



**MENTAL HEALTH RIGHTS OF
GENDER-BASED VIOLENCE
SURVIVORS: A CRITICAL ANALYSIS
OF THE MENTAL HEALTHCARE
ACT, 2017**

By *Saurabh Kumar*

*Research Scholar from National University of Study
and Research in Law, Ranchi*

Abstract

Gender-based violence has serious and long-lasting effects on the mental health of survivors, but Indian laws have not always recognised this important part of women's right to health. The Mental Healthcare Act, 2017 (MHCA) signifies a fundamental transformation in acknowledging mental health as essential to the constitutional right to health as stipulated in Article 21. This research critically evaluates the adequacy of the MHCA in addressing the mental health needs of GBV survivors while fulfilling Indian constitutional and international duties. This research uncovers substantial deficiencies in the implementation of mental health rights for survivors of gender-based violence through a doctrinal examination of statutory provisions, court precedents, and international human rights standards. The paper contends that although the MHCA establishes a progressive framework, its execution is disconnected from the realities of gender-based violence, leading to systemic deficiencies in delivering accessible, affordable, and trauma-informed mental healthcare. The research concludes with suggestions for amendments to laws and policies that would help to close the gap between what the law says and what GBV survivors are entitled to and what they actually experience.

Keywords: Mental Healthcare Act 2017, Gender-Based Violence, Right to Health, Article 21, CEDAW, Trauma-Informed Care

Introduction

Gender-based violence is one of the most common abuses of human rights in the world. It affects almost one in three women at some point in their lives.¹ The National Family Health Survey-5 (2019-21) in India found that 29.3% of women aged 18-49 years have been physically, sexually, or emotionally abused by their spouse.² GBV causes serious and frequently long-lasting mental health problems, such as post-traumatic stress disorder (PTSD), depression, anxiety disorders, suicidal thoughts, and substance misuse, in addition to the physical injuries that happen right away.³

Even though there is a lot of evidence that GBV is bad for mental health, Indian legal and healthcare institutions have historically ignored the psychological aspects of violence against women. The Protection of Women from Domestic Violence Act, 2005 (PWDVA) was an important step forward because it recognised domestic violence as a civil wrong.⁴ However, it does not do much to help those with mental health issues. The Indian Penal Code, now *Bhartiya Nyaya Sanhita*, under the chapter regarding sexual offences primarily emphasise physical proof and injuries, whereas psychological harm is considered of secondary importance.

The Mental Healthcare Act of 2017 made changes to the legislation governing mental health in India. The statute from 1987 has been replaced with the Mental Health Care Act of 2017. Everyone is guaranteed to have access to mental health care under Article 21 of

¹ World Health Organization, *Violence Against Women Prevalence Estimates, 2018 2* (2021).

² Ministry of Health & Family Welfare, *National Family Health Survey-5 (2019-21): India Report 513* (2022).

³ Claudia Garcia-Moreno et al., *Global and Regional Estimates of Violence Against Women: Prevalence*

and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence 51-52 (World Health Organization 2013).

⁴ The Protection of Women from Domestic Violence Act, 2005, No. 43, Acts of Parliament, 2005 (India).



the Constitution. To ensure that individuals are respected, that their privacy is protected, and that they provide informed permission, the Act ensures that everyone has access to mental health care that is paid for by the government.⁷

This research looks at an important but not well-studied question: Does the Mental Healthcare Act of 2017 give us the right legal tools to meet the mental health needs of survivors of gender-based violence? This investigation is especially important right now because mental health problems often endure longer than physical injuries and make it much harder to recuperate, work, and be healthy overall.⁵

The article is divided into six parts. Part II lays the groundwork for the theory by looking at the link between GBV and mental health within the constitutional framework of the right to health. Part III looks at the precise parts of the MHCA that are important for survivors of GBV. It finds both positive and negative aspects. Part IV looks at international human rights norms, especially the CEDAW General Recommendations, and compares India's laws to the best practices around the world. Part V looks at the problems that make it hard for survivors of GBV to get their mental health rights. Part VI ends with suggestions for amendments to laws and policies.

