**Title: Reading Conversion Therapies as Violations of Mental Healthcare Rights: The Case of Anjana Harish**

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**Abstract**

Conversion therapies have been a major source of violence against LGBT+ people and countries across the world have begun to adopt various measures to curb these practices. In India, the recent suicide of a bisexual woman, Anjana Harish, after being subjected to conversion therapy has raised several concerns about these practices despite the decriminalizing of homosexuality in India in 2018. Based on Anjana’s case, this paper analyses some of the difficulties in identifying and controlling conversion therapies and the role of the Mental Healthcare Act (2017) in helping to curb these practices. The paper analyzes conversion therapies as violations of rights to mental healthcare. It also discusses how LGBT+ rights are closely connected with the rights of people with mental illness and emphasizes the need for greater integration of LGBT+ issues with mental health in various forms to strengthen mental healthcare systems.

**Introduction**

Gender and sexual minorities, often referred to as LGBT+ people, are at risk of various kinds of violence owing to their marginalized social status [1]. One of the forms of violence to which LGBT+ people are subjected is conversion therapy. Conversion therapy is a term applied to diverse practices that attempt to change the sexual orientation and/or gender identity of a person who does not identify as cisgender and/or heterosexual to bring them into conformity with these norms [2,3,4,5].[[1]](#endnote-1) Conversion therapy comprises several kinds of interventions and has several sources including medical and religious ones [2,3,4,5]. Some medical forms of conversion therapy include electroconvulsive therapy, hormone therapy, sedatives, and psychotherapy [2,3,4,5]. It could also take the form of betraying confidentiality of LGBT+ clients by therapists by revealing details of counselling sessions to their families without the person’s consent [6]. This is one of the more subtle forms of conversion therapies. Religious counselling, exorcism, and more violent forms of religious conversion therapy have also been documented [2,4,7]. But conversion therapies can assume much more covert forms and are often carried out by the family [8]. These include emotional blackmail, repeatedly asking the person to rethink their sexual or gender identity, enforcing certain norms of dressing and prohibiting others, imposing restrictions on the person’s social circle, confinement within the home or removal from the home, destruction of the person’s property, corrective rape or forced marriage with the aim of changing the person’s sexual orientation and/or gender identity, and other such acts [1,5]. In educational establishments and places of work, conversion practices could take the forms of forcing people to dress or behave in a manner that does not correspond to their sexual or gender identity of choice [1,5]. These forms of conversion therapies are much more difficult to identify, document and measure. Some of them are not explicitly violent and might not even be seen as conversion therapies. Hence, non-institutionalized forms of conversion therapy often evade public attention [2,5]. It has been argued that when conversion therapies are administered to children, they could constitute violations of the United Nations’ Convention on the Rights of the Child (CRC) and in the case of adults, they could be violations of the Convention Against Torture (CAT) and the International Convention on Civil and Political Rights (ICCPR) [9]. However, not all forms of conversion therapies might clearly amount to violations of any of these conventions [9]. Hence, a multi-faceted approach to tackling conversion therapies is needed.

Since homosexuality was declassified from the Diagnostic and Statistical Manual on Mental Disorders (DSM) in 1973 and from the International Classification of Diseases (ICD) in 1990 and transgender and gender diverse identities per se are not classified as psychiatric disorders in these manuals, there is no justification for conversion therapies [10]. Moreover, there is no evidence that conversion therapies work although there is evidence about their iatrogenic[[2]](#endnote-2) effects [2,11]. With the advancement of LGBT+ rights across the world, there is a growing demand for a “global ban on practices of conversion therapy” [4]. Currently, Brazil, Ecuador, Malta and Taiwan have completely banned conversion therapies and partial bans on conversion therapies exist in some parts of the United States, Australia, Germany and a few other countries [3]. Complete bans do not imply that conversion therapies have stopped altogether but that LGBT+ people have some protection against these practices and some modes of legal redressal.

In India, the Indian Psychiatric Society released a statement in 2018 stating that homosexuality was a normal variant of human sexuality and that conversion therapies should not be exist since they do not work [12]. This statement was cited by the Supreme Court in the Navtej Singh Johar versus Union of India judgment (2018) that read down Section 377 that was used to criminalize homosexuality [13]. The judgment itself emphasized that sexual diversity is an aspect of human diversity and condemned conversion therapies while recognizing the vulnerability of LGBT+ people to mental illnesses owing to their marginalized social status. The judgment emphasized the need for mental health professionals to address the mental health needs of LGBT+ people without pathologizing their gender or sexual identity. However, conversion therapies against gender and sexual minorities continue.

