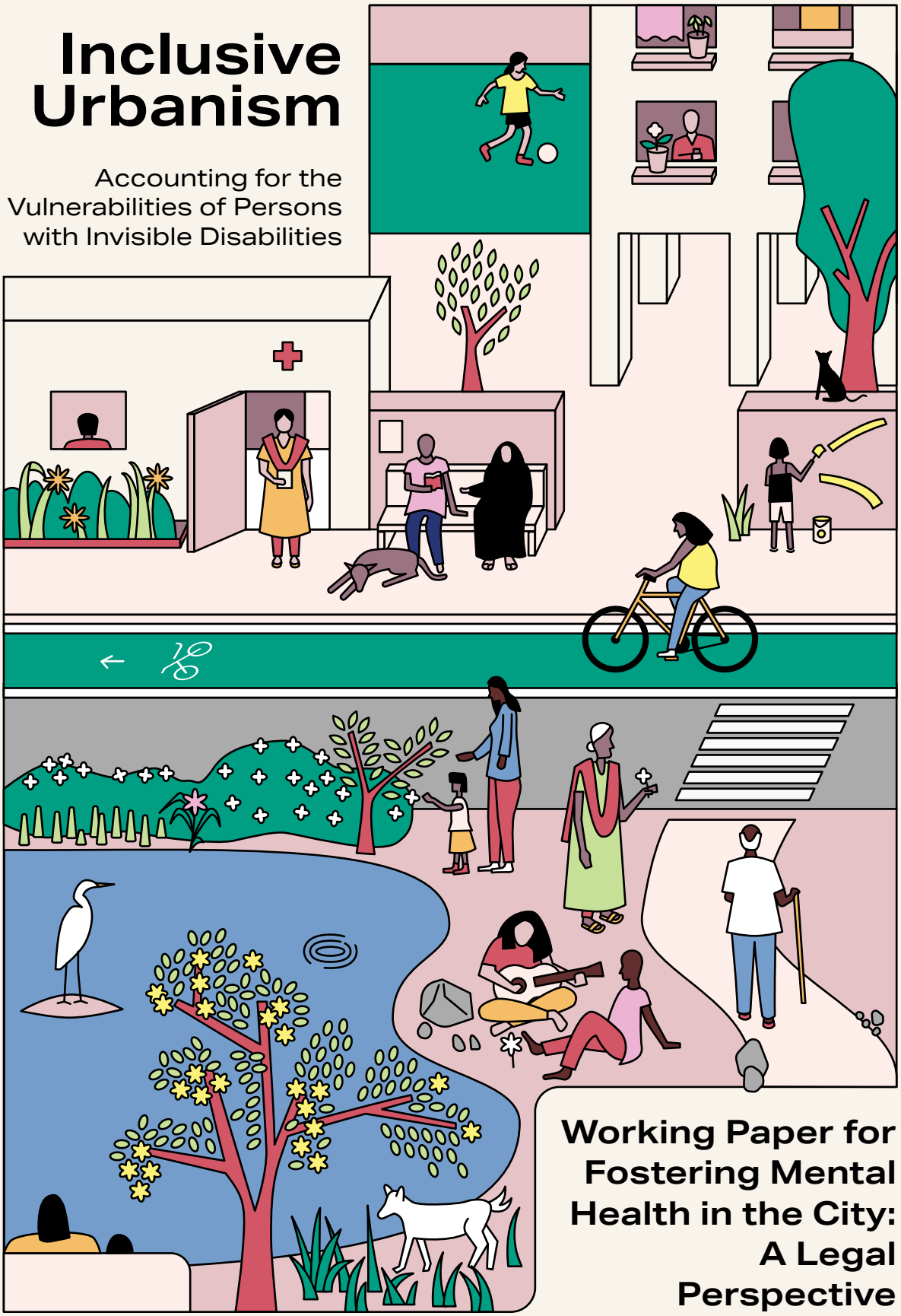
Inclusive Urbanism

Accounting for the Vulnerabilities of Persons with Invisible Disabilities



Working Paper for Fostering Mental Health in the City: A Legal Perspective

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About the Authors

Sneha Visakha is a Senior Resident Fellow at the Vidhi Centre for Legal Policy, Karnataka.

Manmayi Sharma is a Senior Resident Fellow at the Vidhi Centre for Legal Policy, Karnataka.

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I. Introduction

The 'Inclusive Urbanism' working paper series is an attempt to engage with the question of accessibility to urban space from the perspective of less visible, often overlooked and invisible disabilities. The first paper in the series explored the background and key concepts involved in understanding accessibility in the context of cities, particularly for persons with psychosocial, intellectual, and developmental disabilities. This paper is an attempt to explore the question of accessibility, especially for those with mental illness and psychosocial disabilities, and focuses on the role and impact of the urban environment in fostering mental health and well-being for all in Indian cities.

Building on previous work on improving accessibility to urban space, this working paper attempts to delineate various aspects of mental health and attempts to bring into mainstream discussion the importance of a mental health perspective to urban planning and design in creating healthy cities for all its inhabitants. It does so by engaging with emerging concepts in feminist urban planning, restorative urbanism and behavioural access among others, and engages with the legal frameworks that are relevant and applicable to the issue of mental healthcare, rights of persons with disabilities, including municipal laws applicable to cities in Karnataka, notably Bengaluru.

While the overall aim of the working paper series is to help identify gaps and critical points of intervention in the existing legal and policy frameworks and to recommend measures that help create truly inclusive cities for all, this paper critically examines how accessibility must be understood and reimagined in the context of mental illness and psychosocial disability, in order to create liveable, thriving and healthy cities for all.

II. Methodology and Structure of the Paper

For this paper, a mix of research methods was adopted including literature review and stakeholder consultations in the form of semi-structured interviews and a national level roundtable discussion with subject-matter experts, conducted in-person in Bengaluru on 3 April, 2023. This process included consultations with disabled people's organisations ("**DPOs**") working on mental illness and psychosocial disability, feminist and disability studies scholars, psychiatrists, psychologists, architects, accessibility consultants, and researchers in the fields of mental health, law, architecture and psychology. These consultations were useful in highlighting the nuances, gaps and problems involved in exploring various mental health concepts, understanding accessibility for persons with mental illness and the need for a mental health perspective to planning and design in the city.

In this working paper, relevant and applicable legal and policy frameworks at various levels have been enumerated and explained, with a focus on Karnataka, notably Bengaluru. This includes the United Nations Convention on the Rights of Persons with Disabilities ("**UNCRPD**"), the Rights of Persons with Disabilities Act, 2016 ("**RPWD Act**"); the Mental Healthcare Act, 2017 ("**MHCA**") along with the National Mental Health Policy, 2014 ("**NMHP 2014**"); and the Karnataka Mental Healthcare Rules 2021 ("**KMHC Rules**"), among others.

Further, key concepts in mental health are explored, with an examination of how urban accessibility must be understood and reimagined when it comes to persons with mental illness, under the primary legislation on disability and mental healthcare in India, i.e., the RPWD Act and the MHCA, respectively. Finally, this paper attempts to start a conversation on mainstreaming mental health

perspectives to urban planning, design and architecture in Indian cities, and explores how cities can contribute to the promotion of mental health and well-being.