Gender-Based Violence and Mental Health: Constitutional and Conceptual Framework

A. The Right to Health Under Article 21

The Hon'ble Supreme Court of India has gradually come to observe right to life under Article 21 as comprising the right to health, both physical and

mental. The Court held in *Consumer Education & Research Centre v. Union of India*⁶ that the right to health is part of the right to life and that the State must provide healthcare services as part of its constitutional duty. In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*⁷, the court made this law even stronger by stating that Article 21 puts an obligation on the State to protect life, which includes making sure there are enough medical facilities.

The Supreme Court has made significant out of the fact that mental health is just as important as physical health in the Constitution. The Constitutional Bench ruling in the case of *Francis Coralie Mullin v. Union Territory of Delhi* said that the right to life involves living with dignity.⁸ It laid the foundation for later recognition of mental health as part of a dignified life. More recently, courts have made it clear that mental health care is a basic right and that not getting mental health care is a violation of that right.⁹

B. Gender-Based Violence as a Violation of the Right to Health

GBV substantially infringes upon women's right to health by causing both immediate and enduring physical and psychological suffering. The World Health Organisation (WHO) says that violence against women is a serious public health issue that violates women's human rights, including their right to the best possible health.¹⁰ Indian courts have become more and more aware of the health effects of GBV. The hon'ble Supreme Court recognised that sexual harassment at work harms women's health, dignity, and well-being in the case of *Vishaka v. State of Rajasthan*. In *State of Punjab v. Gurmit Singh*¹¹, the

⁵ Indian Penal Code, 1860, No. 45 of 1860, §§ 375-376E (India).

⁶ *Consumer Educ. & Research Ctr. v. Union of India*, (1995) 3 S.C.C. 42

⁷ *Paschim Banga Khet Mazdoor Samity v. State of W. Bengal*, (1996) 4 S.C.C. 37

⁸ *Francis Coralie Mullin v. Union Territory of Delhi*, (1981) 1 S.C.C. 608

⁹ *Gaurav Kumar Bansal v. State of Uttar Pradesh*, 2020 SCC OnLine All 927

¹⁰ World Health Organization, *Understanding and Addressing Violence Against Women: Health Consequences I* (2012).

¹¹ *State of Punjab v. Gurmit Singh*, (1996) 2 S.C.C. 384



court specifically acknowledged the severe psychological effects of sexual abuse on survivors.

Articles 14 and 15 of the Constitution ensure equality, which includes health equity. Gender-based violence causes health inequalities that are worse for women, which goes against the constitutional requirement of substantive equality.¹² In the case of *Githa Hariharan v. Reserve Bank of India*¹³, the Supreme Court ruled that interpreting the Constitution must promote gender justice and abolish discrimination against women.

C. Mental Health Consequences of Gender-Based Violence

Medical literature has a lot of information about how GBV affects mental health. Research repeatedly shows that women who have been assaulted by their partners are much more likely to be depressed, have PTSD, anxiety disorders, and suicidal thoughts than women who have not been mistreated.¹⁴ Research conducted in India reveals that women subjected to domestic abuse are 3.5 times more likely to contemplate suicide and 2.8 times more likely to endure depression.¹⁵

Sexual violence causes a lot of psychological damage. People who have been raped often have severe stress reactions, long-term PTSD, major depressive illness, and complicated trauma symptoms that can last for years or even decades.¹⁶ Additionally, the taboo surrounding sexual abuse in Indian society

exacerbates mental health issues, resulting in social isolation, humiliation, and a hesitance to seek assistance.¹⁷

The mental health burden goes beyond just one person's pain. Women who have mental health problems because of GBV can't work, take care of their kids, or fully participate in society. This keeps them in cycles of poverty and disempowerment.¹⁸ The National Mental Health Survey of India (2015-16) discovered that women with mental disease encounter substantial obstacles in obtaining care, with treatment gaps over 80% for prevalent mental disorders.¹⁹ So, dealing with the mental health effects of GBV is not only a professional necessity, but also a basic prerequisite for women to have their constitutional right to health and equality.

