*Article*

# Perinatal Mental Disorders: The '*Non Liquet*' Facet of Mental Health Legislative Instruments in India

Journal of Health Management
1–9

DOI: 10.1177/09720634241236834
journals.sagepub.com/home/jhm
Sage

**Ritika Behl[1,2], Vivek Nemane[1] and Deborah Sims[3]**

**Abstract**

Due to the impetus provided by the Millennium Development Goals and the Sustainable Development Goals, maternal health has become the subject matter of various legislative instruments worldwide. However, perinatal mental disorders have remained an underestimated public health issue in many countries. High prevalence rates of such perinatal disorders in India have been reported by various evidence-based studies. This makes it imperative to analyse the provisions of the mental healthcare legislative instruments that have been brought into force in India. This article aims to evaluate and analyse coverage of perinatal mental disorders under the provisions of the legislative instruments, especially statutes, providing for mental health in India. Websites of the Government of India, various Indian Ministries and other government agencies were visited to obtain relevant documents regarding the mental health policy and legislation. None of the mental health legislative instruments in India underscore perinatal mental disorders as a public health concern, whereby failing to identify the unique characteristics of perinatal mental disorders. They consequently do not provide for nationwide detection and treatment measures. There is an immediate and pertinent need to highlight perinatal mental disorders through legislative instruments. The National Mental Health Policy, 2014 provides for comprehensive healthcare services; however, it excludes measures for perinatal mental health services. The Mental Healthcare Act, 2017 should be amended to explicitly include women during the perinatal period, along with originally provided mental health services for children and elderly individuals.

**Keywords**

Perinatal mental disorders, reproductive rights, mental health, legislations, Rights of Persons with Disability Act, 2016, Mental Healthcare Act, 2017, India

## Perinatal Mental Disorders and the Surrounding Mayhem

Gender has been regarded as a critical determinant of mental health and mental illness, and women have repeatedly been informed to be twice as prone to developing depression compared to men (WHO, 2001; WHO & UNFPA, 2008). Further, it has also been frequently reported that women are more susceptible to developing mental disorders during the reproductive age, especially during the perinatal period (WHO, 2008; WHO, 2020; WHO & UNFPA, 2008). Perinatal mental health disorders are a less attended public health issue despite having higher prevalence rates in the low-and middle-income countries (LMICs) (Fisher et al., 2012; WHO, 2010).

The affective disorders which can develop during the perinatal period include anxiety, perinatal depression (antenatal depression and postpartum depression) and postpartum psychosis (ACOG, 2018; Stewart et al., 2003; Upadhyay et al., 2017). The World Health Organisation (WHO) has stipulated that after 10–14 days of birth, assessment for psychological wellbeing of the mother is critical if the symptoms of depression and anxiety are not resolved (WHO, 2010). The onset of depression can also begin during the antenatal stage, which can later transpire or exacerbate during the postpartum period (Upadhyay et al., 2017; Wilcox et al., 2020).

Postpartum depression is the most common psychiatric disorder, which can onset within the first 12 months after delivery (Harsha & Acharya, 2019). Postpartum psychosis is the most severe form of perinatal mental disorders, which is considered a psychiatric emergency and requires immediate hospitalisation (Friedman & Resnick, 2009). Postpartum bipolar II disorder, postpartum obsessive–compulsive disorder and postpartum traumatic stress disorder are some of the postpartum psychotic disorders (Howard et al., 2014).

[1]Symbiosis Law School, Pune, Symbiosis International (Deemed University), Pune, Maharashtra, India
[2]Alliance School of Law, Alliance University, Bengaluru, Karnataka, India
[3]Faculty of Health, University of Technology, Sydney, New South Wales, Australia

**Corresponding author:**
Ritika Behl, Alliance School of Law, Alliance University, Bengaluru, Karnataka, India.
E-mail: behl.ritika@gmail.com

Klainin and Arthur (2009) have specified that aetiology of perinatal mental disorders in the Asian region includes various hormonal, obstetric, social and psychological factors. Field (2010) reported that demographic and physiological factors, including socio-economic status, employment and education status, social support, unintended pregnancy, history of child abuse, intimate partner violence, substance abuse, lack of sleep and irregularities in immune system, are risk factors for developing antenatal depression. Dagher et al. (2021) further elaborated and informed that during the early postpartum recovery period, biological factors can play a critical role, and psychological factors can result in recurrence of depression during the first postpartum year.

It has also been reported that the prevalence of perinatal mental disorders varies in Asia itself, and Middle East and South Asia collectively account for higher prevalence than Western countries (Shorey et al., 2018). Epidemiological risk factors and confounding risk factors for perinatal depression are inherently present in the psychosocial, political, economic and cultural environment of the LMICs (Gelaye et al., 2016; WHO, 2000). It has also been observed that generally, multiple risk factors are present in the LMICs. Their interplay can trigger a chain reaction, not just lead to inception of the perinatal depression but can also aggravate it as well (WHO, 2005).

According to the National Mental Health Survey, 2016, one in every 10 persons in India suffers from depression and anxiety, and 20% of these depressed women are either pregnant or are new mothers (Vijayalakshmi et al., 2018). For the year 2019, depression has been reported as the fifth leading cause of years lost to disability (YLD) and fifth leading cause of disability-adjusted life years (DALYs) for Indian women in the age group of 15–49 years (Institute of Health Metrics & Evaluation Website, 2019).