III. Understanding Mental Health in the Context of Cities

The nature of cities and urban spaces determines the quality of life of its various inhabitants significantly. This renders the design, development and planning of cities and urban spaces extremely important to engage with. Whether it is processes that govern and administer housing, or access to water and sanitation, transportation and mobility, access to childcare, health and other services, accessibility, ecology, employment, education, and political participation, all of them have a profound impact on the quality of life, prospects and health of the urban population.

a) A Statistical Snapshot

The Covid-19 pandemic had profound and lasting consequences for public health across the world, especially mental health.[1] Research indicates[2] that there has been a 20% increase in people with mental illness since the Covid-19 outbreak. Even prior to the outbreak of the Covid-19 pandemic, India had been grappling with a mental health crisis. According to a report in 2017,[3] one among every seven people in India had a mental disorder, ranging from mild to severe. The highest disease burden, among mental disorders in adults, in India was found to be caused by depressive and anxiety disorders, followed by schizophrenia and bipolar disorder.[4] However, there is a growing awareness in the existing health institutions in India about the need to tackle mental illness in an urban context. The National Mental Health Survey 2015–16 recognised[5] the impact of rapid urbanisation and high

prevalence of mental disorders in urban areas, and recommended that the National Health Mission[6] clearly define and integrate mental health components for implementation of health services.

Recent statistics from the National Crime Records Bureau ("**NCRB**") suggest[7] that the economic status of suicide victims was highly co-related to suicide (in 2021, 64.2% of suicide victims had an annual income of less than Rs. 1 lakh and 31.6% of suicide victims belonged to annual income group of Rs. 1–5 lakh). This is a clear indicator that poor economic status, lack of income and economic precarity contribute directly to mental health crisis. Among male suicide victims, the highest number was daily wage earners, followed by self-employed and unemployed persons, making economic and job security a significant factor in male suicides. Till economic precarity and deprivation continue to be the characteristic features of urban life, it is clear that mental health problems in cities will continue to persist.

Furthermore, among female suicide victims, the highest number were housewives, followed by students and daily wage earners. Feminist researchers have long-documented the deleterious impacts of patriarchy on women's mental health and some researchers have argued that the Indian women's movement itself was a mental health movement,[8] pointing to the fact that the movement gave women "safe spaces, support and belongingness," which are necessary for any measure of self-healing and recovery. As the data starkly reveals, there are deep seated social and economic inequalities in Indian society, which are contributing to severe psychological and mental health conditions in the population.

In addition to the data enumerated above, it emerged in stakeholder consultations, that the burden of untreated, undiagnosed mental illness in India is extremely high,

with serious repercussions for public health, owing to high levels of stigma, lack of trained mental health professionals, poor or lack of access to mental health services, low investment, and lack of awareness. According to a 2016 Lancet study series on India and China,[9] only 1 in 10 people in India with mental health disorders were thought to be receiving evidence-based treatments, with depression and anxiety being most common among working age adults (aged 20–69 years), with higher numbers of women with the conditions than men.

Furthermore, there is a significant underfunding of mental healthcare and related services in India. For the financial year 2023–24, only 2% of the total budget outlay of the Union government is dedicated to health and related programmes, and within that, for mental health is just 1.03%[10], constituting a mere Rs. 919 crores from the Rs. 89,165 crores of the overall health budget. Amongst the mental health allocation, the funds are primarily directed towards the (i) National Institute of Mental Health and Neuro-Sciences ("**NIMHANS**"), Bengaluru (Rs. 721 crore); (ii) Lokpriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur (Rs. 64 crore) and (iii) the National Tele-Mental Health Programme (Rs. 134 crore).[11]

b) Understanding a 'Right to the City' Approach

The Constitution of India commits to values of justice, liberty, equality and fraternity[12] —the realisation of such values, in the everyday lives of people in our country, depends on laws and policies engaging with and accounting for the experiences of everyday life of people in India. In the context of the city, this is posited by proponents of feminist urbanism, a critical approach[13] to urban theory emerging from feminist critiques from the 1970s, which argues that "everyday lived spaces are neglected as political sites,"[14] highlighting their importance

to building political belonging, citizenship and exercise of fundamental rights and entitlements.

This argument could be located in the "Right to the City" ("**RTTC**") framework, which is not a set of positive rights but a moral one,[15] that engages with the right to urban life. The idea and slogan of the 'right to the city' comes from Marxist philosopher and sociologist Henri Lefebvre, whose highly influential work examining impacts of capitalism on cities and the commodification of urban life, inextricably linked spatial justice as central to any pursuit of justice, whether economic, social or political. Thus, paying attention[16] to spatial relations, articulations around RTTC have been developed[17] by later scholars to be understood as a common[18] right rather than an individual one, recognising the role of collective power in shaping cities. Scholars have argued[19] that the freedom to make and remake cities is a precious, albeit neglected human right.

The RTTC framework is relied on by various marginalised groups seeking to advance justice, including women, (migrant) workers, persons with disabilities among others, to make and exercise their democratic rights-based claims in the city. Scholars have noted that inclusion to the 'public' domain for such groups is achieved through concerted social struggle, through a demand for the right to directly participate in the making of such a 'public,' as stated in "the right to be seen, to be heard, and to directly influence state and society."[20] [21] This is also epitomised in the popular slogan adopted by the disability rights' movement, "Nothing About Us, Without Us"[22] which crystallised the principle of participation[23] in the UNCRPD, a landmark human rights convention that firmly placed disability in the human rights agenda, with a decisive shift from the medical model to the social model.[24] Therefore, it is critical to engage with the right to access urban resources, the right to urban life and the right to urban accessibility for persons with disabilities (and other overlapping groups) in the RTTC framework, to seriously

engage with the issue of spatial justice, in the larger movement for disability justice.

While the disability rights[25] regime in India engages with spatiality, guaranteeing the right to accessibility[26] to urban space, it has been previously[27] pointed out that there is a problem of imagination that ignores the diversity within persons with disabilities and their access needs, especially those with conditions that are not immediately perceivable, such as mental illness and psychosocial disability. This paper engages with the urban environment and its role in improving mental health outcomes, accessibility to persons with mental illness and psychosocial disability. It also explores how cities can create healthy environments for their inhabitants. In order to engage with the city in the context of mental health, it would be useful to trace important concepts in mental health and examine the history of laws and legal institutions that have approached, understood and dealt with mental illness as well as persons with mental illness in India.

IV. Important Concepts in Mental Health

In the context of mental health, various concepts outlining aspects of mental health, illness, disability and well-being are used, and associated terminology is deployed by various actors for different purposes. For instance, clinical practitioners may employ diagnostic categories to describe specific mental disorders for treatment (derived from a medical model), which may include prescribing medication, therapeutic or other such interventions. Psychiatric social workers might employ categories that highlight the socially constituted aspects associated with such conditions (derived from the social model), because their focus might be on facilitating community support

and resources for rehabilitation, empowerment and well-being in their day-to-day life.

It would be useful to further explore these concepts and terms in order to clarify and understand the various aspects of mental health that are important to engage within the context of cities.