The Mental Healthcare Act, 2017: Provisions and Analysis

A. Progressive Features of the MHCA

The MHCA is an important step forward for India's mental health laws. It is built on a rights-based approach that is in line with international human rights norms, especially the UN Convention on the Rights of Persons with Disabilities (CRPD).²⁰

Right to Access Mental Healthcare: Section 18 says that everyone has the right to get mental health care and treatment from mental health services that are

¹² Anuj Garg v. Hotel Ass'n of India, (2008) 3 S.C.C. 1

¹³ Githa Hariharan v. Reserve Bank of India, (1999) 2 S.C.C. 228

¹⁴ Sian Oram et al., *The Lancet Psychiatry Commission on Intimate Partner Violence and Mental Health: Advancing Mental Health Services, Research, and Policy*, 9 *Lancet Psychiatry* 487, 489-92 (2022).

¹⁵ Mohan Isaac et al., *Intimate Partner Violence and Its Relationship to Mental Health in India*, in *Mental Health and Illness of Women* 165, 170-72 (Prabha S. Chandra et al. eds., 2015).

¹⁶ Mary P. Koss et al., *Depression and PTSD in Survivors of Male Violence: Research and Training*

Initiatives to Facilitate Recovery, 27 *Psychol. Women Q.* 130, 131-34 (2003).

¹⁷ Ruchika Prakash et al., *Sexual Violence Against Women in India: A Critical Analysis of the Social and Legal Response*, 21 *Violence Against Women* 1255, 1267-70 (2015)

¹⁸ Claudia Garcia-Moreno & Charlotte Watts, *Violence Against Women: An Urgent Public Health Priority*, 89 *Bull. World Health Org.* 2, 2-3 (2011)

¹⁹ National Mental Health Survey of India, 2015-16: Summary 28 (Nat'l Inst. of Mental Health & Neurosciences 2016)

²⁰ Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, 2515 U.N.T.S. 3.



operated or paid for by the right government.²¹ For victims of gender-based violence who are unable to afford expert care, this option is absolutely necessary. Serious mental health problems that arise as a result of aggressive actions may require prompt medical attention.²²

Right to Equality and Non-Discrimination: It is against the law to discriminate against those who suffer from mental illness in any of the following areas: employment, education, housing, insurance, and government support.²³

Right to Information: The Mental Healthcare Act, 2017, guarantees the right to information and informed consent for persons with mental illness. Section 18(5) requires that individuals be informed of their diagnosis, proposed treatment, possible alternatives, and their rights under the Act in a language and manner they can understand. Further, Section 20 mandates that mental healthcare and treatment shall be provided only with the informed consent of the person concerned, except in narrowly defined circumstances.

For survivors of gender-based violence, whose bodily autonomy has often been violated, these provisions are particularly significant, as they restore control over healthcare decisions and align mental health treatment with trauma-informed, rights-based care.²⁴

Community-Based Treatment: Section 19 of the Mental Healthcare Act, 2017, guarantees the right of persons with mental illness to live in the community and to receive mental healthcare in the least restrictive environment. The provision prioritises community-based services over institutionalisation and seeks to prevent segregation of persons with mental illness from society. This approach is particularly important for survivors of gender-based violence, as institutional settings may re-traumatise individuals whose

experiences of abuse involved loss of control, confinement, or coercion. By promoting community-based, autonomy-respecting care, the Act aligns with trauma-informed and rights-based mental healthcare principles.²⁵