India State-Level Disease Burden Initiative Mental Disorders Collaborators (2020) informed that in the year 2017, one in every seven Indians had a mental disorder, ranging from mild to severe. They also reported that the depressive disorders and eating disorders leading to DALYs were more positively associated with women than with men. They further informed that depressive disorders were positively associated with suicide rates, and such relation was underscored more for women comparatively.

WHO, with the help of series of manuals and guidelines, has been advocating for provision of perinatal mental health services in the maternal health framework. In the mhGap Intervention Guide to be used in non-specialised settings, emphasis has been laid upon ensuring provision of treatment and psychoeducation relating to perinatal depression (WHO, 2016). They have further highlighted women of child-bearing age as 'special population group' for whom gender-determined mental healthcare needs to be facilitated (WHO, 2016).

In the year 2020, WHO further recommended inclusion of maternal mental health services in the early childhood development programmes based on consistent findings about adverse outcomes of perinatal depression and anxiety disorders for the mother and child development (WHO, 2020). Since it is imperative to deal with such predisposing issues, WHO has emphasised on the critical role that can be played by legal systems (WHO, 2017) and how legal reforms can be used as a potent tool (Gostin et al., 2017).

In this background, it becomes imperative to analyse the provisions of the in-force mental health legislations in India and their role in abridging the treatment gap associated with perinatal mental disorders.

## Mental Health Advocacy and Legislative Instruments: The Trajectory of Mental Health Frameworks in India

Appended below are the legislative instruments that have been introduced in independent India for catering to the mental health needs of the Indian population in Table 1.

The first mental health legislations were introduced in British India, where three acts dealing with mental health were adopted, namely: The Lunacy (Supreme Courts) Act, the Lunacy (District Court) Acts and the Indian Lunatic Asylum Act (Narayan & Sikha, 2013). These legislations focused upon the asylum-based care and the conditions of these asylums, and the quality of care delivered warranted reformation of mental healthcare system in India (Duffy & Kelly, 2019). In 1912, the Indian Lunacy Act was passed. However, in India, the traditional understanding about mental disorders has been restricted in nature, where mental health issues were traditionally linked to only severe disorders that require hospitalisation (Nizamie & Goyal, 2010; Mishra et al., 2018).

This approach limited to severe disorders led to stigmatisation and inherent prejudice towards mental health issues in Indian society (Gururaj et al., 2016). With the intent to destigmatise the concept of mental health and to introduce reforms wherein human rights of mentally ill people are upheld, new initiatives were introduced. The Government of India, under ambitious vision of 'health for all by the year 2000', adopted the National Mental Health Programme, 1982. It was later re-strategised as the District Mental Health Programme to expand the outreach and ensure community participation. It also underscored the need of shift from custodial care to providing treatment and care at the primary healthcare level (Mishra et al., 2018).

The National Mental Health Policy, 2014 was introduced to promote mental health and decrease the disease burden arising due to mental illnesses based on the lifecycle approach while providing 'universal access to mental health care', within a rights-based framework.

Since the Indian Lunacy Act, 1912 had become outdated, the National Mental Health Act (MHA), 1987 was launched,