Box: Important Concepts

a. Mental Health: According to the World Health Organization ("**WHO**"), mental health is a state in which an individual 'realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO 2004).[28] Interestingly, while the MHCA does not define the concept or term 'mental health,' the NMHP 2014 indicates[29] that its understanding of "mental health" is in concordance with the WHO, referring to "a state of complete physical, mental and social well-being, and not merely the absence of disease."

b. Mental Illness: The MHCA defines[30] mental illness to mean "a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs, but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterised by subnormality of intelligence". The NMHP 2014 also proceeds to define "persons affected by mental illness" to include "persons with mental illness and significant others such as family members and caregivers."

c. Psychosocial Disability: The term 'psychosocial disability' encompasses "all persons who, regardless of their self-identification or diagnosis, experience discrimination and societal barriers based on actual or perceived mental health diagnosis or subjective distress."[31] It is important to clarify that all persons with mental health conditions are protected by the UNCRPD, whether they consider themselves persons with psychosocial disabilities or not.

d. Psychological Well-Being: Adopting the definition used in the book, Restorative Cities[32] the definition of psychological well-being comprises "multiple mood (affective) and thought (cognitive) components, including:

- Hedonic well-being (happiness, enjoyment)
- Eudaimonic well-being (purpose, meaning, fulfilment)
- Self-actualization (accomplishments, optimism, wisdom)
- Resilience (capacity to cope, lack of maladaptive problem solving, and adaptive emotion regulation)
- Social well-being (healthy relationships)" in addition to healthy cognitive functioning (e.g. attention, working memory).

a) Legal Definitions and Terminology

When it comes to the Indian context, mental health and mental health conditions are defined in numerous ways and this is also reflected in the differences in terminology used in various legal and policy frameworks on mental illness and disability.[33] For instance, in India, the MHCA defines mental illness and lays out rights of persons with

mental illness, and the RPWD Act, in specifying categories of disability, includes persons with mental illness as one of the categories governed by it.

In contrast, international human rights mechanisms and agencies prefer[34] to use the term persons with psychosocial disabilities.[35] For the purpose of this paper, both terms are used (without prejudice to any other terms[36] not covered here) in discussing various aspects of accessibility to urban space, since the access needs of groups that fall under any of these terms, significantly overlap in the context of cities.

The shift from usage of the term persons with 'mental illness' which focuses on impairment, to the term persons with 'psychosocial disabilities', which focuses on attitudinal and environmental barriers, highlights the limitations of the existing social structures that restrict equal participation in society and also endeavours to support de-stigmatisation and move away from pathologizing individuals. However, it is pertinent, to note as legal scholar Amita Dhanda points out, even before the enactment of the UNCRPD, the change in terminologies was part of a de-stigmatisation exercise, "where the stigma of the condition is attempted to be removed by changing the name by which it is referred to… with no change in the ground-level situation of the bearers of the condition, changing of terminology remains a euphemistic exercise".[37]

As noted[38] by researchers, mental illness and mental health exist on a continuum. While the presence of a mental illness can impair some functions, it is possible for some people to lead a healthy life with the necessary support, whether in the form of medical treatment or community support, as needed. However, the absence of mental illness does not translate to optimal mental health directly, and people without a mental illness may struggle to lead a healthy life.[39] This is why a focus on

psychological well-being, which explores various facets of what constitutes an enjoyable and flourishing life, is critical for any approach central to designing and making cities.

V. Fostering Mental Health in Cities: Some Approaches

a) Creating Healthy Cities: A Restorative Urbanism Approach

The WHO identifies[40] key determinants of mental health to be a complex interplay of individual biological and psychological factors, family and community support as well as immediate, and structural factors relating to broader sociocultural, geopolitical and environmental surroundings including infrastructure. This correlation between mental health and the quality of life in a city has been well explored.[41] It is also noted in the New Urban Agenda 2016[42] that integrates health and equity as key principles within urban planning, especially important in the aftermath of the Covid-19 pandemic.

Box: Characteristics of a Healthy City

1. A clean, safe physical environment of high-quality (including housing quality);
2. An ecosystem that is stable now and sustainable in the long term;
3. A strong, mutually supportive and non-exploitative community;
4. A high degree of public participation in and control by the public over the decisions affecting their lives, health, and well-being;

5. The meeting of basic needs (food, water, shelter, income, safety and work) for all the city's people;
6. Access to a wide variety of experiences and resources, with the possibility of multiple contacts, interactions, and communication;
7. A diverse, vital and innovative city economy;
8. Encouragement of connectedness with the past, with the cultural and biological heritage, and with other groups and individuals;
9. A city form that is compatible with and enhances the above parameters and behaviours;
10. An optimum level of appropriate public health and sick-care services accessible to all;
11. High health status (both high positive health status and low disease

Source: WHO Healthy Cities.[43]

Furthermore, several research initiatives have recognised the importance of the experience of nature as a positive social determinant of urban health, often dubbed as 'green cities' approach,[44] to study the role of urban environments in contributing to mental health. Research is being undertaken on how environments can play a role as a buffer[45] from stressors in life, and how certain spaces can help relieve[46] severity of symptoms from mental health conditions such as fatigue, depression, stress and anxiety among others. Some researchers emphasise[47] a "biophilic" (i.e. love of nature) approach to urban design, arguing that city design should necessarily incorporate elements such as direct and indirect experience of nature, experiencing place, space and attachment and being sensitive to nature's patterns, processes and systems.

This has also given rise to concepts such as "restorative urbanism" that prioritises mental health, well-being

and quality of life in city planning and urban design. This emerges from an increasing body of research on 'restorative environments' that engages with the spatial dimension of recovery from mental health conditions, such as the impact of the built environment on mental health. While researchers point out that measuring direct impact on mental health is difficult, they identify[48] several pathways through which the built environment indirectly impacts mental health. These "pathways of influence" encompass[49] physical activity, social engagement, privacy, biophilia (or benefits from contact with nature such as water and greenery), accessibility, attachment and belonging, autonomy and independence, equality, and safety among others. These pathways provide insight into policy and design interventions that would make urban environments more liveable and improve quality of life.

b) Reimagining Urban Accessibility: A Behavioural Access Model

Owing to paucity of research in this field,[50] it is difficult to identify barriers to access for persons with mental illness and psychosocial disability. While the RPWD Act enshrines the right[51] to accessibility to urban space, providing for standards of accessibility for the "physical environment, transportation, information and communications, and other facilities and services," it shows limited understanding and thinking about the access needs for persons with mental illness and psychosocial disability. There is an emphasis on physical barriers or limitations to infrastructure, that are understood to be pertinent to the question of accessibility. In the context of mental illness and psychosocial disability, barriers to access do not arise in the same vein as other disability groups.

This failure to account for the access needs of persons with mental illness and psychosocial disability is also reflected in the Harmonised Guidelines and Standards for Universal Accessibility, 2021 ("Harmonised Guidelines")

which does not take into account the specific and different needs of individuals with mental illnesses and psychosocial disability. However, the MHCA, while it does not address the question of accessibility directly, does account for environmental factors, marking a shift to a psychosocial approach, instead of a strictly medical model. This is also reflected in the case of mental health policies in India, notably, the NMHP 2014 issued by the Ministry of Health and Family Welfare ("MOHFW") which states[52] that—

"A healthy, safe and enriching physical and social environment, promotes individual and community mental health. The predictable negative influences on mental health of poverty, discrimination, malnutrition, environmental factors (including access to safe water, toilets and sanitation), exposure to violence, and absence of parental figures (death, divorce, displacement) affect individuals across their lifespan."

As seen above, there is a clear acknowledgement of the environmental and structural factors that impact the mental health of the individual and communities in question and this is reflected in the spirit of the NMHP 2014, which specifically, highlights[53] the role of union and state governments in the promotion of mental health, prevention and treatment of mental illness in their respective jurisdictions.

In such cases, the question of accessibility is informed by a range of factors, such as stigma, non-discrimination, access to housing and shelter, mental health services, income, employment, safety from gendered violence, access to restorative environments, community support among others, which are covered by the RPWD Act but not explicitly in the context of accessibility for persons with mental illness, and despite measures for their support and access, even when coming within the scope

and category of benchmark disability or those with high-support needs.

