MENTAL HEALTH RIGHTS IN INDIA: A PSYCHO-LEGAL AND CONSTITUTIONAL ANALYSIS WITH EMPIRICAL INSIGHTS

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ABSTRACT

Mental health is increasingly recognised as a constitutional and psycho-social concern in India. Judicial interpretations of Articles 14, 15, 19 and 21 affirm mental health as integral to the right to life and dignity, yet enforcement faces systemic challenges. This paper presents a dual inquiry: an empirical psycho-legal study of thirty postgraduate law students using the PHQ-9, the Beck Depression Inventory ('BDI') and the Big Five Personality Test, and a doctrinal analysis of the Indian constitutional and legislative mental health framework. The findings reveal considerable levels of depressive symptomatology among the sample, with descriptive associations to personality traits that merit institutional attention. Despite the Mental Healthcare Act 2017 codifying mental healthcare as a legal right, gaps in implementation, stigma and infrastructural limitations persist. By reading the empirical data alongside constitutional jurisprudence and recent University Grants Commission ('UGC') policy on student wellbeing, the paper argues for a rights-based institutional framework and identifies concrete legal levers, including section 115 of the Mental Healthcare Act 2017 and the UGC's 2022 to 2023 and 2026 provide collective guidelines capable of converting mental health rights from aspirational ideals into enforceable entitlements. Given the modest sample size, the empirical findings are presented as indicative rather than generalisable, and are offered to illustrate, not establish, the scale of the problem.

Keywords: Mental Health Rights; Psycho-Legal Study; Student Wellbeing; Mental Healthcare Act 2017; Higher Education; Depression and Anxiety among Students.

I. INTRODUCTION

Mental health is an essential component of overall wellbeing and human dignity, increasingly recognised as integral to the right to life under the Indian Constitution.[1] Over recent decades, judicial interpretation of Articles 14, 15, 19 and, most notably, Article 21 has progressively incorporated mental health within the ambit of the right to health as a fundamental right. The Supreme Court of India has held that the right to life guaranteed by Article 21 extends beyond mere survival to encompass the right to live with dignity, which unequivocally includes mental wellbeing.

India's legislative landscape was transformed by the enactment of the Mental Healthcare Act 2017 ('MHCA').[2] The Act introduces provisions on access to mental healthcare services, protection from inhumane treatment, advance directives and nominated representatives, aligning domestic law with international human rights standards, in particular the UN Convention on the Rights of Persons with Disabilities.

Despite these legal and constitutional developments, enforcement of mental health rights remains fraught with systemic challenges. Educational institutions, where a significant proportion of young adults spend their formative years, report high levels of stress, anxiety and depression among students,[3] with implications for academic performance, social functioning and quality of life. This paper presents a dual inquiry into the status of mental health rights in India, combining doctrinal analysis of the constitutional and legislative framework with an empirical psycho-legal study of postgraduate law students using the PHQ-9, the BDI and the Big Five Personality Test. The empirical component is exploratory: it is intended to illustrate how legal entitlements translate or project or fail to translate or fail to project into lived experience within a single institutional setting, not to generalise prevalence rates to Indian law students as a class.

The doctrinal foundations summarised in Part II build on and substantially extend the author's earlier constitutional analysis of this framework;[4] that analysis is treated here in condensed

[1]See Anjali Puranik, 'Mental Health and Constitutional Law in India' (2021) 5(2) Indian Law Review 144, for a detailed analysis of how constitutional provisions intersect with mental health rights in India.
[2]Mental Healthcare Act 2017 (India), Act No 10 of 2017.
[3]G Balamurugan and others, 'Mental Health Issues among School Children and Adolescents Aged 19 Years and Under in India: A Systematic Review' (2024) 24 BMC Public Health 1456.
[4]Ruthresh Kumaran M, 'Constitutional Analysis of the Nature and Enforceability of Mental Health Rights in India' (2025) 3(2) White Black Legal Law Journal 4912.

form, with fuller doctrinal reasoning left to the earlier piece, so that this paper's space is directed to its own distinct contribution: the empirical psycho-legal data in Part IV, the UGC regulatory framework in Part II.B, and the operationalisation of MHCA section 115 through that empirical data in Part V, none of which formed part of the earlier analysis.