Advance Directives and Supported Decision-Making: The Mental Healthcare Act, 2017 incorporates a supported decision-making model that strengthens the autonomy and self-determination of persons with mental illness. Section 5 recognises the right to make an advance directive specifying preferred or refused treatment, while Section 14 allows individuals to appoint a nominated representative to assist in decision-making during periods of impaired capacity. Read with Section 4, which presumes mental capacity unless proven otherwise, these provisions mark a significant shift away from substituted decision-making towards autonomy-respecting care. This framework is particularly significant for survivors of gender-based violence, whose autonomy and agency have often been undermined through coercion and abuse, as it restores control over treatment choices in a trauma-informed and rights-based manner.²⁶

B. Critical Gaps in Addressing GBV Survivors' Needs

I. Absence of GBV-Specific Provisions

The Mental Healthcare Act, 2017 marks a substantial transition towards rights-based mental healthcare; however, it lacks specific provisions that acknowledge gender-based violence as a unique contributor to mental illness or require trauma-informed mental health services for survivors of violence. The Act takes a one-size-fits-all approach to mental health care and treats survivors of gender-based violence the same as everyone else who uses mental health services, without taking into account how trauma-related

²¹ Mental Healthcare Act, 2017, § 18(1)

²² *Id.* § 18(1)(a)

²³ *Id.* § 21.

²⁴ *Id.* § 20

²⁵ *Id.* § 19.

²⁶ *Id.* §§ 5, 14.



problems are different from other mental health conditions.

This omission is important because mental health problems that come from gender-based violence typically need specialised, trauma-focused care instead of regular psychiatric care. Research based on evidence shows that trauma-focused cognitive behavioural therapy (TF-CBT), eye movement desensitisation and reprocessing (EMDR), and trauma-informed care models work better to treat psychological trauma caused by abuse than standard mental health treatments. The MHCA's failure to require or even acknowledge the necessity for specialized approaches jeopardizes the provision of adequate, appropriate, and safe mental healthcare for survivors of gender-based violence, so undermining the practical fulfilment of their right to health.²⁷

2. Inadequate Integration with GBV Protection Frameworks

The Mental Healthcare Act, 2017, functions concurrently with India's legal framework addressing gender-based violence, encompassing the Protection of Women from Domestic Violence Act, 2005, and relevant criminal law provisions. However, it does not create formal mechanisms for coordination or referral between mental healthcare services and GBV support systems. The PWDVA establishes Protection Officers (Section 8), shelter homes (Section 7), and medical facilities (Section 6); however, it does not necessitate collaboration with mental health professionals or the incorporation of psychological care into protection and rehabilitation initiatives, including services provided through One Stop Centres.

This fragmentation of institutions makes it very hard for people who have been victims of domestic violence to get help. A woman who is being abused and is depressed has to deal with different systems that

don't work together to get legal help and mental health care. Section 6 of the PWDVA says that medical facilities must treat survivors, although this requirement has largely been understood to apply to physical injuries, leaving mental health requirements mostly unmet. The lack of legal connections or referral mechanisms between the MHCA and the PWDVA is an important issue for providing complete, survivor-centered care.²⁸

3. Silence on Confidentiality Concerns Specific to Violence Survivors

Section 22 of the Mental Healthcare Act, 2017, guarantees the right to confidentiality of mental health information, subject to limited statutory exceptions such as consent, court orders, and prevention of harm. While this provision offers general protection, it does not address the specific confidentiality concerns of survivors of gender-based violence, particularly in the context of family and matrimonial proceedings. Many survivors fear that disclosure of mental health treatment may be used against them in child custody disputes, with abusive partners alleging that mental health conditions render them unfit to parent.

