ECONOMIC ANALYSIS OF COMMUNITY-BASED INTERVENTIONS IN INDIA'S MENTAL HEALTH LAWS AND POLICY FRAMEWORKS: RESOURCE ALLOCATION AND THE EFFICIENCY

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ABSTRACT

Although there has been an increase in the provision of funds for mental health in India, the prevalence of suicide and mental disease remains a significant burden. This study utilizes a law and economic analysis to evaluate the effectiveness of community-based interventions in the mental health ecosystem. The study aims to harmonize laws and policies with community-based viewpoints, bridge existing gaps, and optimize the allocation of resources for efficient interventions. The objective is to provide information for the purpose of implementing policy changes, empowering communities, and improving economic efficiency within the legal and economic systems of India. Significant inquiries are made concerning the capacity of community-based interventions to provide efficient interventions for suicide prevention, and resource allocation for the same.

Key words: *Mental health, community-based intervention, resource allocation*

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1. INTRODUCTION

The global initiatives addressing infectious and chronic diseases have substantially improved life expectancy worldwide, with the average age rising from 52 years in 1960 to around 72 years in 2020. [2]However, these endeavours have not adequately tackled the issue of untimely death caused by suicide and physical health issues linked to mental disorders. Individuals afflicted with mental health disorders suffer from a lower life expectancy, with men encountering an average decline of 10.2 years and women experiencing a fall of 7.3 years.[3] The COVID-19 epidemic has worsened this disparity.[4]

The mental health policy in India has been affected by various international frameworks highlighting the connection between mental health and broader developmental objectives.[5] In these frameworks, the connection between concerns such as poverty and gender justice with mental health is emphasised. Still, the solutions produced from these frameworks do not have practical application in planning, defining targets, and allocating budgets.

In India, a biomedical approach is dominant in mental health policy and planning, even though alternative frameworks exist.[6] These alternative, community-based approaches prioritise the impact of social and structural factors on mental health, culturally rooted practices, historically disadvantaged identities, and user-centric experiences. It is essential to thoroughly analyse the effects of mental health policies to guarantee that they effectively cater to individuals' and communities' varied and situation-specific requirements.

This paper uses tools of law and economics and explores (1) why community-based interventions are most effective. (2) uses the Coase theorem to understand the impact of criminalizing suicide and the effects community-based interventions can have on the same (2) How community-based

[2] Life expectancy at birth, total (2022), https://data.worldbank.org/indicator/SP.DYN.LE00.IN. (last visited Aug. 4, 2023).

[3] Erlangsen, Annette et al., *Cause-specific life-years lost in people with mental disorders: a nationwide, register-based cohort study*, 4,12 LANCET PSYCHIATRY, 937-945 (2017).

[4] Das-Munshi, Jayati et al., *All-cause and cause-specific mortality in people with mental disorders and intellectual disabilities, before and during the COVID-19 pandemic: cohort study*,11 THE LANCET REGIONAL HEALTH, Europe 10028 (2021).

[5] Sax W, Lang C et al., *Global mental health - views from South Asia and beyond in The Movement for Global Mental Health: Critical Views from South and Southeast Asia*, 7-37 AMSTERDAM UNIVERSITY PRESS, NL AMSTERDAM (2021).

[6] Vijayakumar, Lakshmi et al., *The national suicide prevention strategy in India: context and considerations for urgent action*, 9 THE LANCET. PSYCHIATRY, 2 (2022).

interventions have been integrated in Indian Laws and Policies (3) analyses the mental health budget for 2023-2024 from a fiscal federalism viewpoint to understand budget allocation for community-based interventions.