During the lockdown resulting from the COVID-19 pandemic, there was a case of a 21-year-old bisexual woman named Anjana Harish who died by suicide after having been subjected to conversion therapy by her family [14,15]. Two months prior to her death, she released a video recounting the violence to which she was subjected by a psychiatrist and at two de-addiction centres at the insistence of her family [15]. Anjana’s case provides several insights into the practice of conversion therapy including the primary role of the family, the role of mental health professionals and mental health establishments, the use of medication, physical assault and the deadly iatrogenic effects of some conversion treatments. Anjana’s ordeal also reveals how the safety and well-being of LGBT+ people are closely interconnected with the rights of people with mental illness and/or those seeking mental health treatments. This is not to say that Anjana herself was mentally ill or that gender and sexual diversity are mental illnesses. But Anjana’s narrative provides critical details about mental health spaces as sites of violence not only for LGBT+ people and others who are unjustifiably brought to these spaces but also for people who might actually have mental illnesses and those who might seek out mental health services voluntarily. Using Anjana’s case, this paper also analyzes how safeguards against conversion therapies and other kinds of mental health-related violence against LGBT+ people are provided throughout the Mental Healthcare Act (MHCA) (2017) [16], and not only in the provisions that specifically pertain to gender and sexuality. This analysis would help clarify the comprehensive role of the MHCA in safeguarding the rights of LGBT+ people through provisions intended to safeguard the rights of all those seeking mental healthcare. It is also hoped that this study would facilitate the integration of LGBT+ issues with broader issues of mental health at multiple levels including the formation of networks between LGBT+ people and those with mental illness and strengthening professional ethics and biomedical ethics to ensure safer and more just and equitable mental healthcare access for everyone.

The paper commences with an overview of the Anjana Harish case and a note on terminology to describe conversion therapies. This is followed by an analysis of some of the salient provisions of the MHCA that provide safeguards against conversion therapies based on details from Anjana’s case. There is then a discussion of the connections between conversion therapies and other kinds of violence against people with mental illnesses. The paper ends with a discussion on the formulation of a multi-faceted approach of handling conversion therapies that help to strengthen mental healthcare systems overall.

**An Overview of the Anjana Harish Case**

Anjana Harish was a 21-year-old bisexual woman from Kerala who released a video on a social media site in March 2020 in which she recounted her experiences of medical violence [14,15]. She narrated how she was forcibly taken to a psychiatrist in Coimbatore by her family and some others. Despite her protests that there was nothing wrong with her, she was put under sedatives and was physically assaulted when she resisted. She was then admitted to a deaddiction centre in Pallakad for three weeks where she was confined to a cell. She was later transferred to another deaddiction centre in Thiruvananthapuram where she was given forty injections of unknown substances and administered unnamed medicines. Anjana recounted how the medicines made her feel dizzy, impaired her vision and speech, made her afraid of crowds and the dark, and made her behavior robotic. Post her release from the deaddiction centre, Anjana went to Goa with her friends and her parents continued to make threatening phone calls to her. They filed a missing person’s report and Anjana had to go to the police station in Goa to respond to it. In May 2020, two months following her video, Anjana died by suicide.

**A Note on Terminology**

There are several debates about the suitability of the term conversion therapy since the practices that it entails are not therapeutic but are simply acts of violence [2,4,5]. Calling them “therapies” grants them a legitimacy that they do not deserve. An alternative term proposed is “curative violence” [5] but this term has its own limitations since many attempts at conversion therapy do not necessarily aim to eliminate gender and sexual variance altogether but intend to suppress its expression or to discourage it. This is another limitation of the term “conversion therapy”, as well. In the case of children who do not subscribe to cisgender and/or heterosexual norms, some parents enforce dressing practices, restrict the children’s friends’ circle, and engage the children in stereotypical gender roles as preventive measures against the children identifying as LGBT+ in their adulthood [2]. These practices are not “curative” but “preventive”. Other common terms used for conversion therapy is Sexual Orientation Change Efforts (SOCE) and Sexual Orientation and Gender Identity Change Efforts (SOGICE), which have some of the limitations of the terms conversion therapy and curative violence [9]. The present study uses the term “conversion therapy” and related terms such as “conversion attempts/efforts/treatments” because of their familiarity.

