tragic outcomes. The act does not provide a clear community-inclusion strategy. It does not explain how persons with mental illness and disability will be supported to move into community-based care. When evaluated against UN and WHO standards, it is a limitation because the frameworks stressed on community based and rights-based approach.

A major weakness of NMHP 2014 is recognizing the need for institutional care, especially long-term institutional care, as treatment for mental illness, while evaluating it against the UN and WHO mental health frameworks. It acknowledges that mental healthcare hospitals are traditionally considered a major tool for the treatment of patients (Gupta, 2021). This creates conflict with the UN and WHO frameworks. MHAP recommends shifting away from institutional care towards community-based care, such as mental health care (Organization, 2021). CRPD and Guidance consider deinstitutionalization as an important aspect for the transformation of the mental healthcare system.

Full and effective participation in public decision-making

The main strength regarding the criteria of full and effective participation in public decision-making is that it upholds the right of people with mental health conditions to participate during the planning, development, delivery, and implementation of mental healthcare services. PMHCs are not part of the problem, but those who can understand and contribute to finding solutions, designing, and then implementing (Pinfold et al., 2025). It instantly helps in removing the label of being incapable from people with mental illness. The policy also recommended participation of PMHC in local committees and community monitoring processes (Ministry of Health & Family Welfare, 2014). It strongly conforms with the suggested action of MHAP, which recommends that people with mental illness be given a formal role in influencing the process of law-making (Organization, 2021). It also aligns with Article 21 of CRPD, which requires providing people with mental illness with opportunities to actively be involved in decision-making about policies and plans directly concerning them (Assembly, 2006).

The policy area remains partially aligned in regard to how these provisions will take effect. While it establishes the concept of participation of people with lived experience in public decision-making related to mental healthcare policies, when evaluating through target questions, it is not clearly visible from the suggestions that such participation will carry any weight. There is no point mentioned in the policy that suggests a way or method to assess or raise concern if it is felt by people with mental

health conditions that the consultation is not fair or that their consultation with them will be effectively added into the development process of policies and legislations regarding mental health. This shows moderate alignment with the WHO and UN mental health frameworks. In this regard, the WHO Quality Rights Toolkit provides a very comprehensive plan about how to include people with mental illness in committees for assessment of services, their tasks, and training (Organization, 2012). The CRPD Article 4 also requires states to create awareness, train, and provide support to maximize the involvement and participation of people with lived experience (Assembly, 2006).

There are some important gaps and weaknesses in the criteria of full and effective participation in public decision-making in NMHP 2014, while evaluating it against the UN and WHO mental health frameworks. The MHAP clearly identifies in its implementation options related to the empowerment of people with mental illness and disabilities to form autonomous central and regional organizations of PMHC for their effective participation in the formulation, implementation, and monitoring of mental health legislation (Organization, 2021). MHAP and WHO/OHCHR 2023 emphasized that states need to adopt legislative provisions to grant people with lived experience and their related organizations to have seats in committees or monitoring bodies (OHCHR, 2023). For effective participation and feedback, there should be voting rights guaranteed. The policy of 2014 has no such provisions included. This shows a gap between the language of the document and enforceable participation mechanisms.

Table 2. Evaluation matrix for National Mental Health Policy 2014

Criteria	Strengths	Moderate points	Weaknesses/gaps
Free and informed consent and elimination of coercion.	Dignity, autonomy, human rights, and freedom of choice.	Rights-based language only.	No clear provision of consent, refusal, withdrawal, forced treatment, restraint, seclusion, or ECT safeguards.
Equal recognition before the law.	Non-discrimination; equal opportunity in education, work, housing, identity documents, banking, and wills.	Calls for reform of discriminatory laws.	No clear legal capacity, supported decision-making, legal aid, or remedies.
Quality mental health services	Accessible, affordable, integrated, primary-care-based services.	Rural access, helplines, crisis care, vulnerable groups.	No binding budget, timeline, insurance guarantee, workforce standard, or universal coverage mechanism.
Stigma awareness and elimination of stereotypes	Awareness, training, school education, caregiver support.	Media, counselling, helplines, and contact programmes.	No binding anti-stigma duties, monitoring, or accountability.
Community inclusion	Community services, daycare, short-stay care, housing, education, and employment support.	Recognises vulnerable groups and social determinants.	Still allows institutional care; no clear deinstitutionalisation or peer-led support plan.
Participation in public decision-making	Involvement in planning, implementation, monitoring, and service delivery.	Participation is mentioned generally.	No guaranteed representation, voting rights, or independent user bodies.

3.2. Indian Mental Healthcare Act 2017

After India ratified the UN CRPD in 2007, there was a need to revise the mental health policies and legislation to promote and protect the rights of people with mental health conditions (Malhotra et al., 2024). The old Mental Health Act 1987 was considered insufficient in this regard. The new act, called the Mental Healthcare Act 2017, received the approval of the president of India on April 7th, 2017 (Duffy & Kelly, 2017). The act was introduced to provide a legal framework to improve mental healthcare services and to emphasize the rights of individuals with mental disorders.

Therefore, this act is relevant for this normative evaluation study (Avula et al., 2025). Therefore, this act is relevant for this normative evaluation study because it allows the evaluation of whether this Indian legislation addresses stigma through solid legal protections against free and informed consent, coercion, discrimination, and institutionalization.

Free and informed consent and elimination of coercive

At the level of legal text, MHCA 2017 demonstrates several important strengths in meeting the criteria of free and informed consent and elimination of coercive practices. A major point of the Act is its clear definition of informed consent in section 2(1)(i), which defines informed consent as approval given without use of force or under any influence, fraud, threat, misrepresentation, and only after adequate knowledge has been provided about the risks, benefits of, and alternatives to the specific intervention in a language and manner understood by the person (MoHFW, 2017). This concept strongly aligns with the WHO/OHCHR Guidance and the WHO Quality Rights Toolkit approach because both frameworks emphasize that mental health treatment should be based on free and informed consent rather than be influenced by or substitute decision making (OHCHR, 2023; Organization, 2012). Another provision in Chapter II of the Act is Section 4, which recognizes the capacity of a person with mental illness to make mental healthcare and treatment decisions. This section states that a person with a mental illness must be regarded as having a capacity to make a decision related to their mental illness if they can understand related information, communicate their decision through language use, sign, expression, or any other way. It is also required that information be provided in simple language, through the use of sign language, or any other means. The ability to make informed decisions about one's mental healthcare is central to ensuring that the treatment aligns with an individual's preferences and best interests (Kaur & Dangwal, 2024). This reflects the CRPD guide towards Article 21, freedom of expression and opinion, including seeking and receiving information on an equal basis (Assembly, 2006).

The Act strongly recognizes the right of information in Section 22, according to which the person with mental illness and their nominative representative have the right to information such as the laws under which the person is admitted, the criteria for admission, the right to apply for review, the proposed treatment plan, side effects of it in a language they can understand (MoHFW, 2017). This aligns with WHO/OHCHR Guidance 2023 and the WHO Quality Rights Toolkit, which requires service users to receive information about assessment, treatment, and recovery options in a way a person with mental illness can understand (OHCHR, 2023). The lack of capacity-based safeguards might leave persons with mental illness more vulnerable to abuse, particularly in situations where their decision-making ability is questioned but not properly assessed (Kaur & Dangwal, 2024). WHO/OHCHR and the CRPD/GC No. 6 also explicitly advocate free and informed consent for all adults (Committee, 2018). Section 86(5)(3) of MHCA 2017 upholds this stance and prohibits giving treatment without informed consent and grants the right to admit a person with mental illness on their own request.

In terms of coercive measures, the Act 2017 prohibits the use of the ECT method without the use of anaesthesia and muscle relaxants for minors (Kaur & Dangwal, 2024). The prohibition aligns with the UN frameworks on torture, which consider the use of unmodified ECT an unacceptable medical practice. This also resonates with Article 15 of the CRPD, emphasizing the right to be free from torture and inhuman treatment (Uvais & Joag, 2024). To chain in any manner or form is prohibited under the Act under Section 95(d). In case of ill-treatment or neglect of a person with mental illness,

a police officer can inform a magistrate (MoHFW, 2017). These provisions are very strong as they provide safeguards from torture and abuse, which are in line with Articles 14 and 16 of the CRPD (Assembly, 2006).