In this context, it becomes extremely important to engage with the "behavioural access" to space, that describes the actual utilisation and enjoyment of such spaces, infrastructure and services, notably in the context of healthcare. Operationalising 'access' to care may encompass "seeking services, reaching healthcare resources, and receiving services that are relevant and appropriate to the individual's healthcare needs."[54] Studies find that a person's living situation, both in terms of geography and in terms of people with whom the person lived, had major influences on what services were accessed[55] and point to family-centred services as better able to facilitate access for those with need. In the context of access to health services, especially mental health services, studies exploring[56] different models of access to care[57] engage with behavioural models of health service use, emphasising factors both at the "service level (e.g., geographic location, availability of services, referral mechanisms, coordination of care) and at the individual level (e.g., social support, criminal history, housing)" in order to inform understanding on how and what users are accessing and using health services. Sociologist R M Andersen's 'Behavioural Access to Care Model' proposes that social support is a facilitator for health services use. He argued[58] that in order to access health services, it required the presence of resources that enable people to access care, both at the community and personal level such as proximity, income, travel, waiting times, regular sources of care among others. Health personnel and facilities must be available where people live, work and are equipped with the means and know-how to reach services and use them.[59]

In this regard, unpacking what 'access' means and enumerating the various elements of access, including behavioural aspects is important, so that accessibility is

understood and reimagined in ways that serve the end users. To quote Andersen, *"Any comprehensive effort to model health services' use must consider how people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help."*[60] This assumes overwhelming importance in the context of mental health and mental healthcare services since widespread stigma and lack of awareness contribute to not only a growing disease burden of undiagnosed and untreated mental illness but also, adversely impede access to mental health services, even in contexts where they exist. Therefore, mental healthcare, health and other services must account for behavioural aspects, social context and background, personal and community enabling resources, in order to make their services accessible to the people who most need them and that such services aim to serve.

In view of the above, it becomes clear that state and municipal agencies involved in urban planning, design and governance must play a central role in reducing the disease burden of mental illness, by making mental health and well-being of the city's inhabitants a key priority in planning and design policies. Therefore, the adoption of a mental health perspective in urban planning is critical for the implementation of the MHCA and other extant mental healthcare policies at the local level in Indian cities.

VI. Role of Law in Access to Cities for Persons with Mental Illness and Psychosocial Disability

a) Historical context: Impact of Colonial Legislation

The treatment of persons with mental illness and psychosocial disability in India is significantly impacted by colonisation, which laid the groundwork for institutionalisation, criminalisation and overall erasure of the identity of such persons. Laws such as the Indian Lunatic Asylum Act, 1883 and later, the Indian Lunacy Act, 1912 ("ILA 1912"), and also the use of asylums, were brought in by Great Britain.[61] The legal understanding of a 'lunatic'[62] in the ILA 1912 reflected the notion that persons with mental illness were irrational and lacked the mental capacity to manage their own affairs.[63] They were non-persons that had no legal rights within society, and were deemed to be 'dangerous' such that the public had to be 'protected' from them.[64] The colonial laws prevented persons from occupying space in society as they were subjected to custodial sentences[65] and shut off in asylums[66] or placed in jails or else, simply rendered homeless[67]—these were all places characterised by unhygienic conditions and increased likelihood of human rights violation.[68]

India continued to use the ILA 1912 more than five decades after independence, and it was replaced by the Mental Health Act, 1987 ("**MHA**") only in 1993—the year it was finally brought into effect.[69] To its credit, the MHA improved on the previously stigmatising terminology (albeit using the terms mentally ill and mental retardation in place of 'lunatic'), and introduced a structured institutional framework by way of establishing the central and state authorities for mental health services.[70] However, the MHA still worked as a custodial

law: its scheme of admission was largely through orders of magistrates,[71] with research noting how such judicial orders were repeated word for word, showing the absence of a real inquiry.[72]

In comparison, the Persons with Disabilities (Equal Opportunities Protection of Rights, and Full Participations) Act, 1995 ("**1995 Act**") was enacted two years after the MHA, giving effect to a more progressive, internationally acknowledged understanding of disability at the time.[73] The 1995 Act however, did not have a speaking definition for disability, and simply listed down seven conditions, which included mental retardation[74] and mental illness.[75] While this indicated a focus on the medicalisation of disability, it had sections that detailed what constitutes a deprivation of rights[76] and what was required for the protection and safeguarding of the rights of persons with disabilities.[77]

b) Existing Legal Framework on Mental Healthcare and Disability

The RPWD Act read with the Rights of Persons with Disabilities Rules, 2017 ("**RPWD Rules**") is the primary legal framework on the rights of persons with disabilities, and the MHCA read with the Mental Healthcare (Rights of Persons with Mental Illness) Rules, 2018 ("**MHC Rules**") lay down the substantive legal framework on healthcare for mental illness. While the Department of Empowerment of Persons with Disabilities (*Divyangjan*), Ministry of Social Justice and Empowerment ("**DEPWD**") is responsible for overseeing the implementation of the RPWD Act, the MHCA comes under the purview of the MOHFW.

The RPWD Act represents a marked shift from the narrow perspective of disability to a broad, rights-based approach that incorporates a 'person first', social model of disability. The definition of a 'person with disability,' reflects this shift. Instead of the listed-down definition in the 1995 Act,

the RPWD Act defines[78] a person with disability to mean *"a person with long-term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his (or her) full and effective participation in society equally with others."*

The RPWD Act lays down several broad social rights and welfare-based entitlements for persons with disabilities, which are to be implemented by the 'appropriate government' (which includes the state government).[79] These include, measures to develop accessibility standards,[80] including steps to make art, recreation and sporting events accessible.[81] The RPWD Act has detailed provisions regarding equality and non-discrimination[82] and the provision of reasonable accommodation.[83] It provides persons with disabilities the right to live in a community, such that they cannot be forced into any particular living arrangement and have access to community support services,[84] and mandates the appropriate government to formulate social security schemes, which include provision of a disability pension.[85] On healthcare, the RPWD Act provides for free local healthcare, subject to a cap based on family-income;[86] as well as barrier-free access to persons with disabilities in all hospitals and other healthcare institutions.[87]

While the disability framework in India (i.e., the 1995 Act and the RPWD Act) has developed to reflect the change in understanding and treatment of disability from the medical model to the social and rights-based approaches, the mental health framework has developed in a relatively separate silo of its own. Nonetheless, the MHCA attempts to weaken the negative and prolonged socio-legal impact of the colonial era laws. It guarantees access to affordable, good quality and accessible mental healthcare, without any discrimination on any basis,[88] and makes a push for the provision of affordable mental healthcare by including mental illness within the list of illnesses covered by insurance.[89] It has several provisions that further the right

to community living and less restrictive establishments so that persons with mental illness have alternatives that do not condemn them only to institutionalisation.[90]

The MHCA also incorporates provisions for caregivers of persons with mental illness such that they have a say in the provision of mental healthcare,[91] and are also provided financial assistance by the government.[92] Significantly, the MHCA puts the onus on the state for prevention of suicide and dilutes the criminalisation[93] of the attempt to die by suicide.[94] It incorporates measures for vulnerable communities: those below the poverty line or homeless are given the right to free mental health treatment and services.[95] It ensures that no person with mental illness including children and older persons shall be required to travel long distances to access mental health services.[96] Along with the MHCA's focus on mental healthcare and community living, the RPWD Act greatly enhances other social and rehabilitative aspects through its provisions for non-discrimination and reasonable accommodation.