**Limitations**

The present study specifically uses the Anjana Harish case to analyze conversion therapy as a form of violence in the mental health sector in India. Since conversion therapies are extremely heterogenous in their sources, forms and effects, other case studies of conversion therapies might yield different findings from the analysis here. This study does not aim to be comprehensive but Anjana’s experiences are typical of conversion therapies in terms of the complicity of the family, psychiatric violence and dangerous iatrogenic effects, which make the findings of this study at least partially representative of the phenomenon of conversion therapy in general. This study has also relied on media reports of Anjana’s case since access to other medical records was not possible but this could be a limitation to the analysis. While transgender, intersex and gender diverse people experience many of the same kinds of conversion therapies as sexual minorities, there are some unique forms of conversion treatments that are unique to them such as forced gender assignment surgeries on intersex babies. But this paper focuses specifically on a case of conversion therapy against a person with a marginalized sexual orientation.

**The Mental Healthcare Act (2017) and LGBT+ People**

***Safeguards Against Conversion Therapies in the MHCA***

The Mental Healthcare Act (2017) (MHCA) has been regarded as an anti-discrimination legislation that emphasizes a human rights approach to mental health and illness [17]. The Act positions mental healthcare as integral to public health. For the first time in India, there is a right to mental healthcare. This section discusses the protections offered to gender and sexual minorities against conversion therapies and other forms of violence in mental healthcare spaces as laid down in the Act. Some of these provisions specifically mention gender and sexuality while others are general but still offer safeguards against conversion therapies.

Section 3(1) of Chapter II of the Act states that mental illness should only be defined “in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease of the World Health Organization) as may be notified by the Central Government” [16]. Since non-normative sexual orientations such as homosexuality, bisexuality, asexuality and others are not classified as mental illnesses in the ICD-10 or the DSM-V, no one in India can be diagnosed as mentally ill on the basis of a non-heterosexual orientation [18]. In the case of gender diversity, ‘gender identity disorders’ are currently classified as a diagnostic category under code F64 of the ICD-10 although this category is going to be deleted in the ICD-11 and is to be replaced with a new category of ‘gender incongruence’, which shall be classified in a newly introduced chapter on sexual health [10]. Hence, gender incongruence shall not be classified as a mental disorder in the ICD-11 and mental health professionals will have to rethink their conceptions of gender diversity based on this new classification. The DSM-V currently contains a category on gender dysphoria that medicalizes only the distress that transgender people experience and not trans and gender diverse identities [10]. Therefore, gender and sexual diversity are not classified as illnesses in international diagnostic manuals and the MHCA prevents people from being diagnosed as mentally ill on grounds of their gender and sexual identity.

Subsection 3(a) of Section 3 in Chapter II prohibits mental illness from being determined on the basis of “political, economic or social status or membership of a cultural, racial or religious group, or for any other reason not directly relevant to mental health status of the person” and Subsection 3(b) of the same section prohibits the same on the grounds of “non-conformity with moral, social, cultural, work or political values or religious beliefs prevailing in a person’s community” [16]. These provisions prevent gender and sexual diversity from being classified as mental illnesses merely because they do not reflect the dominant cisgender and heterosexual norms [18]. There have been instances of people from marginalized tribal communities being labelled as mentally ill and confined to in-patient facilities [19]. Similarly, a number of studies have reported cases of women who do not subscribe to stereotypical norms of femininity being diagnosed as mentally ill and even being admitted to mental health establishments [18,20]. Therefore, these provisions protect vulnerable groups from receiving an inaccurate diagnosis of mental illness.

Section 18(1) of Chapter V provides the right to access mental healthcare from a government facility. Section 18(2) of the same chapter guarantees “mental health services of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis” [16]. This provision ensures the right to mental healthcare, and good quality mental healthcare in particular, to gender and sexual minorities, as well. The Navtej Singh Johar judgment that read down Section 377 specifically stated that since the MHCA guaranteed the right to access mental healthcare to gender and sexual minorities, it was paradoxical to criminalize homosexuality through any other legislation [13,18]. This was used as one of the rationales to read down Section 377. Moreover, since LGBT+ people are at a greater risk of experiencing mental health issues often resulting from their marginalized social status [21], access to safe, good quality and affordable mental health services are indispensable for them. These provisions, if adequately implemented, would have a positive impact on LGBT+ people’s trust in professional mental health services and encourage them to seek help whenever necessary without fearing for their gender and/or sexual identity itself being pathologized or treated like an illness.