Indian family courts have, in several cases, treated parental mental health as a relevant—though not determinative factor in assessing the welfare of the child. This practice can create a chilling effect on survivors' willingness to seek psychological care, especially in the absence of any statutory bar on the use of mental health records in custody or matrimonial litigation. The absence of enhanced confidentiality safeguards, survivor-specific privileges, or explicit restrictions on disclosure under the MHCA thus constitutes a significant gap in protecting the mental health rights of survivors of gender-based violence.²⁹

4. Insufficient Accessibility Provisions

²⁷ Judith A. Cohen et al., *Treating Trauma and Traumatic Grief in Children and Adolescents* 28-35 (2006)

²⁸ The Protection of Women from Domestic Violence Act, 2005, § 6.

²⁹ Lenore E.A. Walker, *The Battered Woman Syndrome* 102-08 (4th ed. 2017)



Although Section 18 of the Mental Healthcare Act, 2017 recognises the right to access government-funded mental healthcare, its practical realisation remains severely constrained by systemic shortages in mental health infrastructure and human resources. India continues to face a critical deficit of mental health professionals, with fewer than one psychiatrist and far fewer psychologists available per 100,000 population, well below WHO-recommended levels. Mental health services are overwhelmingly concentrated in urban areas, creating substantial barriers for women in rural and remote regions.

For survivors of gender-based violence, these accessibility barriers are further intensified by coercive control, restricted mobility, financial dependence, and social stigma imposed by abusive partners. While the MHCA adopts a rights-based framework, it does not statutorily mandate mobile mental health services, survivor-focused outreach, or tele-psychiatry mechanisms tailored to the distinct obstacles faced by survivors of violence. The absence of such targeted accessibility provisions limits the Act's capacity to ensure meaningful access to mental healthcare for some of the most vulnerable women.³⁰

5. Economic Barriers and Insurance Coverage

Section 21(4) says that health insurance can't discriminate against people with mental illness, however this rule hasn't been put into practice very well. A lot of insurance plans still don't cover mental health disorders or only cover them in certain ways. The Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana is India's main health insurance program for people who are financially vulnerable. At first, it didn't cover mental health, but it has only recently started to do so in a restricted way.³¹

For destitute GBV sufferers, the lack of adequate mental health services essentially negates their statutory claim under Section 18. The MHCA does not create a complete public mental health service system like basic healthcare infrastructure, which means that many survivors have no options.³²

6. Inadequate Training Requirements

Section 21(4) of the Mental Healthcare Act, 2017 mandates that health insurance providers shall make provisions for medical insurance for the treatment of mental illness on the same basis as physical illness. Despite this statutory requirement, implementation remains uneven, with many insurance policies continuing to limit, cap, or exclude coverage for mental health treatment in practice, particularly for outpatient care and long-term therapy. Although regulatory directions have been issued by the Insurance Regulatory and Development Authority of India (IRDAI), enforcement has been inconsistent.

Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY), India's flagship public health insurance scheme for economically vulnerable populations, initially excluded mental healthcare and has only recently introduced limited inpatient mental health packages, with outpatient services remaining largely uncovered. For destitute survivors of gender-based violence, these gaps effectively negate the statutory right to access mental healthcare under Section 18 of the MHCA. The Act, while rights-based in design, does not establish a comprehensive public mental healthcare delivery system comparable to basic healthcare infrastructure, leaving many survivors without meaningful access to services.³³

International Human Rights Standards and Comparative Analysis

³⁰ *Id.*

³¹ Soumitra S. Datta & Soumyadeep Bhattacharya, *Assessment of the Provisions of the Mental Healthcare Act 2017 Regarding Health Insurance for Mental Illnesses: Where Do We Stand?*, 41 *Indian J. Psychiatry* 377, 379 (2019).

³² *Id.*

³³ Jacquelyn C. Campbell, *Health Consequences of Intimate Partner Violence*, 359 *Lancet* 1331, 1335 (2002).