In addition to the above, there are several policies and programmes that have been great support for realisation of comprehensive mental healthcare services, in parallel to the statutory framework. India has been implementing the National Mental Health Programme since 1982 ("**NMHP 1982**")[97] and the District Mental Health Programme of 1996 ("**DMHP**") that was launched under the NMHP 1982.[98] These two have served as the main components of a mental health framework for the country.[99] While the NMHP 1982 is the earliest policy measure with specific parameters to promote community participation of persons with mental illness—spanning housing, livelihood and recreational activities,[100] the DMHP, which also emphasises a community based approach and provision of mental healthcare especially to vulnerable populations,[101] was started under the NMHP 1982 to decentralise provision of mental health services at the community level. Its implementation is coordinated by

the state department of health and family welfare, which ensures that the required staff and manpower are made available in each DMHP district for implementation.[102]

Though the NMHP 1982 and the DMHP have been implemented for a while, it is the NMHP 2014 that has well detailed measures which take a truly psychosocial approach towards mental health. It encompasses a deeply progressive vision that recognises systemic factors such as social exclusion, unequal opportunities, income disparities, perceived lack of control over one's social and economic life being linked to high rates of depression. It is also sensitive to violence against women as a key risk factor for women's mental health.[103] The NMHP 2014 recognises the vulnerability of persons with "mental health problems"[104] and calls for the adoption of a rights-based approach. It also acknowledges that doing so will reduce stigmatising and discriminatory behaviours.

Available literature has primarily focused on challenges with the ground-level implementation of these programs and policies.[105] This has been attributed to poor services and resources in mental health and allied health facilities as well as the lack of involvement of community leaders, NGOs, and the private sector.[106]

c) Role of Municipal Law

Municipal laws such as the Karnataka Municipal Corporations Act, 1976 ("**KMC Act**"), applicable to municipal corporations across the state (except Bengaluru), the Karnataka Municipalities Act, 1964 ("**KM Act**") applicable to municipalities across the state, and the Bruhat Bengaluru Mahanagara Palike Act, 2020 ("**BBMP Act**")[107] applicable to the city of Bengaluru, contain an enumeration of a series of obligatory, special and discretionary functions that such authorities are expected to discharge as per their mandate. The responsibility for planning, design, provision and maintenance of critical

urban infrastructure is vested in the urban local bodies of the city, which create the pathways for those in the city to access a range of services especially related to health and mental healthcare services within their communities.

The structural and environmental aspects central to fostering a high standard of living and improved quality of urban life can be located in the functions under these municipal laws. For instance, the obligatory functions under the KMC Act cover services such as the provision of public parks, playgrounds and recreational grounds.[108] The discretionary functions[109] assigned to these municipal authorities contain provisions for providing services fulfilling basic needs of food (shops with necessities in times of scarcity[110]), water (drinking fountains in public places as well as bathing places and swimming pools[111]), shelter and healthcare (institutions for the infirm, sick and for persons with disabilities[112]), poverty alleviation measures and measures for the development and maintenance of gardens and trees, spaces dedicated to art, cultural and aesthetic engagement such as music, art galleries, museums, spaces of biological and zoological interest, among others.[113]

Similarly, the Bruhat Bengaluru Mahanagara Palike ("**BBMP**") is also entrusted with core functions[114] including safeguarding the interests of persons with both "physical and mental disabilities" as well as functions on the provision and maintenance of urban facilities and public amenities such as parks, playgrounds, public markets, street lighting, bus stops, and public conveniences. Thus, the BBMP also invariably has a role to play in ensuring that the city is accessible to persons with mental illness and psychosocial disabilities.

VII. Issues For Consideration

When it comes to the utilisation of the legal framework by persons with mental illness and psychosocial disability, there are a few areas which need urgent focus, and the improvement of which will go a long way towards promoting access to mental health and wellness in urban spaces. These areas relate to: a) Stigma and lack of awareness; b) Gaps in envisioning access; c) Gaps in facilitating service provision; d) Gaps in integrating the mental illness and disability frameworks; and e) Role of municipal law in fostering mental health in cities.

a) Stigma and Lack of Awareness

The social model recognises that stigma and lack of awareness of mental illness and psychosocial disabilities act not just as disabling barriers to social participation, but can also lead to their human rights violation.[115] The MHCA has provisions on ensuring a dignified existence to combat long-standing societal stigmas: it puts the onus on the appropriate government to create awareness about mental health and mental illness, along with reducing associated stigma[116] and requires the conduct of sensitisation and awareness training to police and government officers.[117] Significantly, it creates a presumption that the person attempting suicide was under severe stress, on account of which such person cannot be tried under the Indian criminal law.[118]

While the RPWD Act does not employ use of the term 'stigma', it does mandate the appropriate government to conduct, encourage, support or promote awareness campaigns and sensitisation programmes to ensure that the rights of the persons with disabilities provided under this Act are protected.[119] However, much more needs to be done to reduce stigma and generate awareness such that persons with mental illness and psychosocial disabilities

can enjoy equal participation in society and timely access to healthcare.

As detailed above, the NCRB in 2022 reported a severe increase in the number of suicides in the country.[120] It reported the highest ever recorded suicides in the country, since the very inception of such reporting by it in 1967.[121] While Karnataka was one of the top five states that reported a majority of suicides,[122] family problems and major illness[123] were reported as the major causes of suicides as per this data.

Stigma and lack of awareness also impede the effectiveness and reach of existing measures to alleviate mental illness and psychosocial disability. It is reported that only 28% of persons with disabilities in India have a disability certificate.[124] Studies indicate lack of awareness, cumbersome processes and attitudinal barriers among health professionals as being reasons for the difficulty in availing disability certification.[125] Lack of awareness has also been cited as a reason for the low numbers of persons with disability that are recipients of the Central Government's disability pension.[126]

The NMHP 2014 states that the poor awareness of mental illness, along with the myths, stigma and lack of knowledge on treatment availability, are important causes for the high treatment gap in India.[127] Even post the Covid-19 pandemic, and the collective realisation it brought towards mental health related issues, a 2021 survey found that only 41% of India's population aged between 15–21 years felt that people experiencing mental health issues should reach out and get support for mental health problems, compared to an average of 83% for 21 countries.[128]

b) Gaps in Envisioning Access

The provision of accessible mental healthcare in the city requires detailed and comprehensive measures that ensure universal access of quality healthcare, infrastructure and services to the many varied residents of a city. However, both the MHCA and the RPWD Act lack imagination in envisioning the needs of persons with mental illness and psychosocial disabilities, having regard to their immediate support and access requirements.

Further, even though the RPWD Act moves the needle beyond access to basic healthcare, as previously discussed in our research, it still exhibits limited to no consideration of the needs of persons with mental illness and psychosocial disability, with accessibility guidelines and standards only focusing on certain disability groups such as locomotor disability, visual impairment, and hearing and speech impairments.[129] While the RPWD Act sets out accessibility standards for various categories of urban spaces, i.e., physical environment, transportation, information and communications technologies and systems,[130] it still exhibits a lack of imagination in envisioning universal accessibility and incorporating cross-disability perspectives which take into account factors such as sex, economic status, income, age, caste, cultural context among others—all of which can impact accessibility to urban space.