While the relevance of the above provisions to LGBT+ mental healthcare has been discussed elsewhere [18], safeguards against conversion therapies and assurances of LGBT+ people’s right to access mental healthcare are provided through several other provisions of the Act, too.

Section 3(4) of Chapter II states, “Past treatment or hospitalization in a mental health establishment though relevant, shall not by itself justify any present or future determination of the person’s mental illness” [16]. This is particularly relevant for LGBT+ people who are at risk for mental health issues owing to their marginalized social status and who might seek mental health services. Having received any kind of mental health treatment in itself does not justify future diagnosis of and/or treatment for mental illness.

Chapter III of the Act provides for Advance Directives, which allow a person to legally state in writing the kind of treatment they wish or do not wish to receive if they are ever diagnosed with mental illness and they can also nominate a representative to take treatment decisions on their behalf when necessary. Chapter IV of the Act contains provisions for the appointment of nominated representatives by persons with mental illness who can assist the person take treatment decisions or take these decisions on behalf of the person [16]. This provision has specific significance for LGBT+ people whose families of choice might be different from their natal families[[3]](#endnote-3). Also, marriage in a legal sense is not currently possible for same-sex couples although sexual minorities might choose their partners as their nominated representatives. Hence, this provision gives LGBT+ people the right to choose anyone they trust to make mental healthcare decisions for them or assist them in this process.

The MHCA also contains a number of provisions that guarantee people with mental illness the right to make their own healthcare decisions and their right to informed consent. Informed consent is defined as “consent given for a specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to a person adequate information including risks and benefits of, and alternatives to, the specific intervention in a language and manner understood by the person” as per Section 2 (1)(i) of Chapter I [16]. Section 4(1) of Chapter II guarantees people with mental illness the right to make their own healthcare decisions provided they are able to understand information relevant to making the decision, the consequences of making or not making a decision, and if they are able to communicate the decision “by means of speech, expression, gesture or any other means” [16]. Section 25 guarantees the person with mental illness the right to access their medical records [16]. Informed consent would help counter the risk of LGBT+ people being subjected to conversion treatments or any other treatments against their will. If gender and sexual variance are not mental illnesses then the question of challenging the decision-making capacity of LGBT+ people to make their own mental healthcare decisions should not arise.

Chapter XII of the Act comprises various provisions related to “Admission, Treatment and Discharge” of people with mental illness in mental health establishments with separate provisions for independent patients who seek admission on their own, minors and people admitted upon the application of their nominated representatives [16]. Section 89(6) contains provisions for the treatment of people with mental illness who are admitted upon the application of a nominated representative and requires that the person’s advanced directives, if any, be taken into consideration and that the person have the opportunity for assisted decision-making with the help of the nominated representative wherever necessary [16]. Chapter X lays down a number of provisions for the establishment, registration, audit, enquiry and other aspects of mental health establishments [16]. Significantly, mental health establishments under the Act also include institutions that practice “Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy” and not only psychology and/or psychiatry that are operated by either publicly or privately run, as mentioned in Chapter 1 2(p) of the Act [16]. These safeguards are particularly helpful as safeguards against conversion treatments, which take place in institutionalized settings. Since conversion treatments are also carried out in non-psychiatric settings, the inclusion of a range of medical institutions within the category of “mental health establishments” helps to increase the number of institutions covered under the law.

Moreover, Section 20 of Chapter V gives people with mental illness the right to live with dignity and protects them from “from cruel, inhuman or degrading treatment in any mental health establishment” [16]. The right to equality and non-discrimination is further guaranteed in Section 21 of Chapter V that requires mental illness to be treated on par with physical illness[[4]](#endnote-4). Conversion treatments have been classified as “cruel, inhuman and degrading treatment”, according to the United Nations Independent Expert on sexual orientation and gender identity, Victor Madrigal-Borloz [4]. The requirement that mental illness be treated on par with physical illness also serves as a safeguard for LGBT+ people against violence in the mental healthcare settings since the possibility of mental illness cannot be used as a justification for the overturning of informed consent of a person as per this provision.

The Act also provides for decentralization through the establishment of a Central mental Health Authority and State Mental Health Authorities as well as a Mental Health Review Boards to safeguard patient rights, regulate mental health establishments and perform other functions related to the functioning of mental healthcare systems as per the provisions of the Act, thus creating multiple levels of accountability against illegal and unethical practices [16]. Chapter XV of the Act mentions various penalties for violations of the provisions of the Act by mental health establishments, individuals and companies [16].