1.1 Community-based interventions

Community-based health promotion is a method that primarily emphasises preventive measures while also embracing a comprehensive population-focused viewpoint. According to Blackburn, these are holistic, going

beyond the confines of conventional medical environments and actively engaging community stakeholders, media campaigns, public education efforts and implementing environmental strategies. [7][8]

1.2 Economic analysis of community-based interventions.

Pure public goods are non-excludable, non-rivalrous and non-rejectable, making selling them in the market complex. These goods aren't produced for monetary profit and are often government-funded. This structure can lead to the "free rider problem," where individuals use the goods without paying, expecting others to cover the costs. These goods often generate positive externalities, benefiting even non-consumers[9].

Community-based interventions recognise that an individual's behaviour is connected to surroundings.[10] They use an individual's behaviour to impact other individuals and are successful in behavioural improvement.[11] But this also gives rise to moral hazards; people might adopt riskier behaviours, thinking community initiatives will protect them, similar to the “free rider” problem in public goods. Like public goods in economics, community-based health promotion benefits all community members. Such programs aim for broad societal shifts through strategies in varied settings, from workplaces to schools. Central to this approach is Geoffrey Rose's "population

[7]Mittelmark, M B et al., *Realistic outcomes: lessons from community-based research and demonstration programs for the prevention of cardiovascular diseases*, 14,4 JOURNAL OF PUBLIC HEALTH POLICY, 437-62 (1993).
[8] Blackburn, H, *Research and demonstration projects in community cardiovascular disease prevention*, 4 JOURNAL OF PUBLIC HEALTH POLICY (1983).
[9] R A Musgrave, The Theory of Public Finance (McGraw-Hill 1959).
[10] Elder, J P et al., *Community heart health programs: components, rationale, and strategies for effective interventions*, 14 JOURNAL OF PUBLIC HEALTH POLICY, 463-79 (1993).
[11] Schooler C et al., *Synthesis of findings and issues from community prevention trials*, 7 ANN EPIDEMIOL., S54-68 (1997).

strategy," emphasising that small changes across the community can yield significant health benefits, mirroring the widespread benefits of public goods.

The balance between the costs of these programs and their long-term benefits, especially when factoring in potentially risky behaviours by individuals, becomes crucial. Geoffrey Rose argues that subjecting a large population to minor risks could yield more substantial health outcomes than subjecting a smaller group to higher risks.[12] Rose advocates for implementing a "population strategy" instead of a "high-risk strategy," contending that little increase in prevalent risky behaviours can result in significant overall advantages. This idea emphasises the importance of targeting whole communities, including those with little risks, to optimize public health outcomes.[13]

This approach also holds promise for reducing healthcare system costs.[14] Evidence indicates that it would be impractical to assign the job of promoting and preventing mental health solely to mental health practitioners. It is imperative to provide integrated and multidisciplinary services to enhance the scope of available interventions and mitigate the possibility of unfavourable long-term outcomes.

Data from a Stepped Wedge Cluster Randomized Controlled Trial (SW-CRCT) on Atmiyata conducted in 2017-2019 affirmed the effectiveness of community-based interventions. The findings revealed that those under the program intervention are three times more likely to exhibit reduced depression and anxiety symptoms. Preliminary economic evaluations suggest that for every $1 invested, there's a return of $9.35, underscoring its cost-effectiveness.[15] The World Health Organization is among the top 25 global community-based mental health services practices.

Studies on other diseases, like moderate to severe schizophrenia, show that community-based interventions involving supervised community health workers are more effective than facility-only services. Especially in reducing disabilities linked to the condition and in promoting adherence to prescribed medications.[16] The community-based technique used is Assertive Community Treatment (ACT), which is implemented inside the community environment. Research

[12] Rose G., *Sick individuals and sick populations.*, 14 INT. J. EPIDEMIOL, 32-38 (1985).
[13] Rose G., *The Strategy of Preventive Medicine*., NEW YORK, NY. OXFORD UNIVERSITY PRESS, (1992).
[14] Chatterjee, Sudipto et al., *Effectiveness of a community-based intervention for people with schizophrenia and their caregivers in India (COPSI): a randomized controlled trial*, 383 LANCET (LONDON, ENGLAND), 1385-94 (2014).
[15] Atmiyata, *Centre for Mental Health Law & Policy*, https://cmhlp.org/projects/atmiyata/, (Aug 8 2023, 11:06 AM).
[16] Colizzi, Marco et al., *Prevention and early intervention in youth mental health: is it time for a multidisciplinary and trans-diagnostic model for care?*, 14 INTERNATIONAL JOURNAL OF MENTAL HEALTH SYSTEMS, 23 (2020).