A. CEDAW and General Recommendations

India's obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) provide an important framework for assessing the adequacy of the Mental Healthcare Act, 2017. CEDAW General Recommendation No. 19 recognises gender-based violence as a form of discrimination that impairs women's enjoyment of fundamental rights, including the right to health, and urges States Parties to adopt legal and institutional measures that ensure protection, support services, counselling, and rehabilitation for survivors.³⁴

CEDAW General Recommendation No. 35, which updates and strengthens General Recommendation No. 19, further clarifies that States have a due diligence obligation to ensure the availability, accessibility, acceptability, and quality of health services for survivors of gender-based violence, including mental health and psychosocial support. It emphasises that States must provide appropriate health services to address the full range of physical and psychological consequences of gender-based violence.³⁵

In its Concluding Observations on India's combined fourth and fifth periodic reports (2014), the CEDAW Committee expressed concern about the limited availability of psychosocial support and counselling services for women survivors of violence and recommended that India strengthen access to such services. Against this backdrop, the failure of the MHCA to incorporate survivor-specific mental health provisions reflects continuing gaps in India's compliance with its international obligations under CEDAW.

B. WHO Guidelines and Best Practices

The World Health Organisation has issued detailed clinical and policy guidance on responding to intimate partner violence and sexual violence against women, particularly in its *Clinical and Policy Guidelines for Responding to Intimate Partner Violence and Sexual Violence Against Women* (2013). These guidelines emphasise the central role of mental health support in survivor recovery and recommend that women exposed to violence receive first-line psychological support and, where needed, access to specialised mental health services. They further stress the importance of training healthcare providers to deliver empathetic, survivor-centred psychological care.

The WHO guidance underscores the use of trauma-informed approaches that recognise the impact of trauma on health and behaviour, avoid re-traumatisation, and promote survivors' autonomy, safety, and empowerment. It also recommends that mental health services be integrated within broader health systems and violence prevention frameworks rather than treated as isolated interventions. Against this international standard, the absence of any statutory mandate within the Mental Healthcare Act, 2017 for trauma-informed, violence-specific mental health responses represents a missed opportunity to align Indian mental health law with global best practices.³⁶

C. Comparative Jurisdictions: United Kingdom and South Africa

United Kingdom: The United Kingdom has developed a more integrated framework for addressing the mental health needs of survivors of domestic abuse through the combined operation of health and domestic violence legislation. While the Mental Health Act 1983 (as amended) is not designed to address gender-based violence and contains no

³⁴ Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 18, 1979, 1249 U.N.T.S. 13.

³⁵ Committee on the Elimination of Discrimination Against Women, General Recommendation No. 35 on Gender-Based Violence Against Women, Updating

General Recommendation No. 19, ¶ 31, U.N. Doc. CEDAW/C/GC/35 (2017)

³⁶ Committee on the Elimination of Discrimination Against Women, Concluding Observations on the Combined Fourth and Fifth Periodic Reports of India, ¶¶ 37-38, U.N. Doc. CEDAW/C/IND/CO/4-5 (2014).



survivor-specific provisions, mental health support for abuse survivors is delivered through the National Health Service (NHS) via trauma-informed services, referral pathways, and programmes such as Improving Access to Psychological Therapies (IAPT), often in coordination with domestic abuse support agencies. The Domestic Abuse Act 2021 represents a significant legislative advance by recognising emotional and psychological abuse as forms of domestic abuse and imposing a statutory duty on local authorities to provide support services, including counselling and psychological assistance, for survivors residing in safe accommodation. This coordinated approach, linking domestic abuse law with mental health service delivery, demonstrates the importance of legislatively integrating mental health care with violence prevention and survivor protection frameworks.³⁷

South Africa: Domestic abuse is a factor that can lead to mental illness, according to South African legal regulations. With the passage of the Domestic Violence Act in 1998, physical, verbal, and emotional violence were all made illegal. In order to safeguard individuals, the Act grants the courts the authority to order therapy and emergency financial assistance, which may include reimbursement for mental health medical expenses.