The MHCA 2017 also contains provisions that moderate or partially align with the UN and WHO frameworks. This means it includes some safeguards but cannot fully meet the criteria for free and informed consent and non-coercion. The MHCA 2017 allows the treatment of a minor based solely on the informed consent of the minor's nominated representative, according to Section 87(7). No consent from the minor is required. The MHCA 2017 contrasts with the Juvenile Justice (care and protection of children) Act 2015 of India, which dictates provisions related to children, which are in contradiction with the law. Section 15 of the Act talked about the transfer of children aged 16 to 18 to the adult justice system in case of heinous crime. This indicates that the law deemed it possible that people aged 16-18 are capable of adult-like decision-making. In this context, MHCA 2017 contradicts in upholding the rights of young people (Sharma & Kommu, 2019). This also indicates that, in this way, the Act might increase stigma rather than reduce it (Duffy et al., 2019). The Act does not align with CRPD Article 7, which allows children to express their views without any fear and requires that those views be given weightage.

In case of nominated representation, the person appointed can support a person with mental illness in decision-making, but they can also get involved in admission, discharge, and decision-making according to Sections 14-17. Independent admission is ensured, but the phrase “as far as possible” indicates involvement of nominated representatives (MoHFW, 2017). This does not provide detailed criteria or procedures for assessing capacity in complex cases and may leave space for coercive treatment, particularly where the person is considered to require support. This creates a gap when assessed against UN and WHO rights-based frameworks, which emphasize legal capacity, free and informed consent, supported decision-making, and protection from coercion (Uvais & Joag, 2024). Even though the Act places restrictions on the use of seclusion and restraint in mental health facilities (Kaur & Dangwal, 2024) But it allows authorizing the use of restraint with limitations by informing the nominated representative within 24 hours under Section 95. The CRPD/GC No.6 states in this case that disability-based exceptions can reproduce discrimination (Committee, 2018). This also does not align with CRPD Article 12, which emphasizes free will and a person's legal capacity to decide for oneself about a treatment plan (No, 2014).

Despite the Act 2017 making a commitment to introduce policies which incorporate the essence of the CRPD, it contains several weak provisions relevant to the criteria of free and informed consent and non-coercion measures. Key areas of weakness under Section 86(3) are that a person with mental health conditions cannot be deemed as an independent patient if he is unable to understand the purpose, nature, and effects of treatment, and needs decision-making support. (MoHFW, 2017). The CRPD preamble emphasizes the necessity to eliminate discrimination based on disability, highlighting the need to protect the human rights of all individuals with disabilities. Article 4 of the CRPD mandates that government bodies ensure and promote the complete realization of human rights for individuals with disabilities without any form of discrimination. Articles 5 and 12 underscore the principles of equality, non-discrimination, and equal recognition before the law. Considering these CRPD articles, the involuntary inpatient treatment of individuals with psychiatric conditions against their consent may be perceived as a violation of their fundamental rights (Assembly, 2006; Uvais & Joag, 2024).

The Act also takes away the right to refuse staying in a mental health institute on the pretext that the mental health professional may prevent the patient from leaving for 24 hours on the pretext that the person with mental illness cannot understand the purpose of his decision, threatened or attempted to cause bodily harm, behaved violently, or is unable to care for himself (88)(3). All the provisions under Section 90(2)(8)(9)(12) also allow mental health professionals to extend the period of institutionalization up to 90, then 120, and later for 180 days if the same assessment continues as mentioned in Section 88 (3). This provides the reason to keep the person with a mental illness institutionalized for a longer duration (MoHFW, 2017). All these provisions do not align with any UN and WHO mental health frameworks, such as the WHO/OHCHR Guidance 2023, which demands that treatment should be voluntary. (OHCHR, 2023). MHAP considers it a human rights violation because of stigmatization and discrimination (Organization, 2021). Sending people to psychiatric hospitals and other admission units might increase stigma because people would fear being sectioned (admitted against their wishes) as a result of the very existence of such regulations (Duffy et al., 2019).

Equal recognition before the law

Under the criteria of equal recognition before the law, the MHCA 2017 contains many provisions. The act does not allow linking a person's past treatment and medical history to justify any present or future action. This is very important as it prevents mental illness from being used as an excuse for stigmatizing, labeling, or discriminating against the person, or if he wants to pursue any future opportunities for development (Henderson et al., 2026). It somewhat connects to the idea of social inclusion right (Right of employment, housing, and education) of MHAP, but is directly in line with CRPD and right of legal capacity mentioned in the WHO/OHCHR Guidance 2023 document (OHCHR, 2023; Organization, 2021). According to these, discrimination against any person based on disability is a violation of the inherent dignity and worth of the person.

The Act further supports the right of equal recognition through the clauses about the nominated representatives, Sections 14(b), 8 and 9. The person with a mental illness can appoint, change, or revoke the decision to appoint a nominated representative. It is also important that the representative take into consideration the person's wishes, history, values, and culture while supporting the decision-making process related to treatment, Section 17(a)(c). Consequently, under the new legislation, recognizing the legal capacity of a person with mental illness to make informed choices is an important step towards recognition of their human value and dignity. This development was in accordance with Article 12 of the CRPD, with a view to synchronizing the provisions of MHCA, 2017, with the objectives of the CRPD (Domański & Lackoroński, 2023). These clauses partly represent the CRPD Article 12 and General Comment 1, as well as Guidance 2023, which recognize the right to exercise legal capacity; however, the strengths are limited to only these specific sub-sections of the Nominated Representative chapter.

The provision of Section 21 is about equality and non-discrimination. These are the strong clauses in terms of mental health stigma policies. The Act provisions require equal treatment without regard for gender, sex, religion, culture, caste, social or political beliefs (MoHFW, 2017). This is in line with Article 5 of the CRPD, which strictly prohibits discrimination on the grounds of disability, mandating states to ensure protection against discrimination across all spheres. Article 1 of the CRPD highlights the convention's purpose in promoting, safeguarding, and ensuring the full enjoyment of all human rights and fundamental freedoms for individuals with disabilities (Uvais & Joag, 2024). MHAP also

requires states to introduce anti-discrimination laws for legal protection (Organization, 2021). The Act also emphasizes the importance of confidentiality, prohibiting the disclosure of information related to a person with mental illness without their consent. This includes information stored in electronic or digital formats, Sections 23, 24, 25 (Kaur & Dangwal, 2024). The person with a mental illness is also guaranteed the right of legal aid in the MHCA 2017 Section 27. In case of any discrepancy, the person with mental illness can complain to the Mental Health Review Board according to Sections 28 and 82 (MoHFW, 2017). This provides an important mechanism to challenge any unfair treatment. It corresponds to WHO/UHCHR Guidance 2023, which says that current and former mental health service users should have the right to complain about discrepancies in care, treatment, and services. They can also take judicial remedies (OHCHR, 2023).

The MHCA 2017 contains provisions that show moderate or partial alignment with the criteria of equal recognition before the law. In this case, the provisions allow the person with mental illness to choose between approving, revoking, or changing an advance directive, which is a positive sign, but on the other hand, give the review board the power to assess them, modify, or revoke these directions, Sections 10,11 (MoHFW, 2017). This is relevant to mental health stigma because stigma often leads to the assumption that persons with mental illness are incapable or dependent (Habebe et al., 2025). So, the provisions that allow others to override or influence the person's choice reproduce structural stigma. This contradicts WHO/UHCHR Guidance 2023, in which not changing or overriding the decision of a person with a mental illness is not recommended (OHCHR, 2023). The same idea appears in the case of a nominated representative, Sections 14,17, where the person with mental illness is legally allowed to make a decision regarding appointment, and cancellation of the nominated representative, but contrary to that, the central board can make changes in the decision. Also, rather than supported decision making, the provisions open the path for substitute decision making, as a nominated representative can make decisions on behalf of a person with mental illness if they are deemed incapable (Uvais & Joag, 2024). In the MHCA 2017, capacity, advance directives, and nominated representatives are only linked to decisions concerning healthcare; no reference is made to financial decisions (Duffy & Kelly, 2017). CRPD/GC No. 1 also determines that both the advance directive and nominated representative provision don't comply with Article 12, which states that parties shall ensure the rights and responsibilities of a person with mental illness (No, 2014).