**Table 1.** Mental Health Framework in India.

| Programme/Policy/Legislation (Year When It was Introduced/Brought into Force) | Goals/Objectives |
|---|---|
| National Mental Health Program, 1982 | Introduced to 'ensure availability and accessibility of minimum health care for all, especially for the most vulnerable and underprivileged of the population', aimed to 'encourage application of mental health knowledge in general healthcare and social development', promoted 'community participation in mental health services department' and stimulated the concept of 'self-help' (Government of India, Ministry of Health and Family Welfare, https://main.mohfw.gov.in/sites/default/files/9903463892NMHP%20detail_0_2.pdf) |
| Mental Health Act, 1987 | Replaced Indian Lunacy Act, 1912; established psychiatric hospitals and central and state authorities for licensing and supervising them, provide for custody of mentally ill persons who cannot look after themselves and are dangerous for the society, to safeguard their rights, provide legal aid to poor mentally ill persons (Government of India, Ministry of Law and Justice, http://legislative.gov.in/sites/default/files/A1987-14.pdf) |
| District Mental Health Program, 1996 | Aimed to extend mental healthcare services for persons with mental illness in the districts by using the then existing healthcare infrastructure, to provide range of essential health drugs, de-stigmatisation through public health education, treatment and rehabilitation of patients, promoting community participation (Government of India, Ministry of Health and Family Welfare, https://main.mohfw.gov.in/sites/default/files/9903463892NMHP%20detail_0_2.pdf) |
| National Mental Health Policy, 2014 | Aims to reduce distress and disability connected with mental health problems faced during the lifespan, improve understanding of mental health nationally, provide 'universal access to mental health care', 'increase access to and utilisation of comprehensive mental health services' especially for the vulnerable groups, reduce prevalence and impact of risk factors associated with mental health issues, reduce risk and incidence of suicide and attempt to suicide, de-stigmatisation of mental health issues, 'identify and address biological, social and psychological determinants of mental health problems and to provide appropriate interventions' (Government of India, Ministry of Health and Family Welfare, https://nhm.gov.in/images/pdf/National_Health_Mental_Policy.pdf) |
| The Rights of Persons with Disabilities Act, 2016 | Fundamental principles included inherent dignity, individual autonomy to make choices and independence of persons, non-discrimination, full and effective participation and inclusion in the society and respect for differences and acceptance of disabilities (Government of India, Ministry of Law and Justice, https://legislative.gov.in/sites/default/files/A2016-49_1.pdf) |
| Mental Healthcare Act, 2017 | Provides for individual right to access mental healthcare services, detailed procedure for admission, treatment and discharge of mentally ill persons, decriminalisation of suicide attempt by mentally ill persons, prohibits their inhumane treatment and provides for access to free legal services, 'protect, promote and fulfil' rights of mentally ill persons during delivery of the services (Government of India, Ministry of Law and Justice, https://www.indiacode.nic.in/bitstream/123456789/2249/1/A2017-10.pdf) |
| Rashtriya Bal Swasthaya Karyakram, 2018 | Provides services for screening and early intervention for children from birth till 18 years of age, defects at birth, deficiencies, diseases and development delays relating to mental health are covered at community and facility level (Government of India, Ministry of Health and Family Welfare, https://rbsk.gov.in/RBSKLive/) |
| Ayushman Bharat Yojana, 2018 | Ayushman Bharat: Establishment of Health and Wellness Centres (HWCs), comprehensive services and care beyond the MCH to cover non-reproductive health services, areas covered include non-communicable diseases, mental health, etc.<br>Pradhan Mantri Jan Arogya Yojana: Insurance cover of ₹500 thousand for poor and vulnerable families (Government of India, National Health Authority, https://pmjay.gov.in/about/pmjay) |
| National Education Policy, 2020 | Provides for inclusion of basic training in mental health and psychosocial wellbeing in school curriculum, recommended mental health checkups with regular health checkups under School Health Programme, introduction of high-quality support centres in universities, and schools along with well-trained social workers, and counsellors in school ecosystem (Government of India, Ministry of Human Resource Development, https://www.education.gov.in/sites/upload_files/mhrd/files/NEP_Final_English_0.pdf) |

*(Table 1 Continued)*

*(Table 1 Continued)*

| Programme/Policy/Legislation (Year When It was Introduced/Brought into Force) | Goals/Objectives |
|---|---|
| Manodarpan scheme under Atma Nirbhar Bharat Abhiyan, 2020 | Manodarpan scheme was launched by the Ministry of Education for providing psychosocial support and mental health services for mental health and wellbeing of students, teachers and families during and beyond COVID-19 (Government of India, Ministry of Education, https://manodarpan.education.gov.in/index.html) |
| KIRAN Helpline, 2020 | Launched by the Ministry of Social Justice and Empowerment to provide relief and support to persons with mental illness in the wake of COVID-19 pandemic, 24×7 availability of services, 7 days a week, in 13 languages (Government of India, Ministry of Social Justice and Empowerment, https://pib.gov.in/PressReleasePage.aspx?PRID=1652240) |
| Mental Health and Normalcy Augmentation System (MANAS) App, 2021 | National digital wellbeing platform, developed to augment mental wellbeing of Indian citizens, integrates health and wellness efforts of various government ministries, it was initially targeting 15–35 years age group but later started delivering age appropriate life skills and psychological processes for 0–70 years of age, launch of mobile app 'MANAS Mitra' (Office of Principal Advisor to the Government of India, https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1711860; Office of Principal Advisor to the Government of India, https://www.psa.gov.in/manas-mitra). |
| National Tele-Mental Health Program, 2022 | Establishment of 23 tele-mental health centres of excellence, Tele-Mental Health Assistance and Nationally Actionable Plan (Tele-MANAS) initiative to provide 24×7 tele-mental health services in all parts of the country, Tele-MANAS organised at two-tier system (Government of India, Ministry of Health and Family Welfare, https://pib.gov.in/PressReleasePage.aspx?PRID=1866498) |
| National Suicide Prevention Strategy, 2022 | First policy in India to make suicide prevention a public health policy aims to reduce suicide mortality by 10% by 2030, aims to establish effective surveillance mechanisms, establish suicide prevention services in all districts, and integrate mental wellbeing curriculum in all educational institutions (Government of India, Ministry of Health and Family Welfare, https://main.mohfw.gov.in/sites/default/files/National%20Suicide%20Prevention%20Strategy.pdf) |

which came into force in the year 1993. Through the act, emphasis was placed on treatment and the need to safeguard the interests of the mentally ill persons, while introducing changes in used terminologies and establishment of central and state mental health authorities. But the act was heavily criticised because state rules were not formulated even after its implementation (Gururaj et al., 2016). There was a perceived lack of opportunity for patients to challenge doctors' decisions (Sachan, 2013). Additionally, there was a 70–80% of treatment gap for mental disorders (Murthy, 2017), inadequate support for house birth care and protection of rights (Firdosi & Ahmad, 2016), and it was not in consonance with the principles of the United Nations Convention on Rights of Persons with Disabilities (Narayan et al., 2011).