demonstrated that ACT resulted in notable improvement in the decreasing symptoms and severity of illness. Improving overall functioning and quality of life for those with mental disorders.

These interventions have also been linked to a significant rise in individuals seeking treatment for depression, which was seen by enhancing mental health literacy and ensuring equitable contact coverage for depression,[17] something that is covered in the National Mental Health Program but awaits implementation.

1.3 Efficient Suicide Prevention

A Coasean approach [18]to laws examines the reciprocal effects of externalities and the circumstances in which

these externalities may or may not be bargained away with. To understand the various externalities generated by suicide, we combine this lens with the institutional possibilities frontier framework.[19] In the following analysis, we see a tradeoff between private disorder cost and public dictatorship cost.

'Disorder' is defined as the negative externality imposed on individuals due to a suicide attempt and the behavioural response of others due to a death by suicide. 'Dictatorship' refers to the costs imposed by the government to address the suicide attempt, including the violation of human rights. It includes the loss of economic opportunities but does not include the cost of re-entering the economy.

The 'disorder cost' associated with suicide includes health and behavioural externalities. The 'health externality' in this case includes the death of an individual and the increased vulnerability for the next six months if they survive an attempt[20]. This is extended to the individuals who have lost a loved one to suicide as they are susceptible to experiencing suicidal tendencies, posttraumatic stress disorder (PTSD), continued grieving, and depression.[21] These are negative externalities. The

[17] Shidhaye, Rahul et al., *The effect of VISHRAM, a grass-roots community-based mental health programme, on the treatment gap for depression in rural communities in India: a population-based study*, 4 THE LANCET PSYCHIATRY, 2 (2017).
[18] Coase, R., *The Problem of Social Cost*, 3 JOURNAL OF LAW AND ECONOMICS, 1-44; Reproduced in R. Coase. 1988. *The Firm, the Market and the Law*, UNIVERSITY OF CHICAGO PRESS: CHICAGO.
[19] Djankov S et al., *The new comparative economics*, 31 JOURNAL OF COMPARATIVE ECONOMICS, 595-619 (2003).
[20] Inagaki, Masatoshi et al., *Active contact and follow-up interventions to prevent repeat suicide attempts during high-risk periods among patients admitted to emergency departments for suicidal behaviour: a systematic review and meta-analysis*, 19 BMC. PSYCHIATRY, 44 (2019).
[21] JORDAN, GRIEF AFTER SUICIDE: UNDERSTANDING THE CONSEQUENCES AND CARING FOR THE SURVIVORS 1 (John & McIntosh 2011).

'behavioural externality' is how people respond to the situation this can be either negative or positive.

The 'dictatorship cost' imposed by the government in the Indian context is Section 309 of the Indian Penal Code[22] (IPC) and Section 115 of the Mental Health Care Act[23] (MHCA). Section 309 IPC criminalises the suicide attempt. The interim measure implemented by the MHCA, known as Section 115, reduces its impact and presupposes that an individual contemplating suicide is probably undergoing intense emotional turmoil, underscoring the government's need to furnish mental health assistance and rehabilitation.

With this background, a few policy solutions are possible when dealing with deaths by suicide. The one with the least social cost is the most efficient.