Another important provision is about women, children, and family, which shows moderate alignment. The Act states that a child under the age of 3 years should not be separated from a mother who is receiving treatment or admitted to a mental health institution. The decision to keep both mother and child together required review after every 15 days and approval of the authority if separation remains more than 30 days, Section 21 (2,3) (MoHFW, 2017). These provisions present the clear picture of how women with mental illness are assumed to be unfit for parenting, which promotes a stigmatizing view, partially, with CRPD Article 23, which requires the elimination of discrimination in matters of marriage, family, and parenthood. From a stigma policy perspective, these are some provisions that strengthen mental health stigma under the criteria of equal recognition before the law. CRPD Article 7 says that children with mental illness have the right to express their opinion and feel heard while deciding on their treatment or care (Assembly, 2006). The minors or children do not have a choice or say about the nominated representative, as their legal guardian becomes the representative by default. A mental health review board can change and appoint another person as guardian, Section 15. From a stigma point of view, this enforces the assumption that minors are mainly dependent and not capable of thinking of their best interest.

During emergencies, under MHCA 2017, the advance directives may not apply to a person with mental illness, Section 9. According to the WHO/UHCHR Guidance 2023, advance directives are binding in every situation, and there is no other way. The WHO Quality Rights Toolkit also requires admission and treatment to be based on free and informed consent and supported decision-making (Organization, 2012). The provisions also create a route to allow a person with mental illness to face multiple stigmas, such as self-stigma and institutional stigma, because of a person who is a prisoner with mental illness (Gröning et al., 2026) and bound by the decision of legal authority to stay in prison or a mental health institution. The order of authority is enough to decide a person's fate and where he lives, and he himself has no legal capacity or right to decide on a support system, Section 103. The decisions are mainly driven by prison law and criminal procedure. This is a weak provision if we compare it to the CRPD, Article 12, and CRPD/GC No.1, which demands the right to equality and emphasizes recognizing the person before the law as respected and possessing legal capacity (Assembly, 2006; No, 2014).

Quality Mental Health Services

In terms of the criteria of quality mental healthcare services, MHCA 2017 introduced and managed to include many strong provisions that ensured the reduction of discrimination for people with mental illness. It emphasized the right of access to mental healthcare and treatment from mental health services or state funded by every person. The Act explains the right by mentioning that it means services with affordable cost, good quality, accessible geographically without discrimination based on gender, sex, sexual orientation, religion, culture, cast, social or political beliefs, class, disability, and acceptable to a person with a mental illness (Duffy & Kelly, 2019). It guarantees that services include inpatient and outpatient treatment, sheltered accommodation, old age mental health services, Section 18, while evaluating it with UN and WHO mental health frameworks, these provisions strongly conform with MHAP and CRPD Article 25 related to equal access to quality mental health services (Assembly, 2006; Organization, 2021). Including Section 18 of the MHCA 2017 articulates a legally enforceable right to access mental healthcare. It promotes functional recovery and community integration and reduces the long-term discrimination associated with mental illness(Math, 2025).

The act also integrates mental health services into general health care services at all levels, including primary, secondary, and tertiary, under Section 18 (5) (a). It also ensures that no person shall be required to travel a long distance to access mental healthcare services, and they should be available where they live. Section 18(5)(d,c) is supported by the government. The act also ensures the government provides free treatment for people who are below the poverty line, free essential medicines, and equality in quality of service (MoHFW, 2017). These provisions indicate that MHCA 2017 took into account the concept of universal health coverage while formulating the act, which is a fundamental part of the UN and WHO mental health frameworks. The idea is that health and social services must be provided regardless of age, sexual orientation, socio-economic status, ethnicity, and by using the principle of equity (CMHA2013). The act also supports the provisions of facilities in mental health institutions for leisure, recreation, education, and religious practices, Section 20 (2)(c) and 21. These provisions are stigma-relevant and non-discriminatory as they treat mental healthcare and services as a right rather than a charity.

MHCS 2017 shows moderate or partial alignment in terms of detail related to planning, model, and implementation of many mental health services. The act requires taking necessary measures for

introducing budgetary provisions as an important part of mental health policy, but it does not set a fixed percentage, amount, investment target, or timeline around it. Similarly, it does not clearly explain the distribution across local, district, state, and national levels for mental health (57-64) service delivery. This shows partial conformity with MHCA, which emphasized universal health coverage. It also recognizes rights, giving importance to the culture and values of a person while he/she is receiving treatment (Organization, 2021), but there is no clear model or framework provided on how these provisions will be implemented in different settings while keeping in mind India's diverse religious and cultural landscape. So, provisions show commitment to introduce right based and non-discriminatory policy, but it still remains vague as it is not updated according to the action plans and guidance 2023, which provide detailed action plans and governance policy related to mental health.

Stigma awareness and elimination of stereotypes

The MHCA 2017 indicates clear strength under the criteria of stigma awareness and elimination of stereotypes. These provisions introduce it as a government duty by law to organize, manage, fund, and implement programs to reduce stigma around mental illness under Section 30 (b). It is also the duty of the government to spread information about MHCA 2017 regularly through different media such as T.V, radio, newspapers, and online platforms (MoHFW, 2017). This means people should know about the stigma around mental illness. It asks to plan strategies and also fund stigma awareness campaigns, which means stigma is given due importance according to the act. Both provisions align with CRPD Article 8, which mentions that it is the government's responsibility to combat prejudices and stigma related to mental illness. CRPD/GC No. 6 also explains that stigma cannot be countered without raising awareness (No, 2014). Another provision under the same section is about providing regular training to government officials, such as police officers and other relevant officers related to the MHCA 2017. This clearly links with structural stigma (EMEREONY & IWUNW, 2025). MHAP also calls for strategies for the promotion of mental health, with focus on information campaigns to reduce stigmatization and human rights violations against people with mental illness.

In provisions that can be treated as moderate or indirectly linked to stigma awareness, there is a need for an appropriate government plan, design, and implementation for the promotion of mental health by the government under Section 29. This means trying to reduce the chances that mental illness worsens or becomes a disability. It matches the objective 3 of MHAP, which encourages planning interventions, promotion, and prevention plans by 2030 (Singh, 2021). It also includes plans to counter stigma. MHCA 2017 Section 29 can also help to reduce self-stigma by providing mental health literacy and normalizing help-seeking. However, this section does not explicitly mention stigma, but it targets a recovery-oriented message for people with lived experience.

Other provisions that moderately align with UN and WHO frameworks include Section 31(1)(3), which emphasizes the requirement to increase the number of mental health professionals on the basis of population. It requires the government to collaborate with educational institutions for planning, developing and implementing educational institutions for planning, developing and implementing educational programs to increase the number of trained professionals to meet the needs of people with mental illness. The Act also focuses on minimum training for medical officers in public healthcare establishments and medical offices in prisons and jails to provide basic and emergency mental healthcare (MoHFW, 2017). People with mental illness often first come into contact with general

doctors, medical staff in prison, and jail. However, the provisions are partially aligned because they do not expressly require anti-stigma education and human-rights-based training (Naslund & Deng, 2021). It does not mention a major list of first responders, such as firefighters, community workers, and crisis workers, required by WHO/OHCHR Guidance 2023 (OHCHR, 2023).

Community Inclusion

For the community inclusion criteria, the strength of MHCA 2017 starts from the very definition of “Least restrictive alternative,” which means that for a person in need of mental health services, they choose the option that interferes less with their freedom, family life, movement, and community living while helping them under Section 2(j). This allows the person the right of liberty to choose an option that controls their own life. The Act also requires the government to make provisions to provide halfway homes and sheltered accommodations along with home-based recovery service and community rehabilitation services according to Sections 18 and 4 (b) (c) (d). These provisions create an alternative to institutionalization and provide a chance for a person with mental illness to remain close to his / her family and community. A similar concept is more strongly mentioned in Section 18 (5) (b) (c) and 19 (1) (a) (b) that a person with a mental illness should not be kept away from the community and society just because they have a mental illness, and they should not live in a mental institution just because they are homeless or rejected by family (MoHFW, 2017). These provisions show a commitment to step away from the asylum-style model and closer to a rights-based approach. This strongly conforms with Article 19 of CRPD and the CRPD/GC No. 5, which acknowledges the right of the person to choose their own place of residence and not to feel pressured to live in a particular living place (Assembly, 2006; CRPD, 2017). They can access a range of community support services. This helps them in their inclusion within the community and society (Ahad et al., 2023). It finishes the segregation if “us vs then” as well (Kreiner, 2025).