***The Relevance of the Mental Healthcare Act for the Anjana Harish Case***

All the above provisions are significant to understand the various kinds of violation of rights that took place in the Anjana Harish case and some of the complexities entailed in conversion therapies. Anjana was completely denied informed consent in terms of her being admitted to various mental health establishments and being administered unknown substances in the guise of treatments. There is no evidence to suggest that her capacity to make her own healthcare decisions was lacking in any way. She was also subjected to cruel and degrading treatments in the establishments. All the atrocities that Anjana was subjected to were clear violations of Article 21 of the Constitution, which guarantees Right to Life and Personal Liberty.

Anjana’s case also reveals many of the difficulties involved in identifying conversion treatments. Significantly, in her video, Anjana does not specifically mention that she was bisexual or that she was subjected to conversion treatments [15]. She narrates how she kept telling her family and the doctors that she was fine but she was still subjected to various treatments against her will. Since Anjana had been open about her sexuality, her friends and acquaintances helped to establish the case of conversion therapy after her tragic suicide. This is not to cast any doubts on the fact that Anjana was subjected to conversion treatments but to show how difficult identifying a case of conversion therapy could be. Furthermore, one of the mental health professionals at the second deaddiction centre where Anjana was admitted stated that Anjana was being treated for “cannabis and alcohol de-addiction” and not for her sexual orientation [14]. As Anjana says in her video, she did not identify as having any of these issues and kept repeating this to the doctor and her family before being subdued. The medical professional’s claim about Anjana being treated for addiction and not for her sexual orientation also reflects the difficulties entailed in proving that conversion treatments have taken place. A further complication in the case is that Anjana was seeking treatment for depression prior to being abducted and subjected to forced treatment, as disclosed by her friend [14]. The possibility of Anjana’s depression being used as a rationale for the violence to which she was subjected cannot be dismissed although there is no specific evidence for this. This was evident in the Tessy James versus the Director General of Police, Thiruvanathapuram and Others case in 2018 where a trans woman was subjected to a medical and a psychiatric evaluation to “verify” her gender identity since her mother claimed that she was seeking psychiatric treatment and demanded the evaluation [22]. Hence, the violation of the autonomy of LGBT+ people who are seeking mental health treatments is not unknown.

Anjana’s case reveals how cases of conversion treatments can be distorted by multiple parties, including mental health professionals, who might justify the grounds of admission to mental health establishments and administering treatments on grounds other than sexual orientation. This makes it harder for conversion therapies to be identified despite the MHCA’s prohibitions of defining mental illness based on sexual or gender identity or social prejudice of any kind. Other provisions of the Act including those related to informed consent, disclosing medical records, rules for running a mental health establishment, protection from cruel and degrading treatment, treating mental illness on power with physical illness and other related provisions that provide protections to all people including LGBT+ people, would help to protect LGBT+ people from conversion treatments and to penalize those who carry out these treatments. In this sense, safe and equitable access to mental healthcare for LGBT+ people is intrinsically woven with the rights of people with mental illness and/or those seeking mental health treatments to access the same although being LGBT+ is not a mental illness in itself. The central legal and ethical argument in Anjana’s case is that no one should be subjected to the abuse to which she was subjected even if the person has a mental illness or is voluntarily seeking treatment in a mental health setting. Therefore, it is not only the provisions of the MHCA specifically pertaining to gender and sexuality that safeguard LGBT+ people from conversion therapies but several other provisions of the Act that are critical to stop the practice.

**Interconnections between Conversion Therapies and the Violation of Rights of People with Mental Illness**

The violence to which Anjana was subjected – the abduction, the silencing of her voice through drugs and assault, detention, forced medication, denial of informed consent, the distortions of her narrative and the threats to her life – illustrate the violence to which people with mental illness are subjected to, particularly in in-patient facilities. This is not to say that Anjana herself had a mental illness. The claims that she was experiencing depression might be accurate but since there is no further evidence for the same, it would be unethical to identify Anjana as a person with mental illness. But the treatment meted out to her in the name of conversion therapies where she was detained raise several pressing concerns about the vulnerability to violence and neglect of people diagnosed with mental illness. Anjana’s narrative about her suffering is not only a testimony of conversion therapy and of LGBT+ people’s struggle but it is also the narrative of a survivor of psychiatry and mental health institutions.