The Mental Health Care Act, 2002, further reinforces a community-based, least-restrictive approach to mental healthcare, promoting treatment within community settings rather than institutionalisation. Although the Act does not contain survivor-specific provisions, its rights-based orientation provides a legal foundation for addressing trauma-related mental health needs arising from violence. When read together, South African domestic violence and mental health legislation illustrates the benefits of explicitly recognising psychological abuse and enabling financial and service-based responses to mental health harms associated with gender-based violence.³⁸

³⁷ National Institute for Health and Care Excellence, *Domestic Violence and Abuse: Multi-Agency Working*, NICE Guideline PH50 (2014).

³⁸ Mental Health Care Act 17 of 2002 (S. Afr.).

Implementation Challenges and Systemic Barriers

A. Infrastructure Deficits

The statutory promise of access to mental healthcare under Section 18 of the Mental Healthcare Act, 2017, remains largely unrealised due to persistent infrastructure and human resource deficits. International benchmarks suggested by the World Health Organisation indicate that countries should maintain a minimum level of mental health professionals per 100,000 population; however, India's mental health workforce remains well below these recommended levels, with fewer than one mental health professional per 100,000 persons according to recent national estimates.³⁹

At the service-delivery level, the District Mental Health Programme (DMHP), a key component of the National Mental Health Programme, had been implemented in approximately 704 out of 739 districts as of 2022, reflecting progress but also uneven coverage and capacity. For survivors of gender-based violence residing in rural areas, where nearly two-thirds of India's population lives, accessing mental healthcare often requires travel to district headquarters or urban centres. Transportation costs, loss of wages, and the need to conceal treatment from abusive partners constitute significant barriers.⁴⁰

Although tele-mental health initiatives such as the National Tele-Mental Health Programme (Tele-MANAS) have been introduced through executive policy, digital illiteracy, limited internet access, and lack of survivor-focused outreach continue to restrict their effectiveness. The absence of statutory mandates within the MHCA to ensure decentralised, mobile, or survivor-centred service delivery thus remains a major systemic barrier to realising mental health rights for survivors of gender-based violence.

³⁹ Ministry of Health & Family Welfare, National Mental Health Programme, *Implementation Status of District Mental Health Programmes* (2022).

⁴⁰ *Id.*



B. Inadequate Funding

India's health budget gives mental health less than 1%, which makes it very hard to expand services. The National Mental Health Program and the District Mental Health Program are always short on money. The budgets aren't big enough to hire enough staff or build full-service community mental health facilities. Without special budgetary resources for mental health treatment for GBV survivors, they continue to fall through the gaps of the system.⁴¹

C. Stigma and Cultural Barriers

In Indian society, mental illness is heavily stigmatised, and survivors of gender-based violence are often blamed for what happened to them. Women who talk about both violence and mental health issues run the risk of being called "crazy" or "unstable," which could mean losing family support, custody of their children, or their social position. This double stigma makes it very hard for people to get mental health care, making their legal rights mostly useless.⁴²

Cultural beliefs that view domestic violence as a private family issue inhibit individuals from seeking assistance. The National Family Health Survey indicated that 44% of women and 43% of men think that beating your wife is okay in some situations. In these situations, women may not consider their mental health symptoms as real health problems that need treatment, or they may be afraid that getting help for their mental health will make them seem disloyal to their family.⁴³

D. Lack of Trauma-Informed Training

Medical school in India offers scant instruction on gender-based violence (GBV) or trauma-informed care. Psychiatrists and psychologists generally do not obtain specialist training in addressing trauma associated with violence during their initial education. As a result, survivors may come across healthcare providers who don't check for violence, misdiagnose symptoms, or give the wrong therapy.⁴⁴

Research on the experiences of GBV survivors in Indian healthcare settings shows that healthcare providers sometimes blame victims, break confidentiality, and are dismissive. These iatrogenic effects exacerbate trauma and inhibit future help-seeking, underscoring the critical necessity for obligatory trauma-informed competency standards in mental health professional education.⁴⁵