For the provision that moderately connects with the criteria of community inclusion, Section 20 (g) can be mentioned. According to it, a person with a mental illness who is living in a mental health establishment should be given assistance to prepare for life outside the institution and community inclusion. This means preparing a person for daily social interactions, society, and family integration (MoHFW, 2017). This provision introduces an important safeguard for community inclusion, and the person must not face public stigma again or be discredited in any way (Shahwan et al., 2022). However, there is no detailed explanation or development about a mechanism for how this inclusion will be supported by the state or authorities, such as work, employment, peer support, or community follow-up. This does not align with MHAP, which requires a multi-sectoral approach for this purpose to partner with various public sectors, such as the health sector, education, employment, and housing sectors.

Deinstitutionalisation is not merely a reduction of psychiatric beds and the closure of mental health institutions; it is also an ideology, a social movement that demands the community integration of people with lived experience of mental illness in society (Sá-Fernandes et al., 2025). The main weakness related to community inclusion can be read as institutional limitations under Sections 65-72. These provisions provide a very detailed framework and mechanism for the registration of mental health institutions. Provisions also include a framework for audit, inspection, appeal, certification, digital register, and display of board information (MoHFW, 2017). This does not adhere to the UN and WHO frameworks.

Full and effective participation in public decision-making

The MHAC 2017 contains limited strengths beneath the criteria of full and effective participation in public decision-making. According to it, the people with mental illness, caregivers, and two persons from an NGO, which provides services to people with mental illness, respectively, in the central and state Mental Health authorities, and the Mental Health Review Board under Sections 34-46 and 74 (MoHFW, 2017). These provisions are relevant to mental health stigma as they acknowledge people with lived experience as participants in mental health governance and administration. MHAP also propagates the idea to empower people with mental health conditions in mental health policy, its planning, legislation, and evaluation. They should be given a formal role. It also aligns with the WHO/OHCHR Guidance 2023, which encourages the involvement of people with lived experience in public decisions and policies.

However, these same provisions remain restricted in terms of the selection of persons with mental illness, as their nomination and participation depend on authorities. It means not only people with mental illness, but also caregivers and representatives of NGOs who provide services to people with mental illness in Central, State authorities, and the Mental Health Review Board are subject to approval from the State government. This risks that participation remains controlled by state authorities. This causes structural stigma and discrimination issues in the independent and collective voice. CRPD Article 5 and CRPD/GC No. 6 are linked to help understand it with more clarity. It includes participation dimensions of inclusive equality, which explains that persons with mental illness must participate in decision-making affecting them. It means powers are not really transferred to people with lived experience (Assembly, 2006; Committee, 2018).

Table 3. Evaluation matrix of the Mental Health Care Act 2017

Criteria	Strengths	Moderate points	Weaknesses/gaps
Free and informed consent; elimination of coercion.	Capacity presumption, advance directives, dignity, protection from cruel treatment, ban on chaining/unmodified ECT.	Supported admission, nominated representative, and emergency treatment safeguards.	Advance directives can be overridden; supported admission may become substitute decision-making; coercion cannot be fully eliminated.
Equal recognition before law	Parity, non-discrimination, confidentiality, legal aid and the complaint in front of the Review Board.	Advance directives and a nominated representative show partial autonomy.	Legal capacity is limited mainly to healthcare; the Board can modify/cancel choices; weak protection in prison/judicial cases.
Quality mental health services	Right to access affordable, good-quality mental healthcare.	Mental health insurance, minimum standards, and registration of mental health institutions.	Implementation depends on resources; a weak workforce, budget, and service-delivery guarantees.
Stigma awareness and elimination of stereotypes	Government duty to reduce stigma; awareness campaigns; training for police and officials.	Mental health promotion and professional training.	No detailed anti-stigma curriculum; weak monitoring of stigma in institutions, police, prisons, workplaces, or media.
Community inclusion	Least restrictive alternative; halfway homes; supported accommodation; community rehabilitation.	Preparation for life outside institutions.	Institutional model remains strong; no clear deinstitutionalisation timeline; weak peer-led/community follow-up mechanisms.
Participation in public decision-making	Representation of two members in Central/State Authorities and Review Boards.	Includes users, caregivers, and NGOs.	Limited seats; participation may be tokenistic; no strong guarantee of lived-experience leadership or binding influence.

3.3. The Rights of Persons with Disabilities Act 2016

The RPwD 2016 is India's main act related to the rights of people with disabilities. This act was introduced to incorporate the principles of dignity, non-discrimination, individual autonomy, equal opportunities for all, and effective public participation, which are derived from the UN CRPD agreement. The document extensively defines disability as a form of long-term, physical, mental, intellectual, and sensory disabilities. It promoted the concept of inclusive development, emphasizing the importance of mainstreaming disability considerations in policymaking and planning (Kulsum et al., 2024). For this study, the RPwD 2016 is a suitable policy document as it provides a rights-based framework for evaluating how India's mental health policies address the mental health stigma.

Free and informed consent and elimination of coercive practices

The RPwD Act 2016 strongly aligns with the criteria of free and informed consent and elimination of coercive practices when evaluating the reproductive rights of women under Section 10 (India, 2016). It challenges the stereotype that women with mental health conditions are incapable of reproduction. This is important because women with mental health conditions often face double stigma, both as women and as PMHC, as they face serious health, sexual, and reproductive health disparities (Howard et al., 2025). In this context, RPwD aligns with the WHO Quality Rights Toolkit because it requires reproductive health services and safeguards against treatment without free and informed consent (Organization, 2012). It also strongly conforms with Article 23(b) of the CRPD, which demands rights for PMHC to decide freely on the number and spacing of their children and have access to reproduction and family planning education (Assembly, 2006).

For this criterion, the RPwD Act 2016 shows moderate alignment with the UN and WHO mental health frameworks as it partially reflects the principles of free and informed consent through its recognition of life with dignity and respect, autonomy, and legal capacity. Article 12 of CRPD, in connection with Article 25 about health, requires states to introduce provisions that allow the PMHC to enjoy the rights to health care based on free and informed consent. It demands that all healthcare personnel ensure that consultations about treatment can be openly engaged with PMHC (Assembly, 2006; No, 2014). Section 6(2) of RPwD 2016 requires the government to take measures to obtain free and informed consent through available modes and formats of communication. Section 3 also enforces that no person shall be discriminated against on the grounds of disability (India, 2016). However, these provisions do not comprehensively inculcate or establish the right to consent, refuse mental health treatment, or choose alternative treatment. WHO/OHCHR Guidance 2023 states that for PMHC, the right to make decisions about their own treatment is an essential element of health care (OHCHR, 2023).

Although the RPwD 2016 protects against the segregation of children with mental health conditions, it weakens this protection by empowering the court to decide whether it is in the best interest of the child. The provision further suggests that when the parents are unable to take care of the child, the court can order the child to live with relatives, then within the community in a family setting, but may also place the child in a shelter home in exceptional cases. The act prioritizes family engagement but does not completely prohibit institutionalization. The Act strongly aligns with Article 23(4) of the CRPD, as it says that the child should be separated from his or her parents except through judicial procedure. On the other hand, it partly fits the right-based approach and deinstitutionalization required by the WHO/OHCHR Guidance 2023, as it suggests placement in shelter homes.

WHO/OHCHR Guidance 2023 suggests that countries adopt provisions that should obligate mental health professionals to inform and obtain consent of PMHC before control and solitary confinement, use of ECT, psychotropic drugs, or any form of chemical restraint, which has a potential risk of harm (OHCHR, 2023). Articles 15 and 16 of the CRPD also mandate all states to take measures that provide freedom to PMHC from any form of torture or inhuman treatment (Assembly, 2006). From a stigma theory standpoint, this is also important because stigma is not only an attitude but a complete process of labelling, stereotyping, separation, status loss, and discrimination operating through power relations (Rodrigues et al., 2025). Sections 6 and 7 of the RPwD 2016 provide a weak and general foundation by protecting from coercive measures, cruelty, and torture in treatment, or any form of abuse. The Act does not specifically mention prohibiting the use of chains, shackles, psychotropic drugs, or seclusion related to mental illness, which does not conform to UN and WHO mental health frameworks, and shows a gap (India, 2016). Therefore, silence in legislative practices can indicate structural stigma.