These criticisms of the MHA, 1987 eventually led to its amendment in the form of Mental Health Care Bill, 2013. The Mental Healthcare Act (MHCA), 2017, which was later brought into force in April, 2017, was introduced to counter the lacunas of the previous legislation. The new legislation attracted attention internationally as well, for its focus on the protection of human rights by providing every individual right to access mental healthcare services. It seeks to protect individuals from inhumane treatment and to gain access to free legal services. It also outlined procedure for admission, treatment and subsequent discharge of mentally ill persons. Most significantly, it decriminalised suicide attempts by mentally ill persons, besides imposing a duty on the government to rehabilitate such persons to ensure there is no recurrence of attempt to suicide. It also introduced financial liability for violation of the provisions (Duffy & Kelly, 2019; Mishra & Galhotra, 2018).

The RPDA, 2016 complements the Indian MHCA, 2017 by underpinning various social and economic rights of persons by emphasising upon individual autonomy, inclusivity, equality of opportunity, equality between men and women and acceptance of evolving capacities of children with disabilities (Duffy & Kelly, 2019).

## Perinatal Mental Health in India, Women, and Legislative Measures: A Paradoxical Situation

In none of the mental health programmes introduced for upscaling the quality of mental health services and their coverage, the mental healthcare needs of perinatal women have been specifically underscored. Neither did the National Mental Health Programme, 1982 nor the District Mental Health Program, 1996 emphasise the delivery of mental

health services during the perinatal period. Absence of exclusive mental health services for perinatal women places them at the same footing as other individuals within the community, ousting them from the 'special population group' category described by the WHO (2021).

## The Mental Health Act, 1987

The MHA, 1987 defines 'mentally ill person' under Sec. 2(l) as an individual who suffers from any mental disorder other than mental retardation and is in need of treatment. However, nowhere in the act is any mention made about (special) provisions dealing with perinatal mental disorders or needs of perinatal women regarding health services.

## The Rights of Persons with Disabilities Act, 2016

The Rights of Persons with Disabilities Act (RPDA), 2016 under Sec. 2(s) provides a more nuanced definition of 'person with disability' as follows:

'*Person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others.*'

Further, under Sec. 3 of the RDPA, 2016 mental illness has been defined as follows:

*'"mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize reality or ability to meet the ordinary demands of life but does not include retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by subnormality of intelligence.'*

These provisions can be read to have following implications for perinatal women suffering from mental health disorders:

1. Since it has already been informed that major mood disorders, including perinatal mental disorders, result in impaired interpersonal and social functioning (Gupta et al., 2013; Shimada et al., 2018; WHO & UNFPA, 2008), will such impairment consequential to perinatal mental disorders be covered under this provision? It is important to note here that *Divyangjan* (Department of Empowerment of Persons with Disabilities) under the Government of India, Ministry of Social Justice and Empowerment does not notify inclusion of perinatal mental disorders under the RPDA, 2016 (Government of India, Ministry of Social Justice and Empowerment, Department of Empowerment of Persons with Disabilities, https://disabilityaffairs.gov.in/content/).
2. 
   2.1 If yes, then it ironically only covers long-term disability. This will automatically lead to exclusion of conditions like antenatal depression, postpartum depression and anxiety disorders, which can remit in short time duration if the necessary support and treatment are provided.
   2.2 Also, the incapacity of perinatally depressed women to take care of themselves, their children and their families, especially when they are unable to seek the required social support (Gupta et al., 2013), ousters them from 'full and effective participation in society at par with others'.

Also, the RPDA further provides under Sec. 4 that appropriate government and local authorities shall be responsible for ensuring that women and children with disability enjoy their rights equally like others and are provided with the necessary support according to their disability and age. Here, no mention of treatment and psychoeducation relating to perinatal mood disorders and infant care is made mandatory for affected mothers. However, provisions about such measures have been underscored in the WHO mhGap Intervention Guide, 2016 (WHO, 2016) and the WHO mhGap Community Toolkit, 2019 (WHO, 2019).

Additionally, under Sec. 10 of the RPDA, the appropriate government has been made responsible for providing necessary information regarding reproductive rights and family planning to persons with disabilities. But in absence of screening and detection of perinatal mental disorders and requisite treatment and education, how can (disabled) perinatal women exercise reproductive autonomy and make informed choices?

Further, under Sec. 25(2)(f) of the RPDA, it has been provided that the appropriate government and local authorities will take measures and introduce schemes/programmes to promote healthcare and prevent occurrence of disabilities in women during the perinatal period and in their child. But to ensure the same, no measures/guidelines have been introduced for screening, detection, prevention and treatment of perinatal mental disorders. Hence, reproductive mental health and wellbeing remain a neglected goal.

## The Mental Healthcare Act, 2017

The MHCA, 2017 under Sec. 2(1)(s) defines 'mental illness' as follows:

'*a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, capacity to recognize 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 characterized by sub-normality of intelligence.*'

Under this wide definition of mental illness, postpartum mental disorders can be covered effectively, since in India, we follow the International Classification of Diseases (ICD)-10. Under ICD-10, postpartum disorders are placed under 'behavioural syndromes associated with physiological and physical factors' as 'mental and behavioural disorders associated with puerperium', which are not specified elsewhere in ICD-10 (WHO, 1992).

According to ICD-10, under the diagnostic criteria for postpartum depression, at least two of the following symptoms should be present for at least a period of 2 weeks: Depressed mood, loss of interest in normally pleasurable activities and fatigue. Additionally, any four symptoms, including loss of confidence or self-esteem, feeling of guilt, recurrent thoughts about suicide or death, including that of the child, agitation, difficulty in concentration and sleep or appetite disturbance, should also be present (WHO, 1992).