The first is one that only imposes a disorder cost; there can be two possibilities. One is the 'do nothing' response, in which the cost of health externalities keeps increasing; there are no behavioural externalities. In this case, the social cost is high due to negative health externalities. This is unlikely to happen as people are bound to respond. This leads us to the second possibility, in which the 'health externalities' give rise to 'behavioural externalities. If the people's behaviour is supportive, this will decrease the health externality and reduce social costs. But, if the behaviour increases stigma or withdraws support, the health externality will increase the social cost.

The second option is to replace the ambiguity of behavioural externality with a stable dictatorship cost. This can be an effective solution if the solution imposed can decrease the health externalities. Criminalising suicide attempts is an example of this dictatorship cost imposed by governments with the hope that it would deter

individuals from attempting suicide. In the Indian scenario, the dictatorship cost increases the disorder cost instead of reducing it.

After a patient who has made a suicide attempt arrives at a medical facility, the occurrence is documented as both a medical and legal matter under section 309 IPC. The police are notified, and they reach the hospital and contact the family, followed by an interview with the patient. They do not usually press charges against the patient but routinely subject them and their family to persistent harassment and extortion. The lack of explicit instructions under Section 115 of the

[22] Indian Penal Code,1860, § 309, No. 45, Acts of Parliament, 1860 (India).
[23] Mental Healthcare Act, 2017, § 115, No. 10, Acts of Parliament, 2017 (India).

MHCA on approaching someone in that vulnerable state gives rise to difficulties and postponed medical aid. Section 309 functions as an ineffective deterrent, dissuading individuals from obtaining necessary medical help and putting their lives at risk.[24] Resulting in increasing health externalities, rendering the policy solution inefficient. This law should be repealed completely; this will increase help-seeking behaviour, reducing health externalities and reducing social costs. We have seen a positive effect of repealing the law in other jurisdictions like Sri Lanka[25] and the United Kingdom.[26] Doing this won't be the most effective solution, but we will still be in a better place than before.

Replacing the current dictatorship costs with community-based interventions is an efficient solution. We have already witnessed the effectiveness of these interventions above. In this case, if the police officials are sensitised about post-attempt care. As members of the same community, they can act as first responders. This could benefit individuals who live alone, are estranged from their families, or do not have anyone to contact. This will convert the police into an asset in these situations, making them, in a sense, a friend of the last resort. Evidence-based treatments for post-attempt care are proven more cost-effective and result in favourable outcomes for society.[27] Training members of the community will also reduce the stigma. This will also reduce barriers to accessing health facilities. Community members speaking the same language would also reduce the information asymmetry. Engaging the community, health centres, and crisis lines as part of mental health promotion initiatives can enhance resilience and diminish suicidal behaviour.[28] Community interventions have the power to turn the negative behavioural externality into a positive behaviour externality by increasing social support and reducing stigma. This will reduce the social costs, making it the most efficient policy intervention.

2. MENTAL HEALTH LAWS AND COMMUNITY-BASED INTERVENTIONS IN INDIA

In response to global initiatives, India launched the National Mental Health Program (NMHP) in

[24] Inagaki, *Supra*,note no 23.
[25] Lew, Bob et al., *Decriminalizing suicide attempt in the 21st century: an examination of suicide rates in countries that penalize suicide, a critical review*, 22 BMC. PSYCHIATRY, 424 (2022).
[26] J. Neeleman *Suicide as a crime in the UK: legal history, international comparisons, and present implications* 94 ACTA PSYCHIATRICA SCANDINAVICA, (1996).
[27]Centre for Mental Health Law and Policy, *Contact Safety Plan* (Aug 10, 2023, 12:23 PM), https://cmhlp.org/projects/contact-and-safety-planning-casp/.
[28] Vijayakumar L, *Suicide prevention: Beyond mental disorder*, 38 INDIAN J. PSYCHOL. MED., 514-6 (2016).

the late 1970s, focusing on accessibility, primary healthcare integration, and community engagement. The vision expanded through the District Mental Health Program (DMHP), [29]emphasizing basic services and integration into general healthcare. The 2017 Mental Healthcare Act (MHCA) reflected a transformative shift towards prioritizing autonomy and dignity for those with mental illnesses.