Specifically, the Harmonised Guidelines fail to focus on psychosocial disabilities, even when detailing standards for universal design and especially when considering accessibility needs and ensuring mental health and wellness in urban space.[131] Further, while the Harmonised Guidelines represent a step forward, and capture details such as 'equitable' design to avoid prejudice[132] and specific guidelines accommodating for neurodiversity[133] (such as adequate lighting for visual comfort), signage to minimise anxiety and confusion as well as information

provision in both audible and visual form with pictograms to supplement the same,[134] their implementation rests in the hands of the states, union territories and cities—and there is an absence of any mechanism for follow-through action for implementation of the Harmonised Guidelines at a local level.[135]

Similarly, while the Urban and Regional Development Plans Formulation and Implementation Guidelines[136] ("**URDPFI Guidelines**") issued by the Ministry of Urban Development (now referred to as Ministry of Housing and Urban Affairs or "MOHUA") emphasise inclusive planning for all groups of people, including persons with disabilities,[137] and a barrier free environment for safe and free movement across urban spaces,[138] there is little discussion on understanding what accessibility needs for persons with mental illness and psychosocial disability entail, what kind of barriers they might face in cities, and what kind of design interventions would be necessary to make cities more accessible to these groups.

Stakeholder discussions confirm that when it comes to issues pertaining to mental health, what is needed is wider social supports (such as community or family-centred support, access to personal care, and aids and technology to promote one's quality of life) that comprehensively cover a person's lived realities, without which mental illness and psychosocial disability can result in the devaluation of standard of living.[139]

c) Gaps in Facilitating Service Provision

It has been argued that the influence of the colonial era laws and asylum architecture is such that they have become "inextricably mixed into the project of providing mental health services, such that the Indian imagination cannot separate caregiving from asylum practice."[140] One of the primary requirements in an urban space for a person with mental illness and psychosocial disability

is the availability of good quality, accessible healthcare services. The MHCA fulfils an important requirement of the UNCRPD by guaranteeing the right to quality mental healthcare, at accessible cost.[141] However, providing such a justiciable right to India's population of over 1.3 billion[142] is a very big step[143] and implementation remains a big challenge in India, which reportedly has a large treatment gap for mental health disorders, ranging from 70–92%[144] and 73.6% for major mental disorders.[145]

The NMHP 2014 advocates measures[146] in the right direction as it seeks universally accessible, comprehensive mental healthcare services that are widely available to individuals, families and communities, and across life-span related problems. It also emphasises[147] the need for "multidimensional, dynamic and well-being oriented" approaches for issues such as homelessness among persons with mental illness, and also provides avenues for implementation by advocating for coordination of service delivery between local agencies such as urban local bodies, disability and mental health departments, based on existing national policies on homelessness, disability and mental health. Nonetheless, this is a policy document and a systematic implementation of the same remains to be seen.

Quality mental healthcare is far from being realised, as a recent assessment of the state of mental health establishments by the National Human Rights Commission indicates. They are run in deplorable conditions, with acute doctor and staff shortages, and where even 'cured' patients were being kept for prolonged periods.[148] Reports found that none of the institutes had taken effective or long-term measures to ensure that a mentally ill person could exercise her right to community living unfettered, unchallenged and/ or without any hindrance.[149]

Even where the MHCA mandates the provision of less restrictive community-based establishments, halfway homes and sheltered accommodation, "as may be prescribed,"[150] existing law does not as yet prescribe any access or quality standards for such facilities (at the central level or in Karnataka). Not only does this leave scope for ambiguity in various facilities being passed off as coming within the purview of less restrictive accommodation, it also exposes a gap in envisioning standards that can ensure amenities for sports, recreation, vocational training, green spaces for socialising etc., in such facilities, to realise what is indeed "less restrictive."

The MHCA in some instances (such as perceived ill treatment of a person who is also presumed to be mentally ill),[151] relies on police assistance and magistrates' orders for protection and transportation of such persons to mental health establishments without providing alternate options such as reliance upon community healthcare workers, or providing the option of first placing such persons in less restrictive, community-based accommodation. It is reported that more than 50% of people who live in mental healthcare facilities were referred to by the police or magistrates—these are people with histories of homelessness and poverty, who have no place to go after recovery.[152]

Further, even though the MHCA recognises the right to community life, and to not be segregated from society,[153] hardly any of the community-based facilities have been set up.[154] In the absence of implementable measures for rehabilitation, people remain housed in mental health establishments. Thus, in 2021, the Supreme Court of India directed the rehabilitation of persons from mental health establishments to community-based rehabilitation instead of beggar homes or custodial homes, where they had no family to return to.[155] It observed, that "pushing the cured patients who were overstaying in mental healthcare

institutions to beggar homes and old age homes is insensitive". It directed the governments of Maharashtra and Uttar Pradesh to establish 'halfway' homes and rehabilitation centres for persons recovering from mental illness in a fixed time frame – instead of simply redesignating old age or beggar homes as halfway homes.

Provision of mental healthcare is also strained on account of severe paucity of mental health workforce. It is estimated that there are only 1.93 mental health workers per 100,000 population in India. Mental health workforce in India (per 100,000 population) majorly include psychiatrists (0.3), nurses (0.8), psychologists (0.07) and social workers (0.06). These numbers are alarmingly low considering India's increasing mental health burden.[156]

Furthermore, programs such as the National Tele Mental Health Programme (T-MANAS) (a two-tier system comprising of State Tele-MANAS cells, including trained counsellors as first-line service providers at Tier 1 and mental health professionals at DMHPs at Tier 2 to provide secondary-level specialist care) are certainly a welcome step. However, experts caution[157] that such programs alone cannot be the sole programmatic focus nor a long-term solution.

There are also several hurdles in local level implementation of the rights-based mental healthcare framework. Much of the institutional framework under the MHCA that is required to ensure realisation of the rights laid down – such as standard of care to be provided by the mental health establishments, mechanism for complaints against deficiencies – i.e. the mental health review boards have either not been established or are not functional.[158] Specifically, the status of implementation in certain districts of Karnataka is bleak, with reports of there being a lack of psychiatrists, counsellors or other such government facilities. For e.g., it is reported that there

are just two psychiatrists and counsellors in the district government hospitals at Chitradurga and Davanagere.[159]

Even subordinate legislation under the MHCA is lacking in substantive measures aiding in the provision of mental healthcare. While the Central Government has come out with the Mental Health Care (Central Mental Health Authority and Mental Health Review Boards) Rules, 2018, the MHC Rules and the Mental Healthcare (State Mental Health Authority) Rules, 2018—all notified under the MHCA, these largely provide only for the constitution and proceedings of the central or state mental health authority, lay down the technical and functional requirements for the appointment, disqualification and term of members,[160] and incorporate technical provisions for registration of mental health establishments.[161] The same is true of Karnataka: the KMHC Rules do not offer any detail beyond technical requirements for constitution of the Karnataka State Mental Health Authority ("**KSMHA**"). The KSMHA is yet to notify a set of minimum standards for mental health facilities in the state.