The WHO in its latest 2022 Recommendations has emphasized on screening for postpartum depression and anxiety using standardized screening tools including the EPDS and PHQ-9, and its necessity in all settings (WHO, 2022a). Also, adoption of stepped-care approach has been suggested for detecting and managing perinatal mental disorders in women wherein routine screening, and general psychosocial support have been recommended (WHO, 2022b).

ICD-10 has been replaced by ICD-11, which describes non-psychotic perinatal mental health disorders as a 'syndrome' involving 'significant mental or behavioural features, most commonly depressive symptoms' (WHO, 2022c). It has been specified that it results in 'significant impairment in personal, family, social, educational, occupational or other important areas of functioning', where such functioning if maintained, can only be a result of 'significant additional effort' (WHO, 2022c).

However, Sec. 18 of the MHCA, 2017, which provides for 'right to access mental healthcare', includes provisions for mental health services for children and elderly individuals (under Sec. 18(4)(e)) but does not include perinatal women in need of mental health services. Also, Sec. 18 provides for 'access to mental healthcare and treatment' from services provided or funded by the 'appropriate government'.

Here, the 'Appropriate Government' under Sec. 2(1)(b) of the MHCA, 2017 broadly includes central and state governments. But there are no policies/schemes that have been introduced by the central government of India to deal with perinatal mental health or for inclusion of perinatal mental health services within the maternal healthcare framework. Additionally, wide disparity can be observed in the approach adopted by state governments towards perinatal mental health in India.

Sec. 21(2) & (3) of the MHCA, 2017 provide that no child below the age of 3 years should be separated from their mother if the mother is receiving treatment or rehabilitation at a mental health establishment unless she poses risk to a child. However, this progressive initiative has not received much support from the psychiatrist who are apprehensive about admitting the mother–child together in such circumstances (Desai & Chandra, 2023).

Kerala was the first state to incorporate perinatal mental health services within the maternal health framework and provides for screening, detection and treatment of perinatal mental disorders under the programme Amma Manusa (Mother's Mind) (Ganjekar et al., 2020). Later, other states including Karnataka also started including antenatal mental health services in the maternal and child health services in 'Thayi card', which provides information regarding screening of mental health condition of pregnant women (Desai & Chandra, 2023).

Hence, the cumulative readings of these legislative provisions lead to a situation where access to perinatal mental health services in other states, apart from Kerala and Karnataka, is impeded. More so, the lack of awareness about perinatal mental disorders and shortage of trained mental healthcare workforce further adversely affects the state of mental health and wellbeing of perinatal women.

Though the National Mental Health Policy, 2014 explicitly discusses about 'holistic approach to health', which is effective beyond the culturally conditioned psychosocial factors, the transmission of such approach in action remains questionable regarding perinatal mental healthcare.

Further, if we cumulatively read into the following provisions:

(i) Section 21(1) of the MHCA, 2017, which provides that 'the persons with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare services', where they should not face any discrimination based on gender, sex and sexual orientation.
(ii) Sec. 2(s) and Sec. 4 of the RPDA, 2016
(iii) Art. 15(3) of the Indian Constitution, which provides for protective discrimination for women
(iv) Art. 47 of the Indian Constitution, which provides for 'primary' duty of the state to improve public health conditions

We can essentially establish the duty of the state to introduce exclusive policies and guidelines relating to perinatal mental disorders and provide perinatal mental health services within the maternal and child health framework. The protective discrimination jurisprudence under Art. 15(3) of the Indian Constitution takes into account the psychosocial factors that have led to complications in realisation and enjoyment of women's rights.

Moreover, when women are prone to developing perinatal mental disorders because of variety of factors, their 'health equity' becomes dependent upon legislative enforcement mechanisms. Here, legislative provisions in terms of policies and legislations which treat their mental health at par with their physical health can lead to effective realisation of reproductive rights and right to health during the perinatal period.

Also, Section 18(5)(a) of the MHCA, 2017 provides for integration of mental health services into general health services. Therefore, integration of mental health services, focusing upon

perinatal mental disorders, under the existing maternal healthcare service infrastructure is in consonance with the provisions of the mental health legislation as well. It has also been highlighted by the WHO in multiple publications that inclusion of perinatal mental health services within the maternal and child health framework should be undertaken (WHO, 2008; WHO, 2018).

It has been specified that such inclusion of perinatal mental health services within the existing maternal healthcare framework will be helpful in limiting financial expenditure by utilisation of the existing healthcare infrastructure and by training the already present healthcare personnel (WHO, 2018). This will also be effective in tackling the criticism of the mental health legislation for not providing an insight from gender perspective and for dealing with gender-related mental health problems like establishment of mother–baby units (Sharma & Kommu, 2019).