2.1 Integration Challenges in Legal Framework

While the NMHP encouraged community participation, implementation of DMHP leaned towards a biomedical model, particularly emphasizing psychotropic medications.[30] Criticisms of the DMHP include administration, financing, and dominance by one institution, hindering creativity and integration of alternative models.[31]A notable review using oral histories from those involved in the creation of both the NMHP and DMHP reveals that the NMHP was possibly too ambitious and became overly dominated by one institution, NIMHANS.[32] This has potentially stifled creativity and the integration of other models, such as those from NGOs. The MHCA, aligned with the CRPD, faces criticism for being Western-centric and prioritizing individual rights over family-centric care. Challenges in implementation and resource allocation impede its impact.[33] 'Pills that Swallow Policy,' an ethnographic study, criticizes the DMHP's medication-centric focus, arguing it silences community voices and reinforces care barriers.[34] Despite recognizing alternative models in policy documents, their underfunding and tokenistic integration hinder effective implementation and comprehensive mental health planning.

2.2 Facade of Progress

[29] Shastri M, *Deconstructing the DMHP: Part 1 - Introduction to India's District Mental Health Programme*, INDIA MENTAL HEALTH OBSERVATORY, CENTRE FOR MENTAL LAW & POLICY, ILS. 2021, https://cmhlp.org/wp-content/uploads/2021/11/Issue-Brief-DMHP-I.pdf.
[30] Ecks S, *'Pharmaceutical citizenship: antidepressant marketing and the promise of demarginalization in India'*, 12 ANTHROPOL. MED., 239-254 (2005).
[31] Varma A, *Deconstructing the DMHP: Part IV - A Critique of the District Mental Health Programme*, INDIA MENTAL HEALTH OBSERVATORY, CENTRE FOR MENTAL LAW & POLICY, ILS. 2021, https://cmhlp.org/wp-content/uploads/2021/11/Issue-Brief-DMHP-IV.pdf.
[32] Van Ginneken N, Jain S, Patel V, Berridge V, *'The development of mental health services within primary care in India: learning from oral history'*, 8 INT. J. MENT. HEALTH SYST., 30 (2014).
[33] Math SB, Basavaraju V, Harihara SN, Gowda GS, Manjunatha N, Kumar CN, Gowda M, *'Mental healthcare act 2017 - aspiration to action'*, 61 INDIAN J. PSYCHIATR., S660-S666 (2019).
[34]Jain S, Jadhav S, *'Pills that swallow policy: clinical ethnography of a Community Mental Health Program in northern India'* 46 TRANSCULT. PSYCHIATR., 60-85, (2009).

The mental health policy in India has been greatly affected by international frameworks such as the Sustainable Development Goals (SDGs), the Movement for Global Mental Health (MGMH), and the World

Health Organization's (WHO) Mental Health Action Plan. These frameworks highlight the connection between mental health and broader developmental objectives.[35] Nevertheless, although the connection between concerns such as poverty and gender justice with mental health is emphasized, the solutions produced from these frameworks do not have practical application in the process of planning, defining targets, and allocating budgets. The assumptions of the Mental Global Mental Health (MGMH) framework, as seen in Indian mental health programs, prioritize pharmacological therapy for mental diseases and indicate a significant lack of access to treatment in low- and middle-income countries (LMICs).[36] Critics question the validity of the term "treatment gap" and suggest using "treatment difference" or "care gap" instead to incorporate a wider range of mental well-being resources. The implementation of the "task-shifting" technique, which involves providing specialized training to primary workers, is considered a potential answer. However, there are worries about the potential strain it may have on workers, especially marginalized women, and the reinforcement of biomedical supremacy.[37]There is also a risk of these 'trained' volunteers overshadowing local understandings and relations in mental health, as biomedical psychiatry often dismisses local mental health interpretations as mere superstitions or barriers to treatment.[38]