Equal Recognition before law

The RPwD Act 2016 moderately integrates with the UN and WHO mental health frameworks concerning legal holding rights to register for an electoral role. According to the CRPD Article 29 and CRPD/GC No. 1, Article 12, legal capacity is an inherent right of a person, and he should be recognized as a legal person before law. This means holding and exercising the right to register and be on the electoral roll. Sections 11 and 15 of the RPwD 2016, in this regard, partially align as they require the Election Commission of India and the State Election Commission to ensure that all polling stations are accessible for PMHC. The act also requires the government to designate authorities to set up support mechanisms for PMHC so that they can exercise their legal capacity. This can indirectly support PMHC in accessing the electoral role and also allow it to overcome structural stigma, which can occur through organizational rules and procedures that intentionally or unintentionally restrict rights for PMHC (Voldby et al., 2022).

Section 13 of the RPwD 2016 states that the appropriate government shall ensure that PMHCs have rights, equally with others, to own or inherit property, movable or immovable, to have access to bank loans and mortgages. The implication for PMHC is that they can enjoy legal capacity on an equal basis with others in all aspects of life and have the right to equal recognition everywhere, like any other person, before the law (Math et al., 2019). According to Article 12, paragraph 5 of CRPD, national governments need to ensure the right of PMHC to own and inherit property and not be deprived of their property. The WHO Quality Rights Toolkit also supports the idea of treating PMHC as a person with legal capacity to make decisions.

The RPwD Act 2016 shows strong alignment with the right to education. The Act defines Inclusive education as students learning together with or without disabilities, and teaching methods are adapted to meet different learning needs. In relation to this, Section 16 includes admission without discrimination, educational opportunities for sports and recreation, making building facilities accessible, monitoring participation and progress. Section 17 highlights measures such as conducting a school survey to identify children with disabilities, providing books, other learning materials, and scholarships, and modifying the school curriculum to meet the needs. Sections 18 and 32 are about providing and ensuring participation of PMHC in adult education. It also introduces measures to reserve 5 % seats for people with disabilities, including PMHC. These provisions are in line with the approach of community-based mental healthcare settings and right to access to education services at

all levels and life-long learning embedded in MHAP and WHO/OHCHR Guidance 2023 (OHCHR, 2023; Organization, 2021). It also conforms with Article 24 of the CRPD about the right to access to education. The Act promotes awareness and advocacy, helping to reduce societal stigma and fostering a more inclusive and supportive environment for persons with disabilities. Overall, the RPwD Act has the potential to reshape societal perceptions, empower individuals with disabilities, and build a more equitable and inclusive India (Kulsum et al., 2024).

Discrimination and stigmatization of people with mental illness have always existed and have led to lost opportunities for employment, social interaction, and self-sufficiency, and PMHC sinking into poverty (Chaudhary, 2025). To combat this, the RPwD 2016 introduced many work and employment-related measures. The complete Chapter 4 includes provisions such as a prohibition against disability-based discrimination in government employment, vocational training to raise aspiration for self-employment, protection from promotion, and prevention of dismissal and reduction in rank based on mental illness. (India, 2016). Sections 34, 36, and 37 further promote inclusivity in work and employment by reserving government jobs for Persons with disabilities, including those with mental illness (Kulsum et al., 2024). These measures conform with Article 27 of the CRPD, which addresses facilitation of employment, equal remuneration to the PMHC (Biswal et al., 2022).

The Act of 2016 strongly conforms to the accountability mechanism. Article 5 of the CRPD about equality and non-discrimination, obligates state parties to protect the PMHC from any adverse treatment, along with providing means to file a complaint or bring a lawsuit to court in case of non-compliance (Committee, 2018). The WHO Quality Rights Toolkit also requires that service users are safe from negative repercussions from the results of filing a complaint, and disciplinary action should be taken against violations of the rights of PMHC (Organization, 2012). The RPwD 2016 adheres to these requirements by proposing different measures. Section 7 is strongest as it requires legal remedies such as a reporting procedure for abuse, protection, and police information about legal aid. Section 12 ensures guaranteed access to courts or investigating bodies without discrimination. Section 23 provides an employment-related grievance system, and Section 84 creates special courts for speedy trials against offenses (India, 2016). From a stigma theory perspective, these measures protect from structural stigma. Further, Section 92 punishment for atrocities against persons with disabilities, such as punishments under the legislation for such atrocities, is 6 months, extendable to 5 years with or without fine. The implication of this section from the perspective of a person with a mental disability is that atrocities against them are punishable. This clause will be most beneficial for PMI, who are discriminated against, stigmatized, and can be particularly vulnerable to abuse and violation of their rights (Math et al., 2019).

WHO/OHCHR Guidance 2023 requires states to produce legislations which makes support decision-making available for PMHC in the context of mental health care. It also clarifies that support does not amount to substitute decision-making (OHCHR, 2023). CRPD/GC No. 1, Article 12 strongly emphasized that states parties have an obligation to provide access to support in utilizing legal capacity. It repeatedly states that the laws related to guardianship and trusteeship must be revised (No, 2014). The RPwD 2016 provides partial protection for support decision-making through Section 13, which recognizes the right of legal capacity and allows PMHC to modify and dismiss support decision-making. It also prohibits the use of undue influence on PMHC while providing support, respecting the rights and dignity. However, Section 14 remains weak in this context as it permits limited guardianship and legally binding decisions taken on behalf of PMHC (India, 2016). This does

not fully prohibit substitute decision-making and protect the will of the person in mental healthcare treatment.

The UN and WHO mental health frameworks reinforce the concept of legal capacity under the legislation, which recognizes the person as a representative of power who engages in transactions, creates, and ends legal relationships (OHCHR, 2023). This indirectly supports family and marriage decisions. Articles 23 and 12 of CRPD also consider legal capacity essential for the exercise of social, economic, and political rights. The denial of legal capacity led to being denied many basic rights, such as the right to marry anyone and form a family of his own (Assembly, 2006; No, 2014). In terms of weakness and gaps related to the criteria of equal recognition before law, the RPwD 2016 does not contain any direct provision related to marriage or divorce rights. There is also a clear gap in guaranteeing the right of PMHC to obtain a birth certificate, passport, or identity card. The exclusion of such provisions comes under the term of indirect discrimination, which means that legislation and policies appear neutral at face value but have a unbalanced negative effect on PMHC (Committee, 2018).

According to the WHO/OHCHR Guidance 2023, every legally adult person should have the right to make advance directives regarding their mental health care interventions. Legislation must ensure that these directives are binding (OHCHR, 2023). The RPwD 2016 does not present any such legislation related to an advance directive directly in the document. It generally presents ideas about protecting and recognizing the legal right of a PMHC, but no specific clause mentions the right of a living will or advance directive. Advance directives can significantly improve the results for PMHC as these directives reduce the risk of criminal justice and avoid involuntary treatment (Swartz & Swanson, 2026). Absence of laws related to this right indicates legal disadvantage and can contribute to stigma (Kågström et al., 2025).

Quality mental health services

Section 25(1)(a) is also a strength because it obligates the government and regional authorities to provide health care in the vicinity, especially in rural areas. This helps to address geographical disparity in the provision of mental health care facilities in faraway areas of India (India, 2016). It supports Article 25 of the CRPD, which also obligates states to provide health care services as close as possible to people's own communities settings, including in rural areas (Assembly, 2006). To address stigma and discrimination, it is also necessary to provide widely available and accessible services in the areas closer to PMHC (Kaur et al., 2023).