User and survivor movements against the coercive nature of psychiatry emerged in the United States and the United Kingdom since the 1960s and ‘70s and spread to other parts of the world [23]. These movements were led by both consumers of psychiatry who challenged psychiatric authority and by survivors of psychiatry who were involuntarily and unjustly subjected to psychiatric treatments. These movements were very diverse in their demands and programmes but they had a few common objectives, which included challenging the psychopharmaceuticalization of mental healthcare or the excessive use of medication for mental illness, violence against people in in-patient facilities and demands for greater de-institutionalization of people in these facilities. The World Network of Users and Survivors of Psychiatry (WNUSP) played a key role in negotiating and formulating the provisions of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which indicates the important role that users and survivors are playing in framing policies intended to protect their own rights [24]. In India, a number of NGOs, civil rights organizations and user and survivor networks also played a critical role in framing the MHCA, too [25].[[5]](#endnote-5) This marks an important move towards the inclusion of people with mental illness and their allies in mental healthcare policy- and decision-making.

At the same time, survivor narratives of people who endure psychiatric violence are rare owing to the effects of the violence itself and the stigma surrounding mental illness alongwith various other factors. But it is only through personal narratives that psychiatry can be critiqued and reformed. As mentioned earlier, documentation and measurement of conversion therapies are extremely challenging. Anjana’s story is a rare instance of a person recounting their own experiences of psychiatric (and other medical) violence. Narratives such as these should be treated as testimonies of violations not only against LGBT+ people but also against people with mental illness and/or those in in-patient facilities although Anjana herself was not mentally ill. It is only through this consideration that the silences and gaps of medical and psychiatric abuse can be understood and mental healthcare systems can be made more just and equitable for everyone.

The second important finding that emerges from an analysis of Anjana’s case that has significant implications for the rights of all people with mental illness is psychiatric institutionalization. The MHCA privileges community care and the integration of persons with mental illness into the community and long-term institutionalization in a mental health establishment is the last resort, as contained in subsection 5 of Section 18 in Chapter V of the Act. The same subsection also calls for the integration of mental healthcare with general healthcare settings at the primary, secondary and tertiary levels. These provisions are in accordance of the human rights and anti-discrimination orientation of the Act that seeks to make mental healthcare an integral part of public health. Although a detailed discussion of the history of legislations preceding the MHCA is beyond the scope of the paper, it is important to mention that deinstitutionalization, an increasing thrust on patient rights and increased involvement of users and consumers of mental health services is observed from the Indian Lunacy Act (1912) to the Mental Health Act (1987) and finally the MHCA [26]. Confining people to mental health institutions was originally considered necessary to protect the rest of society from these people [26]. But mental health policies over the years have gradually attempted to shift to a more rights-based approach to mental healthcare [26]. At the same time, deteriorating quality of infrastructure, living conditions and services in mental health establishments is cause for concern and the emphasis on community care does not neglecting the plight of those in institutions [26,27]. The guidelines for the establishment, registration, maintenance and audit of mental health establishments under the MHCA and penalties for non-compliance will hopefully have positive implications for the well-being of those in institutionalized care. Anjana’s narrative is testimony to the violence and complete breach of provisions of the MHCA that is taking place in some mental health establishments and the imperative for the provisions of the MHCA to be leveraged to safeguard the rights of all residents of these institutions through more demands for accountability. Her narrative also emphasizes the need for greater community-based care as far as possible.

**Multi-faceted Approach to Tackling Conversion Therapies**

The previous sections explored the ways in which the vulnerabilities of LGBT+ people and people with mental illness are closely interconnected. It also explored the relevance of various provisions of the MHCA to protect LGBT+ people from conversion therapies and emphasized the importance of narratives of conversion therapies to be read as user/survivor narratives that provide evidence of human rights violations committed by mental health professionals and in mental health establishments. This section emphasizes the need for a multi-faceted approach to tackling conversion therapies that also entail safeguarding the rights of people with mental illness.