Moreover, in the absence of any accessible government records, it can be gathered from news reports that halfway homes had not been made operational by the Karnataka Government till 2018, and that till then, Bengaluru had only five such homes, that were privately run and prohibitively expensive.[162] There are also reports of government run short stay homes that were in deplorable conditions—infested with insects and mosquitoes, without any social workers or sufficient attendance by a doctor.[163] Further, though the Karnataka Mental Health Review Board has been set up, there is little to no information accessible as regards its status of functioning, with it not even having a functioning website.

d) Gaps in Integrating the Mental Illness and Disability Frameworks

When it comes to mental illness and psychosocial disability, India has a nebulous policy environment involving multiple ministries, archaic legislative provisions and poor political will to reform the mental health sector.[164] While the RPWD Act looks at mental illness as a disability for which it provides social welfare measures and other entitlements to enable full participation in society, the MHCA, on the other hand, is focused on the provision of healthcare for the treatment of mental illness. Both laws are implemented by different ministries: at the Union level, while the MOHFW is charged with overseeing the implementation of the MHCA, the RPWD Act falls under the aegis of the DEPWD. Stakeholder consultations indicate that the presence of two separate implementing authorities gives ample opportunity for passing on responsibility: for e.g. in asking for rehabilitation measures one is asked to approach the DEPWD (which has provisions that go beyond healthcare and are more comprehensive). Moreover, it was also gathered that as the MOHFW has more funds than the DEPWD, the question of which authority to approach becomes strategic where mental health is concerned.[165]

Another example of the need for better integration of the two laws is displayed in the provisions concerning caregivers (defined in the MHCA and RPWD Act as persons who provide care and assistance to persons with mental illness and disability, free of cost).[166] The MHCA acknowledges the mental health impact on families and provides for mental health services to support the family of such persons,[167] and also provides for due acknowledgement of the considerations and opinions of family members and caregivers in the provision of mental healthcare.[168] Moreover, caregivers and organisations representing caregivers are also represented in the constitution of the central mental health authority[169] and

the mental health review board.[170] However, the same level of consideration is absent in the RPWD Act which has no such commensurate provisions. The only relevant provision talks about provision of an allowance for caregivers of persons with disabilities with high support needs.[171]

e) Addressing the Role of Municipal Laws in Fostering Mental Health

Previous research[172] notes how the structural problems that plague urban planning frameworks impede the participation of persons with disabilities in urban planning and design processes, including persons with mental illness and psychosocial disability. Further, as noted above, the municipal laws of Karnataka contain several obligatory and discretionary functions that can help foster an improved quality of urban life. While some of the obligatory functions lay down the need for parks and recreational grounds—green spaces that are linked to improved mental health outcomes—however, it is only the discretionary functions as mentioned above, which are assigned to these municipal authorities (spanning the provision of basic provisions, water, shelter, healthcare as well as spaces for art, museums, etc.), that truly reflect a progressive, political vision of what constitutes liveability and quality of life within a city. Though this reflects a deeper understanding of the inextricable links between urban environment, infrastructure and quality of life impacting the overall health, especially mental health in the city, these are not given priority consideration, given as they are reflected only under the discretionary functions.

VIII. Way Forward

The issue of addressing mental health in urban settings is a complex and multi-faceted one, requiring a sustained, multi-pronged approach. The following are some of the ways in which the various challenges involved in fostering mental health and well-being in the urban context may be addressed:

a) Addressing Stigma, Generating Awareness and Sensitisation to Mental Health

Stigma surrounding mental illness is one of the most important and challenging aspects to be tackled for persons with mental illness and psychosocial disability, within both the undiagnosed and diagnosed populations. Addressing stigmatisation through a focus on creating a conducive behavioural environment in services and facilities in cities is crucial in terms of making urban spaces accessible for people with mental illness and psychosocial disabilities.

Despite specific requirements in the RPWDA Act and the MHCA to generate awareness and reduce stigma associated with mental illness, there has been limited implementation of the same. There is an urgent need to prioritise awareness about mental health through avenues such as implementing nationwide programmes, introducing modules on socio-emotional health at various levels of education, deploying media strategically for mental health advocacy and communication (as previously seen in polio eradication campaigns), to name a few. Such programmes should target a broad range of stakeholders, including persons with mental illness and psychosocial disability, families, health workers, schools, community stakeholders, and/or the general public.

Furthermore, the MHCA requires sensitisation and awareness training to police and government officers

on various issues.[173] Given the existence of an inherent power imbalance between healthcare staff and the users of the services,[174] there is a need for specific training measures for healthcare staff employed in various mental health establishments. There is also an urgent need for awareness generation in coordination with local level initiatives. Given that existing programmes on mental health, such as the DMHP have been in operation and provide for 'awareness camps' for "dissemination of awareness regarding mental illnesses and related stigma through involvement of local Panchayati Raj Institutions (PRIs), faith healers, teachers, leaders etc.," the statutory framework of MHCA needs to explicitly call for coordination with such local level initiatives.

b) Addressing Gaps in Envisioning Access

There is an urgent need to incorporate a *behavioural access to care* model, in developing guidelines for accessibility for persons with mental illness and psychosocial disability.

At present, the Harmonised Guidelines do not reflect such an approach, limiting accessibility standards to primarily interventions catering to physical access, audio-visual access, digital and informational access to services and infrastructure.

In order to develop specific accessibility standards, it is critical to engage with persons with mental illness and psychosocial disability, their caregivers, mental healthcare professionals and other relevant stakeholders, including organisations and mental health establishments, in order to develop a comprehensive understanding of the various elements of behavioural access in Indian cities. This exercise must also be undertaken with special cognisance of the complex and sensitive challenges faced by women with mental illnesses and psychosocial disabilities. Furthermore, it is necessary to be sensitive

to factors such as economic status, age, religion, caste, marital status and access to resources among others that affect such groups in the city. One of the key tasks for different states and cities is to then integrate the Harmonised Guidelines into state-level planning laws, local building bye-laws and other municipal codes governing future urban development and infrastructure projects, to incorporate such elements of behavioural access at every stage, and realise the guarantee of the legal framework on mental health and disability.

c) Addressing Gaps in Facilitating Service Provision

The reach of mental health services also needs to be expanded and accessible in cities, at the local, community and neighbourhood levels, particularly in the context of the recognition of an increase in mental health issues owing to the Covid-19 pandemic.

i) Addressing the Needs of Caregivers

It is extremely important to take into account the needs and concerns of caregivers, including family or community members, who provide support to persons with mental illness and psychosocial disabilities. Ensuring that caregivers are provided with the adequate support and consideration is extremely important, especially in regard to female caregivers, who are often disproportionately burdened with caregiving and domestic responsibilities. As noted in multiple stakeholder consultations, deinstitutionalization and reintegration of persons with mental illnesses in their communities is highly dependent on the ability of the family and community respectively, to continue to provide ongoing support. For the effective implementation of existing mental healthcare and disability policies, it is important to adopt family–centric and community-oriented approaches in mental healthcare service provision.

ii) Increased Budgetary Allocation

There is an urgent need to increase budgetary allocation to mental healthcare and service provision in India. As noted earlier in the paper, the 2022 Union budget allocated an abysmally low proportion of funds to mental healthcare, with a disproportionate amount reserved for two mental health institutions. Without robust and proportional financial backing, successful implementation of the various mental healthcare policies and initiatives will continue to remain a challenge. Further, it is critical to improve community-based mental healthcare services, developing community-based models (including in partnership with NGOs) and strengthening the DMHP at the community level, as mandated by the MHCA through adequate and sufficient budgetary allocations.

d) Addressing Gaps in Integrating Mental Health and Disability Frameworks

The integration of mental healthcare and disability service provision with primary and secondary healthcare centres is vital and needs to be strengthened. For instance, programs such as the Brain Health Initiative by NIMHANS trains general physicians in screening and treating mental health patients and one day per week is dedicated in primary and secondary healthcare centres to take care of people with neurological illnesses.[175] There is an urgent need to scale such programs across Karnataka and investing in infrastructure at primary and secondary healthcare centres for the effective deployment of mental healthcare programs.