The National Tele-Mental Health Program has embraced technology, which has been emphasized throughout the pandemic. This has resulted in benefits such as a wider reach, but it also presents obstacles, including the existence of a digital gap.[39] The current approach, which is primarily

[35] Sax W, Lang C, *'Global mental health - views from South Asia and beyond' in The Movement for Global Mental Health: Critical Views from South and Southeast Asia*, AMSTERDAM UNIVERSITY PRESS, NL AMSTERDAM, pp. 7- 37, (2021).
[36] Gautham MS, Gururaj G, Varghese M, Benegal V, Rao GN, Kokane A, Chavan BS, Dalal PK, Ram D, Pathak K, Singh RK Lenin, Singh LK, Sharma P, Saha PK, Ramasubramanian C, Mehta RY, Shibukumar TM, NMHS Collaborators Group, 'The National Mental Health Survey of India (2016): prevalence, socio-demographic correlates and treatment gap of mental morbidity' (2020) 66 Int. J. Soc. Psychiatr. 361-372, https://doi.org/10.1177/0020764020907941.
[37] Kottai SR, Ranganathan S, *'Task-shifting in community mental health in Kerala: tensions and ruptures'* (2020) 39 MED. ANTHROPOL. 538-552, https://doi.org/10.1080/01459740.2020.1722122.
[38] Ecks S, 'Mental ills for all - genealogies of the movement for global mental health' in Sax W, Lang C (Eds), *The Movement for Global Mental Health: Critical Views from South and Southeast Asia* (AMSTERDAM UNIVERSITY PRESS, NL AMSTERDAM, 2021) pp. 41-64, https://doi.org/10.5117/9789463721622.
[39] Grover S, Sarkar S, Gupta R, 'Data handling for E-mental health professionals' (2020) 42 INDIAN J. PSYCHOL. MED.

influenced by biological psychiatry, fails to take into account other forms of knowledge and practices, hence marginalizing non-biomedical viewpoints.[40] While mental health in India is receiving considerable attention, the community-level approach that predominantly focuses on biomedical remedies fails to acknowledge the valuable insights that can be offered by varied viewpoints. The efficacy of the National Mental Health Policy in reconciling conflicting perspectives and offering guidance is still questionable, as its rights-oriented approach has not been completely put into action since its inception in 2014.

3. BUDGET ANALYSIS THROUGH A PUBLIC GOOD AND FISCAL FEDERALISM LENS

Fiscal federalism concerns the financial responsibilities split among various government levels. The theory aims to allocate funding efficiently, centralising goods with broad externalities and localising those with narrow impacts.[41]

As we have seen, community-based interventions are pure public goods with broad externalities. However, these programs are to be lacking support as evidenced by the 2023-2024 budget allocations.[42] The tertiary components of the National Mental Health Programme (NMHP) (India's community-based programme) are merged with the broader Tertiary Care Programme[43], funding for which has been reduced by 42%. This is concerning, especially considering the NHRC's reports on the subpar conditionsof public mental health institutions.[44] The National Suicide Prevention Strategy (NSPS)[45] introduced by the government last year has unfortunately not secured dedicated

85S-91S, https://doi.org/10.1177/0253717620956732.

[40] Kaplan B, *'Revisiting health information technology ethical, legal, and social issues and evaluation: telehealth/telemedicine and COVID-19'* (2020) 143 INT. J. MED. INF. 104239, https://doi.org/10.1016/j.ijmedinf.2020.104239.

[41] P A Samuelson, *The Pure Theory of Public Expenditure*, 36 THE REVIEW OF ECONOMICS AND STATISTICS, 387 (1954).

[42] Centre for Mental Health Law and Policy, *Union Budget for Mental Health* 2023-24., Keshav Desiraju India Mental Health Observatory, (Aug 7, 2023, 6:12 PM), https://cmhlp.org/wp-content/uploads/2023/02/Budget-Brief-2023-v3.pdf.