## Goals and Objectives of the National Mental Health Policy, 2014 and Perinatal Mental Health Services

| | |
|---|---|
| Goals of the National Mental Health Policy, 2014 | 3.1.1 To reduce distress, disability, exclusion morbidity and premature mortality associated with mental health problems across lifespan of the person |
| | 3.1.2 To enhance understanding of the mental health in the country |
| | 3.1.3 To strengthen the leadership in the mental health sector at the national, state and district level |
| Objectives of the National Mental Health Policy, 2014 | 3.2.1 To provide universal access to mental health care |
| | 3.2.2 To increase access to and utilisation of comprehensive mental health services by persons with mental health problems |
| | 3.2.3 To increase access to mental health care, especially to vulnerable groups, including homeless persons, persons in remote areas, educationally, socially and deprived sections |
| | 3.2.4 To reduce prevalence and impact of risk factors associated with mental health problems |
| | 3.2.5 To reduce risk and incidence of suicide and attempted suicide |
| | 3.2.6 To ensure respect for rights and protection from harm of persons with mental health problems |
| | 3.2.7 To reduce stigma associated with mental health problems |
| | 3.2.8 To enhance availability and equitable distribution of skilled human resources for mental health |
| | 3.2.9 To progressively enhance financial allocation and improve utilisation for mental health promotion and care |
| | 3.2.10 To identify and address the social, biological and psychological determinants of mental health problems and to provide appropriate interventions |

Additionally, introduction of policies and services focusing upon perinatal mental health will be in consonance with the goals of the National Mental Health Policy, 2014 (Goal 3.1.1. and 3.1.2). It can not only lead to curtailment of disabilities amongst perinatal women and reduction in adverse reproductive outcomes (of perinatal mental disorders) but also a deeper understanding of perinatal mental health. It will also ensure fulfilment of the objective of the policy wherein comprehensive mental health services to perinatal women can be provided.

Further introduction of policies focusing on perinatal mental disorders will also provide a nuanced understanding about the multiple psychosocial risk factors and the impact of their interaction. Such deepened understanding can help in tackling these issues and their impact, which will be helpful in attaining the objective 3.2.4 of the Mental Health Policy. It will also help in fulfilling objective 3.2.1 of providing 'universal access to mental health care'.

More so, it will also be helpful in reducing maternal deaths due to suicide, especially since suicidal maternal deaths are being flagged as a consistent maternal health issue over the years (Maya, 2019). It can work as a breakthrough. Also, it will be helpful in averting cases of neonaticide and infanticide, which are committed by mothers suffering from postpartum psychosis. Hereby, the objective 3.2.5 and 3.2.6 of the National Mental Health Policy, 2014 will also be accomplished.

Other vulnerable caregivers present in the same household, including adolescents, might also need such protection. Most importantly, comprehensive success can be achieved by fulfilling objective 3.2.10 of the National Mental Health Policy, 2014, wherein by dealing with perinatal mental disorders, we can directly deal with social determinants of the mental health. Appropriate health interventions, including community health interventions, can be effectively introduced for the same.

In India, where caregivers and families are mostly reluctant to seek out professional support for mental health issues, provision of perinatal mental health services can play an extraordinary role. Since women are generally not provided with support to deal with perinatal mental health issues because they are accepted as part and parcel of pregnancy and new motherhood, it becomes even more critical. Having an understanding of perinatal mental disorders can also deeply influence the approach of Indian society towards other mental disorders/illnesses, particularly depression. This can effectively lead to de-stigmatisation of mental health issues, particularly during the perinatal period, whereby we can achieve the objective 3.2.7 of the Policy, 2014.

Especially in India, where families are the major source of support and care if the woman of the house is incapacitated to provide for other individuals like children, adolescents and old aged individuals, it can have grave short-term and long-term consequences for them. Families are in need of information and guidance to deal with adverse mental health

conditions of perinatal women, which affect not just the women in question but also impact the whole household. 'Right to family' is also significantly affected where multiparous women continue to give birth while their parenting abilities are severely impaired by presence of such perinatal mental disorders.

Providing perinatal mental health services within the existing maternal healthcare framework by training the existing and future healthcare personnel will also help in fulfilling objectives 3.2.8 and 3.2.9 of the Policy, 2014, whereby skilled human resources for mental health will increase, and financial budgeting will remain in harmony with the utilisation of services.

## Conclusion

The current Indian legal framework regarding mental healthcare has adopted a limited understanding of mentally ill persons and persons with disabilities. It is evident that the needs of women suffering from perinatal mental disorders and requiring support and mental health services are not given due consideration in these legislative instruments.

Perinatal period has far-reaching consequences for the mother–child pair, families and for societies. Providing key mental healthcare services during this period can be helpful in preventing adverse reproductive health outcomes and the consequent intergenerational impact, which deeply affect the society in the long term. The provisions of the MHCA, 2017 (read with the National Mental Health Policy, 2014) need to be expanded and amended to cover perinatal mental disorders. It will also enable us in achieving the goal of 'Universal Health Coverage' established under the National Health Policy, 2017.

### Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

### Funding

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

### References

American College of Obstetricians & Gynecologists (ACOG). (2018). ACOG Committee Opinion no. 757: Screening for perinatal depression. *Obstetrics & Gynecology*, *132*(5), e208–e212.

Dagher, R. K., Bruckheim, H. E., Colpe, L. J., Edwards, E., & White, D. B. (2021). Perinatal depression: Challenges & opportunities. *Journal of Women's Health*, *30*(2), 154–159.

Desai, G., & Chandra, P. S. (2023). Perinatal mental health in India: Time to deliver! *Journal of Psychiatry Spectrum*, *2*(1), 1–2.