The RPwD 2016 moderately adapts to the UN and WHO frameworks when assessing the targets for universal and free health care and integration of mental health facilities with general health care. MHAP targets 2.3, according to which 80% of countries will have to integrate mental health into primary health care by 2030, under the objective of comprehensive, integrated, and responsive mental health care (Organization, 2021). This target mandate states to integrate mental health care with primary health care, which will also ensure universal health coverage. The RPwD 2016 provides only partial protection for equality in health care for PMHC. It does not imply that mental health is equal to physical health care or integration of mental health into primary health care. Section 25 of the Act broadly mentions access to health care, barrier-free hospitals, and priority treatment, but it does not fully address stigma in mental health services (India, 2016). Section 24 also mentions medical aid, medicine, and surgery free of cost, but it is only for people who fall below an income bracket, and

this does not come under universal health care or a rights-based approach (Chaudhary, 2025). When the institutional policies distinguish individuals with mental health issues and cause them to be denied resources, it is discriminatory and institutional stigma (Habebe et al., 2025).

The RPwD 2016 also shows moderate alignment related to reducing discrimination in health insurance for mental health diseases. Article 25 of the CRPD prohibits discrimination against PMHC in the provision of health insurance and requires that it be provided fairly and reasonably (Assembly, 2006). The WHO/OHCHR Guidance 2023 emphasized the need for all insurance plans, regardless of the insurance agency, to cover mental health care services, which include outpatient and inpatient services, psychosocial interventions, and psychosocial drugs. (OHCHR, 2023). Despite RPwD 2016 acknowledging the importance of insurance as part of public services in Sections 24 (3)(j) and 26 (India, 2016) these provisions are not as comprehensive as outlined in CRPD and the WHO/OHCHR Guidance 2023.

To consider the cultural differences while providing mental health care services is important not only for the native people but also for the ethnic and religious minorities (OHCHR, 2023). There is a need to allocate a budget for culturally suitable mental health care proposals. The RPwD 2016 undermines the importance of culturally sensitive and respectful mental health care. Section 2 (c) in the definitions recognizes cultural, social, institutional, and structural barriers in the effective participation of PMHC, and Sections 2 (w)(x) include religious, cultural, and rehabilitation places in public services and buildings (India, 2016). They do not specifically assign legal responsibility to the government for introducing mental health services, which are culturally competent, nor do they guarantee that PMHC can continue religious and spiritual practices during care, even though such interventions can reduce the occurrence and impact of stigma related to mental illness (Fekih-Romdhane et al., 2023).

Stigma awareness and elimination of stereotypes

It is well understood that mental health stigma is a problem of knowledge, lack of it, or ignorance. (Kågstöm et al., 2025). Due to this, the WHO/OHCHR Guidance 2023 and CRPD urge states to conduct awareness-raising programs and public campaigns for improving awareness of mental health and respect for the rights of PMHC (Assembly, 2006; OHCHR, 2023). The RPwD underscores the importance of promotion and prevention of mental illness and stigma. Section 7(1)(d) and 25(2)(h) both obligate awareness and make information available through television, radio, and other mass media about the prevention of abuse, violence, and wrong perception related to PMHC. Section 39 is the strongest provision because it requires awareness programmes that promote inclusion, respect for diversity, and recognition of the abilities of PMHC (India, 2016). From the mental stigma perspective, educating people about factual information related to mental health, mental illness, and how stigma affects the recovery of PMHC can help in efforts to reduce the impact of mental health stigma (Kreiner, 2025).

The RPwD 2016, in part, aligns with the UN and WHO mental health frameworks in the context of human resource training about respecting the rights of PMHC. The WHO Quality Rights Toolkit strongly supports training on human rights, legal capacity, support decision-making, informed consent, discrimination, and coercion (Organization, 2012). Sections 17, 25, and 47 are relevant but provide incomplete safeguards for training and awareness. Sections 17 and 25 are regarding training teachers, staff, and professionals for inclusive education and providing basic knowledge to the local community and health workers. Section 47 is the most relevant in this regard as it ensures training

for health care professionals, medical staff, and public officers (India, 2016) but does not mention zero corecion and de-escalation. It is because stigma is often created by the very people who should be helping PMHC, such as psychiatrists and counselors(Kreiner, 2025).

Community Inclusion

Mental health stigma remains a significant barrier to seeking care and promoting overall well-being. Community strategies have emerged as a crucial framework for addressing this stigma by cultivating an environment that supports acceptance and early interventions (EMEREONY & IWUNW, 2025). The RPwD 2016 strongly supports person-centered and rights-based community inclusion through Section 5 because it recognizes the right of PMHC to live in the community, not be forced into a living arrangement, and access to in-house community support services. Section 24 further strengthens this by providing social security schemes during crises and emergencies such as natural disasters. Sections 40-46 are particularly important as they promote accessibility of services for PMHC. This includes access to transport facilities, access to information and communication technology through print, electronic media, and audio, products for general use, and the building structure plans, adhering to the needs of people with disabilities (India, 2016). These provisions comply with the objectives of MHAP, which also suggest that services that are based on community for mental health care needs to encompass a rights-based approach and present a target for the member states to double the number of community-based services by 2030 (Organization, 2021). The RPWD Act of 2016 details the fundamental right of individuals with disabilities to reside where they choose and partake in community living. The act also aims to uphold basic human rights for all people to control their living circumstances and participate fully in society (Chaudhary, 2025).

The MHCA talks about the need for a community support service for MHCP in collaboration with multiple sectors. This will facilitate the participation of PMHC in different opportunities and community activities, such as employment, education, sports, and recreational activities (Organization, 2021). The RPwD 2016 presents provisions such as Sections 29-30, which are important because they recognize cultural, recreational, and sports participation by law, not as an optional welfare facility. Sections 65-71 are directly relevant to this approach as they ensure the creation of Central and State advisory boards responsible for policy development, interdepartmental coordination, cooperation with NGOs, and recommendations on social participation and monitoring of laws and policies. The active involvement of stakeholders, including government bodies, local authorities, and civil societies, will be crucial to ensure that PMHC can fully participate in society and enjoy their lives with complete independence. By implementing these recommendations, India can move closer to building an inclusive society where PMHC will be valued and enjoy equal opportunities (Kulsum et al., 2024).

The RPwD 2016 shows weak alignment and a gap with peer-led and peer support services. According to the WHO/OHCHR Guidance 2023, peer support facilities can provide help to individuals to gain and maintain health, well-being, and social inclusion, navigate the mental health and social structure more efficiently (OHCHR, 2023). However, the Act does not provide specifically for peer-led mental health work, peer-led mental health services, or certification into mental health services. This is a significant gap as through these services, people with lived experience can share their stories, normalize mental health issues, and challenge stigma. It can reduce self-stigma and bring empowerment in PMHC (Ahad et al., 2023).

Stigma surrounding mental health conditions delays diagnosis and treatment. This can be dealt with through early interventions through collaborative efforts between local organizations and community leaders (EMEREONY & IWUNW, 2025). The RPwD 2016 shows weak alignment in addressing the need for community-level mental health services at an initial stage. Some provisions do support community living, health care, and rehabilitation services, but they are not directly concerned with early detection through community outreach. The Act does not abide by the human rights standards set by the UN and WHO frameworks, especially the WHO/OHCHR Guidance 2023, which suggests that mental health should be initially provided at the community level, and if options at this level are not available, then only inpatient services can be offered to the patient (OHCHR, 2023).

The WHO/OHCHR Guidance 2023 recommends legislation to boost the adoption of deinstitutionalization with a visible timeline for closing all forms of institutions, such as mental health care institutions, and replacing them with an inclusive community support system (OHCHR, 2023). The RPwD 2016 does not adhere to these recommendations, while in Sections 49-55, which create a legal framework for the registration, regulation, revocation, and assistance of institutions for persons with disabilities. Section 50 is particularly weak as it recognizes institutions for the care of mentally ill persons licensed under the law (India, 2016). These provisions do not support institutional closure; they regulate and preserve institutional care. This is important from a mental health stigma perspective, as institutionalization is closely linked to structural stigma because it separates PMHC from ordinary community life and can reinforce social exclusion and unequal treatment (Sá-Fernandes et al., 2025).