Following the Anjana Harish case, there were some questions about whether India requires specific laws banning conversion therapies against LGBT+ people. But there have also been very valid arguments that the current legal system already comprises safeguards against conversion treatments. Article 14 of the Constitution that guarantees the Right to Equality, Article 19(1)(a) that guarantees Freedom of Speech and Expression and Article 21 Right to Life, the Mental Healthcare Act (2017) [28] and the Navtej Singh Johar judgment are some of the existing legal safeguards against conversion therapies for gender and sexual minorities. These legal provisions also protect the rights of people with mental illness and/or those who seek mental health treatments in general. The Navtej Singh Johar judgment, in its reference to the MHCA to read down Section 377, also enables for further amendments to existing laws to safeguard the rights of people with mental illness. While distinctive laws banning conversion treatments as they exist in Taiwan, Brazil, Ecuador and Malta could push states and healthcare professionals to take an explicit stand against conversion therapies rather than remain neutral, they do not necessarily guarantee that conversion therapies will not take place [3]. Such bans would just force conversion therapy practices to go underground and be carried out by unregulated practitioners in non-healthcare settings, which is already the current scenario [29]. Bans specifically against conversion therapies can very likely have some implications for the formal healthcare sector but might not be effective for the large unregulated healthcare sector and religious sources of conversion therapy in India. Moreover, as discussed in the beginning of the paper, conversion efforts might not take on explicitly “therapeutic” forms and could be in the form of various kinds of persuasion tactics adopted by the family, the community, educational institutions or places of work, which might or might not be explicitly coercive. Therefore, a range of protections against conversion treatments that are included within various existing legislations pertaining to child protection, domestic violence, anti-rape, consumer protection, labour and others could be contemplated to increase the scope of protection of LGBT+ people against conversion therapies, if at all any further legislative protections against conversion therapy are sought. In other words, all laws that protect the rights of LGBT+ people in various avenues of social life are safeguards against conversion therapies. This paper adopts the stance that further legislative measures against conversion therapies are unnecessary and the MHCA, which offers protections to LGBT+ people alongwith people with mental illnesses, are adequate.

Anjana’s case illustrates an important limitation in attempts to impose bans on conversion treatments, which is the role of the family in coercing people into conversion treatments. Families have been found to play a decisive role in subjecting LGBT+ people to conversion treatments [8]. It is likely that most people would hesitate to report instances of conversion therapy if there is a possibility of their family members being subjected to strict legal sanctions [2]. Counselling of families and sensitization efforts are likely to be more effective. This is true for instances of conversion therapies carried out by religious figures or community leaders wherein people might hesitate to report such instances for fear of retaliation from the community [2]. The need for community sensitization and awareness is also emphasized in the care of people with mental illness. Mental health advocacy efforts that include community sensitization and the facilitation of care of people with mental illness in community settings help change attitudes towards mental health to include human rights approaches to caring for people with mental illness. Integrating knowledge about gender and sexual diversity in mental health literacy efforts would help to bring down attitudinal barriers against people with mental illness and LGBT+ people and are essential accompaniments to existing legislative measures.

For healthcare professionals, and mental healthcare professionals in particular, arguments grounded in professionalism and bioethics could be used to advocate for the rights of people with mental illness and against conversion therapies on LGBT+ people. The American Psychiatric Association [30] and the American Psychological Association [31] have clearly stated their stance that conversion therapies are unethical since there is no evidence to prove that gender and sexual variance are psychiatric disorders and in need of treatment. Moreover, there is no evidence to suggest that conversion therapies work. Over 65 professional organizations of healthcare and mental healthcare professionals from across the world have issued statements against conversion therapies [2,3]. The Indian Psychiatric Society [32], Indian Association of Clinical Psychologists [33] and the Association of Psychiatric Social Work Professionals [34] have issued statements against conversion therapies following the Anjana Harish case. These statements clearly demarcate the boundaries of psychology, psychiatry and other fields of modern medicine to exclude conversion therapies as unethical and not evidence-based [2,3,11]. In advocating against conversion therapies, these professional bodies are taking an initiative to make mental healthcare safer, more accessible and more scientifically and ethically grounded for everyone, and not just for LGBT+ people. In India, some studies have pointed out that mental health professionals in India have kept changing their attitudes towards conversion therapies and the non-pathological status of homosexuality in accordance with court judgments regarding the same [35]. It is likely that with the decriminalization of homosexuality, there will likely be increasing consensus among mental health professionals about accepting gender and sexual diversity as forms of human diversity.

Professional ethics become an important way to discourage conversion therapies particularly in India where there is an inconsistent licensure system, particularly for psychology [36]. There is also a severe dearth of licensed mental health professionals and professional mental health services and a blurring of the distinction between the formal and the informal sectors in healthcare in general [36,37]. Defining professional boundaries and ethics becomes all the more imperative to ensure the legitimacy of professional mental health services [38].