II. CONSTITUTIONAL AND REGULATORY FRAMEWORK

Mental health rights in India are anchored in constitutional provisions and recent legislative and regulatory reform, particularly in the post-pandemic period. Although the Constitution does not explicitly mention 'mental health', its provisions have been expansively interpreted by the judiciary to encompass mental wellbeing as intrinsic to fundamental rights.[5] The doctrinal route by which the judiciary reached this position while running through *Francis Coralie Mullin v Administrator, Union Territory of Delhi* on dignity as a component of Article 21, *Bandhua Mukti Morcha v Union of India* on the state's positive obligation to secure conditions for a life of dignity, *Sheela Barse v Union of India* on humane treatment in custodial and institutional settings, and the suo motu proceedings following the Erwadi fire on regulation of psychiatric institutions specifically sets out at length in the author's earlier doctrinal treatment of this framework and is not repeated in full here.[6] What matters for present purposes is the settled conclusion those cases establish: Article 21's guarantee of a dignified life encompasses mental wellbeing, and the state bears a positive obligation to secure the institutional conditions that make that guarantee real, the obligation against which Parts IV and V below test one institution's practice.

The MHCA marks a paradigm shift toward a rights-based framework, affirming the legal entitlement of persons with mental illness to access quality mental healthcare without discrimination.[7] Section 18 affirms the right of every person to access mental healthcare and treatment from services run or funded by government, mandating that such services be affordable, of good quality, geographically accessible and provided without discrimination. Mental Health Review Boards provide institutional oversight and grievance redressal. The Act's alignment with India's obligations under the UN Convention on the Rights of Persons

[5]Constitution of India 1950, arts 14, 15, 19 and 21. These provisions collectively underpin the rights-based approach later adopted in the Mental Healthcare Act 2017.
[6]Francis Coralie Mullin v Administrator, Union Territory of Delhi (1981) 1 SCC 608; Bandhua Mukti Morcha v Union of India AIR 1984 SC 802; Sheela Barse v Union of India (1986) 3 SCC 632; In re: Deaths of 25 Chained Inmates in Asylum Fire in Tamil Nadu, Suo Motu WP (C) No 334 of 2001 (SC). For fuller treatment of this line of authority, see Kumaran (n 4).
[7]Mental Healthcare Act 2017, Statement of Objects and Reasons.

with Disabilities[8] underscores its transformative intent, though scoping reviews of clinical and stakeholder opinion identify persistent concerns about clinical feasibility, caregiver burden and implementation capacity.[9] A 2021 Parliamentary Standing Committee review found insufficient infrastructure, a critical shortage of trained mental health professionals and poor budgetary prioritisation across public mental health institutions.[10]

A. Section 115 and the Decriminalisation of Attempted Suicide

Of particular relevance to a student population is section 115 of the MHCA, which decriminalises attempted suicide and creates a statutory presumption that a person who attempts suicide was, unless proved otherwise, under 'severe stress' and is entitled to care, treatment and rehabilitation from the appropriate government rather than prosecution under section 309 of the (now repealed) Indian Penal Code.[11] The author has previously noted this provision's significance in decriminalising suicide as a mental health concern rather than a criminal act.[12] This paper develops that observation further by connecting the section 115 presumption directly to the empirical severity data reported in Part IV: where a validated instrument places a student in the moderate-to-severe depression range, section 115 supplies the statutory basis for treating that student as a person under severe stress entitled to institutional care, not disciplinary or academic penalty. That operational link between a psychometric finding and a statutory presumption which are rather than the existence of section 115 itself but it is the contribution of this Part.