[43] Shastri M. *Deconstructing the DMHP: Part 1 - Introduction to India's District Mental Health Programme.* India Mental Health Observatory, Centre for Mental Law & Policy (2 Aug 2023, 10:07 AM) https://cmhlp.org/wp-content/uploads/2021/11/Issue-Brief-DMHP-I.pdf.

[44]National Human Rights Commission India, *NHRC says all the 46 Government Mental Healthcare Institutions across the country depict very pathetic and inhuman handling by different stakeholders; issues notices* (Sep 25, 2023, 3:08 PM) https://nhrc.nic.in/media/press-release/nhrc-says-all-46-government-%20mental-healthcare-institutionsacross-country-depict.

[45]Ministry of Health & Family Welfare. *National Suicide Prevention Strategy* (Aug 7, 2023, 8:09 PM)

funds for its rollout.

Other government programs that acted as mitigating factors for psycho-social determinants of mental health have also seen a reduction in the budget. The Ministry of Social Justice and Empowerment's budget have increased, but the Welfare of Persons with Disabilities has seen a 17% reduction. The Mahatma Gandhi National Rural Employment Guarantee Scheme (MNREGS), which aims to ensure a minimum of 100 days of wage employment to its beneficiaries, has had its Budget Estimate (BE) for 2023-24 reduced by 18%. A

2021 report from the National Crimes Record Bureau highlighted that 26% of those who died by suicide were daily wage earners.[46] Several studies have indicated that poverty reduction programs, such as MNREGS, can potentially lead to a decrease in suicide rates and promote better mental health outcomes.[47]

3.1 Investment in Exclusive, Non-Public Goods

With a significant 16% increase in allocations towards institutions like Lokpriya Gopinath Bordoloi Regional Institute of Mental Health, the T-MANAS program, and NIMHANS receiving a 29% budgetary surge,[48] it is clear that there's an emphasis on centralised, institutional, and digital approaches to mental health.

Though mental health institutions and services are essential, they do not align entirely with the principles of pure public good. The services provided by such institutions inherently possess rivalry; if one individual secures an appointment, another cannot access that same time slot. Moreover, while these institutions may provide subsidised care, they are not entirely free, creating barriers for thoseunable to afford them. This deviates from the non-excludability characteristic of pure public goods; with the inclusion of private partnerships, there is an implicit suggestion of revenue generation. While the increased allocation for mental health is a positive step, the emphasis is more on centralised, institution-based interventions rather than community-based programs.

https://main.mohfw.gov.in/sites/default/files/National%20Suicide%20Prevention%20Strategy.pdf.

[46]Ministry of Health and Family Welfare, *National Crime Records Bureau,* Government of India (Sep 3, 2023,7:09 PM) http://ncrb.gov.in/.

[47] Mahashur et al., *Impact of Poverty Reduction Programs on Suicide, Mental Health and Wellbeing*, Centre for Mental Health Law and Policy (2022).

[48]National Institute of Mental Health and Neuro Sciences (NIMHANS). NIMHANS *Annual Report 2020-21* (5 Sept 2023, 9:09 PM) https://nimhans.ac.in/wp-content/uploads/2022/09/NIMHANS_AR_2020-21_English.pdf.

4. CONCLUSION

Community-based mental health programs epitomise pure public goods, providing non-excludable and non-rivalrous benefits beyond direct recipients to society. Their value does not lie in immediate monetary returns; they demand government investment for long-term societal well-being. We have seen the impact of externalities on efficient suicide prevention. The laws in India are currently serving as a negative externality. Moreover, there is a decrease in funding for community-based programmes while increasing services, which

adds to the access barriers. This adds to the negative externalities, increasing the social cost. Making the intervention ineffective. Community-based models have the highest chances of reducing social costs and efficiently preventing deaths due to suicides. Thus, India needs to rethink its approach to suicide prevention, which is currently casting a massive burden on the country.