In terms of biomedical ethics, conversion therapies violate all four principles of autonomy, beneficence, non-maleficence and justice [39]. Some studies on medical practitioners’ attitudes to conversion treatments have revealed ambiguous justifications for carrying out these therapies [40]. One of the reasons that practitioners have given for conversion therapies is that people sometimes seek out these therapies themselves. Would denying patients treatment in these circumstances not be a violation of autonomy? This is a crucial ethical predicament that has been addressed by the American Psychological Association [11]. The report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation provides information and guidance to mental health professionals on helping people navigate possible conflicts between their religious beliefs and sexual orientation or any other experiences they might be having that urge them to seek out conversion therapies. The report guides mental health professionals in helping their patients think beyond fixed gender and sexual identities and accept the fluidity of these identities. The report clearly outlines the iatrogenic effects of conversion treatments including anxiety, depression, suicidal ideation, impotence and loss of sexual feelings among others and the lack of evidence for conversion therapies meeting their goal of eliminating gender and/or sexual variance. Thus, even in cases where patients request conversion therapies, it is unethical for a professional to comply. Doing so would be a violation of the ethical principles of non-maleficence and beneficence. It is the duty of the medical professional to give the patient the necessary information about the dangers of conversion therapy and to help alleviate their distress in order to facilitate informed decision-making. Merely giving in to a demand for conversion therapy is not a respect of the person’s autonomy. Moreover, conversion therapies are premised on a devaluation of gender and sexual diversity, which makes them inherently unjust. Just as it would be unethical – and potentially illegal – for a healthcare professional to administer any kind of medication or therapy simply on the patient’s demand when the professional is aware of its ineffectiveness and potentially dangerous effects, the same argument is true for conversion therapies, as well.

**Conclusion**

That conversion therapies are unethical because gender and sexual diversity are not psychiatric disorders is undoubtedly true and widely accepted. However, the elimination of conversion therapies is imperative not only for the well-being of LGBT+ people but also to improve the functioning of mental healthcare systems as a whole. No person with a mental illness or seeking mental health treatment should be subjected to unethical, unjust, unscientific and ineffective treatments that violate their rights. Analyzing accounts of conversion treatments would help to reveal many of the difficulties entailed in identifying, documenting, measuring and curbing these practices. These analyses also reveal the violations of rights of people with mental illness and/or those seeking mental health treatments. The present study used the Anjana Harish case to document some of the problems associated with conversion therapies and attempted to show how the rights of LGBT+ people are closely linked with the rights of people with mental illness and that various provisions of the MHCA which aim to protect the rights of people with mental illness and demand accountability from mental health professionals and establishments help to curb conversion therapies. It is hoped that studies emphasizing the ways in which the rights of LGBT+ people are implicated in the rights of people with mental illness will enable stronger networks between these two groups, which would help in mutual depathologization although being LGBT+ people in itself is not a mental illness. The study also emphasized the need for efforts to curb conversion therapies to be addressed through various existing legal provisions, community sensitization efforts, integration with mental health advocacy efforts, professional ethics and bioethics. This approach would shift LGBT+ issues and conversion therapies as minority concerns to using LGBT+ perspectives to build more effective and ethical mental healthcare systems for everyone.

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1. A “cisgender” person is one who identifies with and accepts the gender that was assigned to them at birth. A “heterosexual” person is one who is sexually attracted to people of the opposite sex. [↑](#endnote-ref-1)
2. Iatrogenesis refers to illnesses that are caused by medical interventions. [↑](#endnote-ref-2)
3. “Family” in the Act is still defined as “a group of persons related by blood, adoption or marriage” and there could still be tensions in mental healthcare decision-making for LGBT+ people between the family and the nominated representative who might not be a member of the person’s family in the sense determined by the Act. But the Act provides for decision-making by nominated representatives, which could potentially safeguard the decision-making rights of LGBT+ people. [↑](#endnote-ref-3)
4. This particular provision is considered to be a rationale for safeguarding the rights of people with mental illness under the Hindu Marriage Act (1955) and the Special Marriage Act (1954) where mental illness is the grounds for divorce. This discriminates between mental illness and physical illness and the MHCA can be used to contest it (Kapoor). [↑](#endnote-ref-4)
5. The MHCA is based on the UNCRPD and reflects many of its provisions. [↑](#endnote-ref-5)