Duffy, R. M., & Kelly, B. D. (2019). India's Mental Healthcare Act, 2017: Content, context, controversy. *International Journal of Law & Psychiatry*, *62*, 169–178. https://doi.org/10.1016/j.ijlp.2018.08.002

Field, T. (2010). Postpartum depression effects on early interactions, parenting, & safety practices: A review. *Infant Behavior & Development*, *33*(1), 1–6. https://doi.org/10.1016/j.infbeh.2009.10.005

Firdosi, M. M., & Ahmad, Z. Z. (2016). Mental health law in India: Origins & proposed reforms. *British Journal of Psychiatry International*, *13*(3), 65–67.

Fisher, J., de Mello, M. C., Patel, V., Rahman, A., Tran, T., Holton, S.,Holmes, W. (2012). Prevalence & determinants of common perinatal mental disorders in women in low- & middle-income countries: A systematic review. *Bulletin of the World Health Organization*, *90*(2), 139H–149H.

Friedman, S. H., & Resnick, P. J. (2009). Postpartum depression: An update. *Women's Health*, *5*(3), 287–295.

Ganjekar, S., Thekkethayyil, A. V., & Chandra, P. S. (2020). Perinatal mental health around the World: Priorities for research & service development in India. *British Journal of Psychiatry International*, *17*(1), 2–5.

Gelaye, B., Rondon, M., Araya, R., & Williams, M. A. (2016). Epidemiology of maternal depression, risk factors, & child outcomes in low-income & middle-income countries. *Lancet Psychiatry*, *3*(10), 973–982.

Gostin, L. O., De Bartolo, M. C., & Katz, R. (2017). The global health law trilogy: Towards a safer, healthier & fairer world. *Lancet*, *390*(10105), 1918–1926.

Gupta, S., Kishore, J., Mala, Y. M., Ramji, S., & Aggarwal, R. (2013). Postpartum depression in North Indian women: Prevalence & risk factors. *Journal of Obstetrics & Gynecology of India*, *63*(4), 223–228.

Gururaj, G., Varghese, M., Benegal, V., Rao, G. N., Pathak, K., Singh, L. K., Mehta, R. Y., Ram, D., Shibukumar, T. M., Kokane, A., Singh, L. R. K., Chavan, B. S., Sharma, P., Ramasubramanian, C., Dalal, P. K., Saha, P. K., Deuri, S. P., Giri, A. K., & Kavishvar, A. B. National Institute of Mental Health & Neuro-Sciences. (2016). *National Mental Health Survey in India, 2015–16: Summary*. https://main.mohfw.gov.in/sites/default/files/National%20Mental%20Health%20Survey%2C%202015-16%20-%20Mental%20Health%20Systems_0.pdf

Harsha, G. T., & Acharya, M. S. (2019). Trajectory of perinatal mental health in India. *Indian Journal of Social Psychiatry*, *35*(1), 47–54.

Howard, L. M., Molyneaux, E., Lee-Dennis, C., Rochat, T., Stein, A., & Milgrom, J. (2014). Non-psychotic mental disorders in the perinatal period. *Lancet*, *384*(9956), 1775–1784.

India State-Level Disease Burden Initiative Mental Disorders Collaborators. (2020). The burden of mental disorders across the states of India: The Global Burden of Disease Study 1990–2017. *Lancet Psychiatry*, *7*(2), 148–161.

Institute of Health Metrics & Evaluation Website. (2019). *Global burden of disease compare data visualization*. https://vizhub.healthdata.org/gbd-compare/

Klainin, P., & Arthur, D. G. (2009). Postpartum depression in Asian cultures: A literature review. *International Journal of Nursing Studies*, *46*(10), 1355–1373.

Maya, C. (2019). Health dept. flags maternal suicides. *The Hindu*. https://www.thehindu.com/news/national/kerala/health-dept-flags-maternal-suicides-in-state/article29938004.ece

Mishra, A., & Galhotra, A. (2018). Mental Healthcare Act, 2017: Need to wait & watch. *International Journal of Applied & Basic Medical Research*, *8*(2), 67–70.

Mishra, A., Mathai, T., & Ram, D. (2018). History of psychiatry: An Indian perspective. *Industrial Psychiatry Journal*, *27*(1), 21–26.

Murthy, R.S. (2017). National Mental Health Survey of India 2015-16. *Indian J Psychiatry*, *59*(1), 22–24.

Narayan, C. L., & Shikha, D. (2013). Indian legal system & mental health. *Indian Journal of Psychiatry*, *55*(Suppl. 2), S177–S181.

Narayan, C. L., Narayan, M., & Shikha, D. (2011). The ongoing process of amendments in MHA-87 & PWD Act-95 & their implications on mental health care. *Indian Journal of Psychiatry*, *53*(4), 343–350.

Nizamie, S. H., & Goyal, N. (2010). History of psychiatry in India. *Indian Journal of Psychiatry*, *52*(7), 7–12.

Sachan, D. (2013). Mental health bill set to revolutionise care in India. *Lancet*, *382*(9889). https://doi.org/ 10.1016/s0140-6736(13)61620-7

Sharma, E., & Kommu, J. V. S. (2019). Mental Healthcare Act 2017, India: Child & adolescent perspectives. *Indian Journal of Psychiatry*, *61*(Suppl. 4), S756–S762.