Full and effective participation in Public Decision-making

The RPwD 2016 provides strong compliance with the UN and WHO mental health frameworks in relation to participation and consultation of PMHC in public decision-making. Sections 60-71 establish Central and State advisory bodies that include people with disabilities and representatives of organizations concerning them. These boards advise governments to develop disability policies, coordinate departments and NGOs, and recommend non-discriminatory measures. Section 27 (3) also obligates consultations with NGOs in rehabilitation policy (India, 2016). This corresponds well with Article 29 of the CRPD, which states that countries need to guarantee promotion of active involvement of persons with disabilities in conducting public affairs without discrimination and on an equal basis with others, form and join organizations of persons with disabilities at international, national, and local levels (Assembly, 2006). The significance of recognizing the main role that PMHC can play in efforts to reduce mental health stigma and discrimination can be highlighted through meaningful collaboration between PMHC and other stakeholders (Gronholm et al., 2024). Therefore, this criterion should be evaluated as strong alignment related to accessible and binding participation of PMHC.

Table 4. Evaluation matrix of the Rights of Persons with Disabilities Act 2016

Six criteria	Strong alignment	Moderate alignment	Weak alignment
1. Free and informed consent/elimination of coercion	Sections 6, 7, 10(2) protect against cruel treatment, abuse, exploitation, and infertility-related procedures without free informed consent.	Section 13(5) protects autonomy and prohibits undue influence.	No clear ban on involuntary hospitalization, seclusion, forced medication, chemical/mechanical restraint, or full mental-health treatment consent framework.

2. Legal capacity / supported decision-making	Section 13(1)–(2) recognizes property rights, financial control, and equal legal capacity.	Sections 13(3)–(5), 15 support safeguards and support arrangements.	Section 14 still allows limited guardianship; no clear advance directives, nominated attorneys, or health-service recognition of supported decision-making.
3. Equality in education, employment, and services	Sections 3, 16, and 20 provide equality, non-discrimination, inclusive education, reasonable accommodation, and government employment protection.	Sections 17, 19, 21–23 support training, vocational schemes, equal opportunity policy, records, and grievances.	No mental-health-specific ban on stereotypes such as incapacity, dangerousness, inconvenience, or unreliability; private employment protection is weaker.
4. Healthcare, social protection, and insurance	Section 25(1)(a) supports free healthcare in the vicinity, especially in rural areas.	Sections 24–27 support social security, healthcare access, insurance, rehabilitation, and health awareness.	No clear mental-health parity, universal mental health coverage, free mental healthcare for all, or equal private/public insurance protection.
5. Awareness, anti-stigma education, and training	Section 39 supports awareness, sensitisation, inclusion, empathy, respect for diversity, and disability-rights education.	Sections 7(1)(d), 17, 25(2)(d)(g), 47 support public awareness, teacher/staff training, PHC training, and professional disability-rights training.	No specific mental-health-stigma training, zero-coercion training, de-escalation, trauma-informed training, or binding anti-stigma manuals.
6. Community inclusion, deinstitutionalization, and participation	Sections 5, 29–30, 40–46 support community living, cultural/sporting participation, accessibility, transport, ICT, and public services.	Sections 60–71 support advisory boards, consultation, coordination, and monitoring.	Sections 49–55 regulate institutions instead of closing them; no clear deinstitutionalization, community-first mental healthcare, peer-led services, or binding consultation outcomes.

Conclusions

1. The study used the UN and WHO mental health frameworks for normative policy evaluation, including the Comprehensive Mental Health Action Plan 2013-2030, UN-CRPD, UN-CRPD General Comments No. 1, 5, and 6, WHO Quality Rights Toolkit, and Mental health, human rights and legislation Guidance and practices 2023. The application of UN and WHO frameworks is important because they are formulated in consultations with member states, keeping in mind the human rights and disability frameworks accepted all around the world. These guiding frameworks work best for analysing where the states stand in achieving the goals and aims they set while developing and ratifying these documents. These documents focused on the use of person-centered and rights-based mechanisms to devise standards such as legal capacity, free and informed consent, and community inclusion to ensure better mental health care for PMHC. These standards were the basis for the six criteria used in this research work to analyse the Indian mental health stigma policies. The criteria include free and informed consent and elimination of coercive practices, equal recognition before law, quality mental health care, stigma reduction and elimination of stereotypes, community inclusion, and full and effective participation in public decision-making. These criteria are important as they move away from general statements about stigma and inclusion to whether the Indian policy documents contain concrete rights-based safeguards. This provides a clear base for normative qualitative evaluation for Indian mental health stigma policies.

2. India is recognized majorly for its efforts to improve mental health care, particularly through legislation and reform aimed at aligning with the UN and WHO rights-based standards. The significant steps in this regard are the introduction of NMHP 2014, MHCA 2017, and RPwD 2016. One of the major aims of these policy documents and acts was to propose measures and actions that could integrate a human rights-based approach to combat mental health stigma and discrimination against people with mental conditions. The extent to which these efforts were successful in achieving this aim is evaluated through criteria derived from the UN and WHO mental health frameworks. This assessment of the Indian mental health stigma policy documents shows that they do not contribute equally to stigma reduction efforts. The MHCA 2017 appeared strongest while evaluating the criteria of the free and informed consent, as it mentioned the privilege to receive information and decision-making power for PMHC. The NMHP 2014 and RPwD 2016 broadly mention human rights and dignity, but do not specifically include provisions about free and informed consent. MHCA 2017 also ensured the introduction of restrictive measures on the use of coercive measures, such as ECT, but NMHP 2014 and RPwD 2016 contributions remained weak in this criterion also. The assertion of provisions such as advance directives and integrated medical health care facilities in all three policy documents brought Indian mental care efforts into a new light. These provisions provide the idea that PMHCs are recognized as equals in terms of legal capacity and health care facilities. From the stigma theory standpoint, these actions will help to reduce self-stigma and structural stigma around PMHC, as they will not fear using these rights and services. The inclusion of mental health in insurance policies is also one very important initiative emphasized by MHCA 2017. The RPwD 2016 discussed this briefly and vaguely, and the NMHP 2014 did not include it in policy measures. Across the six criteria, the strongest alignment was found in training human resources, stigma awareness campaigns, and community inclusion through education and employment, and adequate living facilities. These provisions show a radical change towards the rights-based approach, which is clearly visible in all three policy documents, which can help weaken the cycle of stigma introduced by Link&Phelan by addressing labelling, stereotyping, separation, status loss, and discrimination.

3. The study discovered that the Indian mental health stigma documents remain strong in their rights-based language, but some major gaps and limitations exist when analysing them in terms of

operational strength. The practical and enforceable mechanism is missing concerning many provisions, which leads to vagueness regarding implementation and monitoring. The rights-based reform requires adequate funding, geographically accessible mental health, and community-based services. Absence of comprehensive policy design, realistic timeline, implementation, and enforcement mechanism does not fully support a stigma-free mental health system. When comparing these documents with the UN and WHO mental health frameworks, a major gap appears in relation to substitute decision-making, which is included in all three policy documents in the form of a judicial magistrate, nominated representative, or legal entity. The UN and WHO frameworks consider this a denial of the legal rights of PMHC to liberty and decision-making. The absence of the right to marriage or divorce, parenthood, and accessing legal documents such as a passport is a significant gap under the criteria of equal recognition before law. Without these, anti-stigma provisions remain symbolic and might not eliminate structural discrimination that PMHCs face. Institutionalization remains one of the principal policy limitations when compared with the UN and WHO mental health frameworks in terms of stigma reduction efforts. Although the policy documents show a gradual shift towards community-based care and social inclusion, all three documents do not provide a blueprint or strategy for deinstitutionalization. The NMHP 2014 recognizes the importance of community care and inclusion, but also supports long-term stay in institutional care for recovery. The MHCA 2017 and RPwD also include provisions about halfway homes, supported homes, and social protection. However, these documents also contradict the UN and WHO frameworks while allowing registration for mental health institutions, without consent, admission, or long-term institutional care. This can increase stigma around PMHC by placing them in a separate institutional setting. The stereotypes will emerge more strongly that they are dangerous and incapable of living a normal community life. Thus, India's mental health stigma policies show a significant progressive step towards rights-based standards set up by the UN and WHO mental health frameworks but to fully align with these international human rights standards, it requires comprehensive, well-integrated, with other sectors (private sector, NGOs, education, media) and binding provisions that help to take practical measures.