E. Fragmentation Between Legal and Health Systems

The lack of cooperation between legal protection systems and mental health care leads to failures. Protection Officers under the PWDVA seldom possess knowledge regarding mental health resources or training to identify mental health issues. Mental health providers also often don't know about the legal protections that are available to survivors of GBV or how to help clients who are still being abused make safety plans.⁴⁶

The Nirbhaya Fund set up One Stop Centres (Sakhi Centres) to give survivors of violence all the help they need in one place. In theory, these centres provide medical, legal, and psychological help. But review

⁴¹ Soumitra Pathare & Rajesh Nagpal, *Mental Health Financing in India: An Analysis of the National Mental Health Programme Budget Versus Actual Expenditure*, 4 PLoS ONE e7424 (2019)

⁴² Ravi Philip Rajkumar, *Stigma and Mental Health in India: Perspectives from Social Science Research*, 62 Indian J. Psychiatry S62, S64-65 (2020).

⁴³ Ministry of Health & Family Welfare, *National Family Health Survey-5 (2019-21): India Report*

⁴⁴ Swapnajeet Sahoo & Adarsh Tripathi, *Training in Psychiatry: Issues and Challenges in India*, 64 Indian J. Psychiatry S210, S212-13 (2022).

⁴⁵ Padma Bhate-Deosthali et al., *Poor Standards of Care: Violence Against Women in Healthcare Institutions*, in *Violence Against Women in India: A Comprehensive Analysis* 201, 205-10 (Kalpana Kannabiran ed., 2012).

⁴⁶ *Id.*



studies show that psychological services are often the weakest part, with many centres not having certified mental health specialists or only delivering short, one-time therapy sessions that aren't enough to help with trauma-related issues.⁴⁷

Conclusion

The Mental Healthcare Act, 2017, marked a significant shift in Indian law by recognising access to mental healthcare as a statutory entitlement grounded in the constitutional guarantee of life with dignity under Article 21 of the Constitution of India. Internationally, India is bound by obligations under the International Covenant on Economic, Social and Cultural Rights (Articles 11 and 12) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) to ensure access to health services, including mental healthcare, for women subjected to violence.

This study demonstrates that the Mental Health Care Act (MHCA) does not adequately address the mental health requirements of victims of gender-based violence, notwithstanding the progress that has been made. There are many barriers that prevent the protection of rights related to mental health. Some of these include the absence of gender-based violence (GBV) standards, the partial incorporation of laws such as the Protection of Women from Domestic Violence Act of 2005, problems with implementation, and institutional barriers that are systemic in nature. It is still difficult for survivors to obtain mental health therapy that is prompt, cheap, and based on their own experiences.

Women's health, safety, and self-esteem are all put in jeopardy when they are subjected to violence. In accordance with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and Articles 14 and 15 of its constitution,

India is obligated to provide victims of abuse with proper mental health care. These pledges are disregarded by the laws and institutions that are now in place.

In order to accomplish Sustainable Development Goals 3 (good health and well-being) and 5 (gender equality), national mental health legislation and policies need to make it clear that violence against women has an impact on mental health. It is not enough to simply have notional rights; we need to make significant reforms to laws, policies, funding, and institutions in order to counteract these impacts.

The findings of this study suggest that the Mental Health Care Act (MHCA) should be amended to include survivor-specific trauma-informed mental healthcare standards; that institutional integration between mental health services and gender-based violence (GBV) protection mechanisms should be improved; that public mental health infrastructure and workforce development budgets should be increased; and that mental health and legal professionals should be required to receive trauma-informed care. Under both domestic and international law, India is obligated to provide medical care that is compassionate, equitable, and effective to all women, including those who have been abused. By taking these steps, India may be able to accomplish its purpose.

⁴⁷ Centre for Health and Social Justice, *Evaluation of One Stop Centres: Key Findings and Recommendations* 42-48 (2020)