Shimada, K., Kasaba, R., Fujisawa, T., Sakakibara, N., Takiguchi, S., & Tomodo, A. (2018). Subclinical maternal depressive symptoms modulate right inferior frontal response to inferring affective mental states of adults but not of infants. *Journal of Affective Disorders*, *229*, 32–40.

Shorey, S., Chee, C. Y. I., Ng, E. D., Chan, Y. H., Tam, W. W. S., & Chong, Y. S. (2018). Prevalence & incidence of postpartum depression in healthy mothers: A systematic review & meta-analysis. *Journal of Psychiatric Research*, *104* (September), 235–248. https://doi.org/10.1016/j.jpsychires.2018.08.001

Stewart, D. E., Robertson, E., Dennis, C. L., Grace, S. L., & Wallington, T. (2003). *Postpartum depression: Literature review of risk factors & interventions*. University Health Network Women's Health Program. https://poliklinika-harni.hr/images/uploads/380/who-postpartalna-depresija.pdf

Upadhyay, R. P., Chowdhury, R., Salehi, A., Sarkar, K., Singh, S. K., Sinha, B., Pawar, A., Rajalakshmi, A. K., & Kumar, A. (2017). Postpartum depression in India: A systematic review & meta-analysis. *Bulletin of the World Health Organization*, *95*(10), 706C–717C.

Vijayalakshmi, P., Gandhi, S., Ramachandra Ganjekar, S., Desai, G., & Chandra, P. S. (2018). *Maternal mental health promotion: Facilitator's training manual for auxiliary nurse midwives in India*. National Institute of Mental Health & Neuro-Sciences (NIMHANS) Publication No. 146, https://nimhans.ac.in/wp-content/uploads/2021/03/ANMs-Manual_Final.pdf

WHO (World Health Organization) & UNFPA (United Nations Population Fund). (2008). Maternal mental health & child health & development in low & middle income countries. *Report of the WHO-UNFPA meeting held in Geneva, Switzerland, 30 January–1 February*. https://iris.who.int/bitstream/handle/10665/43975/9789241597142_eng.pdf?sequence=1

WHO (World Health Organization). (1992). *ICD-10 classifications of mental & behavioral disorder: Clinical descriptions & diagnostic guidelines*. https://cdn.who.int/media/docs/default-source/classification/other-classifications/9241544228_eng.pdf?sfvrsn=933a13d3_1&download=true

WHO (World Health Organization). (2000). *Women's mental health: An evidence based review*. https://iris.who.int/bitstream/handle/10665/66539/WHO_MSD_MDP_00.1.pdf?sequence=1

WHO (World Health Organization). (2001). *The World Health Report 2001: Mental health new understanding, new hope*. https://iris.who.int/bitstream/handle/10665/42390/WHR_2001.pdf?sequence=1&isAllowed=y

WHO (World Health Organization). (2005). *Mental Health Atlas Report, 2005*. https://iris.who.int/bitstream/handle/10665/43230/924156296X_eng.pdf?sequence=1&isAllowed=y

WHO (World Health Organization). (2008). *Millennium Development Goal 5—improving maternal health, improving maternal mental health*. https://iris.who.int/bitstream/handle/10665/43975/9789241597142_eng.pdf?sequence=1

WHO (World Health Organization). (2010). *WHO technical consultation on postpartum & postnatal care*. https://iris.who.int/bitstream/handle/10665/70432/WHO_MPS_10.03_eng.pdf?sequence=1

WHO (World Health Organization). (2016). *mhGap Intervention Guide for mental, neurological, & substance use disorders in non-specialized health settings. Version 2.0*. https://www.who.int/publications/i/item/9789241549790

WHO (World Health Organization). (2017). *Advancing the right to health: The vital role of law*. https://apps.who.int/iris/bitstream/handle/10665/252815/9789241511384-eng.pdf?sequence=1&isAllowed=y

WHO (World Health Organization). (2018). *mhGap operations manual*. https://www.who.int/publications-detail-redirect/mhgap-operations-manual

WHO (World Health Organization). (2019). *mhGap Community Toolkit, mental health gap action programme (mhGap)*. https://www.who.int/publications/i/item/the-mhgap-community-toolkit-field-test-version

WHO (World Health Organization). (2020). *Improving early childhood development: WHO guideline*. https://www.who.int/publications/i/item/97892400020986

WHO (World Health Organization). (2022a). *WHO recommendations on maternal and newborn care for a positive postnatal experience*. https://www.who.int/publications/i/item/9789240045989.

WHO (World Health Organization). (2022b). *Guide for integration of perinatal mental health in maternal and child health services*. https://www.who.int/publications/i/item/9789240057142

WHO (World Health Organization). (2022c). *ICD-11 for mortality and morbidity statistics*. 6E20: Mental or behavioral problems related with pregnancy, childbirth or the puerperium, without psychotic symptoms. https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2ficd%2fentity%2f1124422593

Wilcox, M., McGee, B. A., Ionescu, D. F., Leonte, M., LaCross, L., Reps, J., & Wildenhaus, K. (2020). Perinatal depressive symptoms often start in the prenatal rather than postpartum period: Results from a longitudinal study. *Archives of Women Mental Health*, *24*(1), 119–131.