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List of information sources

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2. Indian Mental Healthcare Act 2017
3. The Rights of Persons with Disabilities 2016

Appendices

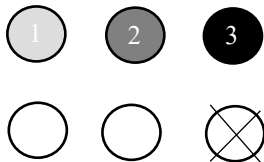
Appendix 1. Checklist of targeted questions for assessing Indian mental health stigma policy.

This checklist will provide insight into Indian mental health stigma policies and how far they align with UN and WHO frameworks and their Right-based approach.

It includes a point scale (1–3) to allow grading in the evaluation:

- ☐ 1 Not at all
☐ 2 Partially
☒ 3 Significantly

Rating 1 - 3



This checklist also includes a box to add a justification/comment for the choice of rating and what remedial actions can be taken in this regard.

3.1 Free and informed consent and elimination of violent practices:

Question	Rating	Comment
1. Does the policy enable the right to consent or refuse to choose treatment or alternative medical treatment?	○○○	
2. Does policy enable the right to informed consent without threat, manipulation and unnecessary influence?	○○○	
3. Does policy uphold the right to revoke consent whenever he wants?	○○○	
4. Does policy provide the right to people with mental illness to get information about their treatment in simple language and ask sufficient questions before they give their consent?	○○○	
5. Does policy provide the right to people with mental illness to get information about use of informed consent and refusal?	○○○	

6. Does policy prohibit control confinement and solitary confinement within mental health services?	○○○	
7. Does policy in-line with right-based approach prohibit use of force in form of involuntary hospitalization and admission into asylums?	○○○	
8. Does the legislation prohibit separation of children with mental health disorders and keeping them in social care institutions?	○○○	
9. Does policy prohibit all forms of use of drugs and chemical restraints, such as the use of mind-altering drugs without informed consent?	○○○	
10. Does policy prohibit means of torture and cruel treatment (such as chains and shackles)?	○○○	
11. Does the policy provide safeguards against use of coercion in form of interventions such as	○○○	

involuntary electroconvulsive therapy?		
12. Does policy recognize the women right to free and informed consent about their sexual and reproductive health and rights. (such as sterilization, contraception and abortion)?	○○○	

3.2 Equal recognition before law

Question	Rating	Comments
1. Does the policy provide legal holding rights to register to be on the electoral role or apply for a birth certificate, identification card or a passport?	○○○	
2. Does policy guarantee respect for the right of marriage, family, parenthood and reproduction?	○○○	
3. Does policy guarantee for the right to own property, the actions taken by person with mental disability and psychosocial disability to sell or buy property.	○○○	

4. Does the policy provide the right not to be replaced by any educational institution or excluded from any office or service due to mental illness and disability?	○○○	
5. Does the policy prohibit treating people with mental health and psychosocial disability as incapable and inconvenient in a formal or professional context?	○○○	
6. Does policy ensure that all institutions, public or private to remove discriminatory laws and change harmful practices?	○○○	
7. Does the policy guarantee the legal capacity of a person with a mental health disability and psychosocial disability to use mental health services?	○○○	
8. Does the policy protect the right to complain against any form of discrimination, report abuse, and challenge unfair treatment?	○○○	

9. Does the policy provide the right not to be replaced by any educational institution or exclusion from any office or service due to mental illness and disability	○○○	
10. Does the policy prohibit treating people with mental health and psychosocial disability as incapable and inconvenient in a formal or professional context?	○○○	
11. Does the policy provide persons with mental illness the legal capacity to decide on their mental health care and treatment?	○○○	
12. Does the policy introduce a binding concept of right to gain information about diagnoses, medical assessment, and state of health?	○○○	

13. Does the policy uphold the right to get information about full treatment before intervention, which includes proposed intervention, anticipated effects of intervention treatment, and possible alternative options?	○○○	

3.3 Provision of mental healthcare services

Question	Rating	Comments
1. Does the policy ensure mental health is essential as physical and mental health with equality and no discrimination?	○○○	
2. Does the policy guarantee mental health as part of the state's responsibility, included in the general health plan?	○○○	
3. Does the policy target the budget to increase mental health investment?	○○○	

4. Does policy indicate the use of funds in a specific direction (away from asylums and psychiatric institutions)?	○○○	
5. Does policy ensure the budget is distributed at all levels of government authorities (local, national, and regional)?	○○○	
6. Does the policy take into consideration how geographical location affects access to mental health services?	○○○	
7. Does the policy contribute to making mental healthcare free of cost?	○○○	

8. Does the policy reduce discrimination in health insurance?	○○○	
9. Does the policy abide by the principle of equal access to health insurance (private, government, and mixed health insurance)?	○○○	
10. Does the policy ensure that mental services are covered by all health plans offered by investors?	○○○	
11. Does the policy obligate that the person with a mental health condition feels comfortable, as services may be influenced by culture, belief, and traditions?	○○○	

12. Does the policy ensure that differences in concepts and understanding about mental health are kept in mind while treating a person?	○○○	
13. Does the policy allow to continue religious and spiritual practice?	○○○	

3.4 Stigma awareness and elimination of stereotypes

Question	Rating	Comments
1. Does the policy include awareness campaigns to increase public knowledge about mental health disabilities?	○○○	
2. Does the policy ensure awareness campaigns to stop stereotypes and prejudices about people with mental illness and disabilities?	○○○	

3. Does the policy ensure awareness campaigns to inculcate respect for and the rights of people?	○○○	
4. Does the legislation include mandatory training about how to respect the rights of people with mental health disabilities and psychological disabilities?	○○○	
5. Does the policy have mandatory training for educational institutions about how to respect and treat people with mental health disability with equality?	○○○	
6. Does the policy make it part of school curricula to provide information about the rights and respect of people with mental disabilities?	○○○	

7. Does the policy create binding rules and principles in policy manuals of education and restrictions regarding stigmatizing attitudes towards them?	○○○	
8. Does the policy create binding rules for educational institutions and workplaces for the rights of person with disabilities and restrictions regarding stigmatizing behaviour towards them?	○○○	
9. Does the policy ensure obligatory training for all first responders, such as firefighters, emergency healthcare workers, community workers, and crisis workers (training covers respect of legal capacity, human rights-based approach, zero coercion, de-escalation and communication techniques, rights of persons with mental health conditions and psychosocial disability).	○○○	

10. Does the policy ensure obligatory training for healthcare providers and social care providers about not stigmatizing and stereotyping during treatment and human rights education to help comply with the rights-based approach?	○○○	
11. Does the policy emphasize revising curricula in medical training and nursing schools to add information about anti-stigma and a human rights-based approach?	○○○	
12. Does the policy set binding regulations to show a realistic portrayal of people with mental illness instead of showing them as dangerous and violent on electronic sources and media?	○○○	

3.5. Community Inclusion:

Question	Rating	Comments
1. Does the policy allow integration of mental health	○○○	

with primary care so it can help everyone access services at the initial stage?		
2. Does policy ensure person-centered and rights-based community services?	○○○	
3. Does the policy ensure that mental health care services are provided first at the community level for better inclusion?	○○○	
4. Does policy, in contrast to the biomedical model, support the program that is tailored to the needs of a person with mental illness?	○○○	
5. Does the policy support approaches in collaboration with other sectors related to gaining control of life and	○○○	

have hope for future by person with mental illness?		
6. Does the policy assure the integration of peer led and peer run services in community settings?	○○○	
7. Does the policy ensure person-centered and rights-based community services?	○○○	
8. Does policy ensure training and certification of peer-led work?	○○○	
9. Does the policy support closing all forms of mental healthcare centers, including mental health institutions and asylums?	○○○	

10. Does policy support approaches in collaboration with other sectors related to gaining control of life and have hope for future by person with mental illness?	○○○	

3.6. All-inclusive participation in public decision-making process:

Question	Rating	Comment
1. Does the policy allow people with mental health disorders to contribute to developing mental health care and support more responsive to their needs?	○○○	
2. Does the policy guarantee close consultation with people with mental health conditions via representative organizations?	○○○	
3. Does the policy grant seats to organizations of people with mental health conditions on any public mental health	○○○	

committee or monitoring board?		
4. Does the policy guarantee timely and fair consultation?	○○○	
5. Does the policy ensure that the results of the consultations with PMHC taken into account and reflected in decision making?	○○○	