Further, the process of issuing disability certificates, provision of disability pensions and other entitlements needs to be streamlined and decentralised to ensure that persons with psychosocial disabilities can seek such services. There is a critical need to organise targeted camps at the district and taluk level for persons with disabilities to generate awareness about various rights

and entitlements under the MHCA and RPWD Act, as well as to facilitate the process of certification and service delivery for persons with mental illnesses and psychosocial disabilities.

e) Addressing the Role of Municipal Laws in Fostering Mental Health

Persons with mental illnesses, in many cases, are disproportionately exposed to precarious and poor living conditions, struggle with unemployment and homelessness, rendering them extremely vulnerable to abuse, neglect, and in the case of women and girls, to higher risk of violence. One of the key problems faced by persons with mental illness and psychosocial disability, especially from vulnerable communities affected by poverty and lack of resources is inaccessibility to critical urban infrastructure. This could range from basic necessities such as access to running water, Water, Sanitation and Hygiene (WASH) infrastructure, stable housing, employment opportunities, and services such as adequate mental healthcare, educational and leisure opportunities, access to green and blue spaces among others. It is critical for municipal and state agencies to invest in essential urban infrastructure, prioritising areas and neighbourhoods in which economically and socially disadvantaged communities reside.

It is also critical to ensure that there are linkages between urban housing schemes and prioritisation and support to persons with mental illnesses in accessing such schemes. The state government is uniquely placed to ensure coordination amongst various departments and play a pivotal role in the planning, implementation and monitoring of mental health programs in their respective states. It is critical to build an ecosystem that involves private mental healthcare providers, user groups, academic and research institutions, civil society organisations among others in

order to facilitate a seamless integration of mental health services across various cities and towns in the state.

Furthermore, there is a need to emphasise decentralised planning approaches that model cities as sustainable, environmentally conscious and also favourable to the mental health of its residents. There is an urgent need for partnership and cooperation with such municipal authorities to foster the creation of community-oriented service facilities for persons with disabilities, women, children and other vulnerable groups, and in turn ensure the creation of cities that promote the overall mental health and well-being of its residents. This requires urban local bodies to take cognisance of their role in fostering mental health in cities across Karnataka.

Moreover, there must be emphasis laid on providing green spaces, blue spaces and other forms of exposure to urban nature, with a view to create restorative environments which help in ensuring the mental health and well-being of the city. Ensuring access to such spaces in cities, such as parks, lakes as well as recreational spaces, cultural and heritage sites and leisure, that are, in particular, universally accessible to persons with mental illness especially women, girls and those from other marginalised communities is important.

IX. Conclusion

The issues discussed in previous sections indicate how there is a clear and urgent need to focus on the urban environment and its role in fostering mental health in Indian cities. This working paper briefly outlines the ways in which urban environments play a significant role in their impact on mental health. In doing so, it engages with relevant and applicable laws, policies as well as urban planning approaches to point out how accessibility and quality of life in cities for persons with mental illness and

psychosocial disability is influenced by attitudinal barriers, stigma, provision of community support, and the provision of specific environmental surroundings.

To enable translation of ideas from a broader principles-based level, to the local level, it is essential that municipal, state and central agencies work to prioritise mental health and well-being as a key, cross-cutting focus area, especially in the context of urban planning and policies related to urban infrastructure, transport, housing, employment, facilities and service provision. This paper hopes to draw attention to the many reasons why, and specific areas where, it is critical to incorporate a mental health perspective in the planning and design of urban spaces and to rethink what accessibility for persons with mental illnesses and psychosocial disability means in the city, especially in regard to accessing public space, healthcare and mental healthcare services. The ultimate aim is to begin by starting a conversation that helps to reframe thinking surrounding mental health in cities, especially in Karnataka.

Annexure: Case Studies

a) Mental Health Resource Kits for Better Mental Health Outcomes

Bangalore Urban Mental Health Initiative or BUMHI: With the goal of promoting better mental health outcomes, the National Institute of Mental Health and Neurosciences, Bengaluru (NIMHANS), in collaboration with the Biocon Foundation, launched BUMHI in 2021. The initiative aims at creating a mental health resource kit towards facilitating self-care and informal community care in mental health. After consulting a myriad of stakeholders, including psychologists, psychiatrists, public health professionals, social workers, etc. to understand perceptions, priorities and concerns in the area of mental health among urban residents, the initiative entailed preparation of 14 modules. It is proposed that these modules will be used for training and imparting skills to individual volunteers, who will then provide first aid support to persons with common mental illnesses and then refer them to mental healthcare facilities for extensive treatment. As a pilot project, it is proposed that these modules will be first utilised at apartment complexes in BBMP South Zone.[176]

b) Facilitating Community Care by Non-Governmental Organisations

i) The Banyan:

Based out of Chennai, the Banyan provides a range of mental health services in institutional and community settings for persons with psychosocial disabilities, who are homeless or living in poverty. The Banyan works in Tamil Nadu, Kerala and Maharashtra. Its work includes:

- 'Home Again': This offers permanent housing for persons with mental illnesses and psychosocial disabilities requiring long term care. Specific

support services, such as, healthcare, household management, economic transactions, socialisation, among others, are also offered. The model has been replicated for residents institutionalised long-term or with no exit options in three psychiatric facilities located in Kozhikode, Thrissur and Thiruvananthapuram (in collaboration with the Kerala state government) and at the Regional Mental Hospital, Ratnagiri (in collaboration with the Maharashtra state government).[177]

- Emergency Care and Recovery Centres or ECRCs: The ECRC approach provides multidisciplinary, person-centric, hospital-based care for homeless persons with mental illnesses and psychosocial disabilities with the goal that such persons may eventually move back to their families or communities. Therapeutic and person-centric care at the hospital itself may entail crisis intervention and psychological therapies along with individualised care plans. By way of an example, this model has been replicated by the National Health Mission, Government of Tamil Nadu in five district hospitals and is completely funded by the state.[178]

- 'NALAM': This entails offering community mental health services through action taken at the grassroot level by locally recruited and trained persons in villages and urban wards (such as identifying persons with mental illnesses and psychosocial disabilities in communities, home visits, counselling, etc.) and referring the matter to the closest clinic, if required. The model has been replicated in nine wards of Chennai (two are in collaboration with Loyola College and Stella Maris College) and at the Shahapur Taluk in Maharashtra (in collaboration with the Integrated Rural and Human Development Project, Tata Institute of Social Sciences).[179]

ii) Bapu Trust for Research on Mind and Disclosure:

Based in Pune, Bapu Trust's work has been focusing on autonomy and independence of persons living with mental illnesses and psychosocial disabilities by creating enabling environments where such persons can exercise their rights without barriers. Through its 'Seher' community mental health and inclusion programme, Bapu Trust works in 25 low income communities or slums in Pune with the support of five nodal centres and 10 additional outreach points, covering a population of 8,00,000 persons towards making such communities psychologically contained. With the objective of zero-coercion in mental healthcare, communities are made tolerant and inclusive of the mental health needs of a diversity of people, including those with mental illnesses and psychosocial disabilities. The programme uses strategies, such as, capacity development of local neighbourhood psychosocial support network (both formal and informal), partnering with local government and other non-state agencies to bring in disability within development, preparing communities at grassroot level for giving care to persons with mental illnesses and psychosocial disabilities, and providing specific well-being services.

Moreover, with the larger goal of deinstitutionalisation, inclusion and living independently within communities, under the 'Going Home Project', Bapu Trust has been working specifically on inclusion of women with mental illnesses and psychosocial disabilities within the community, who have recovered but are still living at the Regional Mental Hospital at Yerawada, Pune. By partnering with the hospital, Bapu Trust provides creative therapeutic psychosocial interventions and skill training that prepares women with mental illnesses and psychosocial disabilities to transition out of the hospital. It also creates opportunities to give women choices regarding affordable housing and livelihood, and through the Seher programme, fosters support systems within communities for facilitating community inclusion.[180]

Endnotes

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