B. UGC Regulatory Framework for Higher Educational Institutions

The doctrinal and statutory framework above operates alongside a distinct regulatory layer specific to higher education, which is the setting of the empirical study reported in this paper. In 2022 to 2023, the UGC issued Guidelines for Promotion of Physical Fitness, Sports, Students' Health, Welfare, Psychological and Emotional Well-Being at Higher Educational Institutions of India, directing every higher educational institution ('HEI') to establish a Student

[8]Convention on the Rights of Persons with Disabilities (adopted 13 December 2006, entered into force 3 May 2008) 2515 UNTS 3.
[9]NA Uvais and others, 'Perceptions regarding the Indian Mental Healthcare Act 2017: A Scoping Review' (2024) 93 Asian Journal of Psychiatry 103914.
[10]Parliamentary Standing Committee on Health and Family Welfare, Report on the Functioning of the Mental Healthcare Act 2017 (Rajya Sabha 2021).
[11]Mental Healthcare Act 2017, s 115.
[12]Ruthresh Kumaran (n 4).

Services Centre responsible for stress and emotional adjustment support and to embed mental health support within campus life.[13] More recently, following the Supreme Court's observations on student suicides linked to academic pressure in *Sukdeb Saha v State of Andhra Pradesh*, the UGC circulated draft Guidelines on a Uniform Policy on Mental Health and Well-Being for Higher Educational Institutions, which as of this writing remain at the public consultation stage. The draft guidelines would mandate a dedicated Mental Health and Well-Being Centre and a monitoring committee in every HEI, with one mental health professional for every hundred students and a twenty-four-hour helpline.[14] Together, the 2022 to 2023 guidelines and the 2026 draft form the most direct regulatory bridge between the constitutional and MHCA framework discussed above and the institutional duty of care owed specifically to students such as those surveyed in this study.

III. METHODOLOGY AND ETHICAL PROTOCOL

This study adopts a mixed-method design combining doctrinal legal analysis with an empirical psycho-legal survey of postgraduate law students. Data were collected through the anonymous administration of three validated instruments using the PHQ-9, the BDI and the Big Five Personality Test, introduced to thirty postgraduate law students (ten male, twenty female) at a single institution. Participation was voluntary, responses were anonymised, and informed consent was obtained prior to administration.

The instruments are described below.

PHQ-9 (Patient Health Questionnaire-9): a clinically validated nine-item tool screening and measuring depression severity based on DSM-IV criteria. Each item is scored 0-3, giving a total range of 0-27, interpreted as 0-4 (minimal), 5-9 (mild), 10-14 (moderate), 15-19 (moderately severe) and 20-27 (severe).[15]

Beck Depression Inventory (BDI): a twenty-one-item self-report instrument, each item

[13]University Grants Commission, Guidelines for Promotion of Physical Fitness, Sports, Students' Health, Welfare, Psychological and Emotional Well-Being at Higher Educational Institutions of India (UGC, first circulated 6 May 2022, issued 2023).

[14]Sukdeb Saha v State of Andhra Pradesh 2025 SCC OnLine SC 1515; University Grants Commission, Draft Guidelines on Uniform Policy on Mental Health and Well-Being for Higher Educational Institutions (circulated for public consultation, 13 January 2026). As these guidelines were in draft form at the time of writing, their final content and date of notification should be verified before this paper is finalised for publication.

[15]Kurt Kroenke, Robert L Spitzer and Janet BW Williams, 'The PHQ-9: Validity of a Brief Depression Severity Measure' (2001) 16(9) Journal of General Internal Medicine 606, reporting that a score of 10 or above shows 88% sensitivity and specificity for major depression.

scored 0-3, giving a total range of 0-63, interpreted as 0-13 (minimal/normal), 14-19 (mild), 20-28 (moderate) and 29-63 (severe).[16] The PHQ-9 and BDI were administered concurrently to permit cross-validation of self-reported depressive symptoms; formal concordance between the two instruments (e.g. a correlation coefficient between total scores) was not computed for this dataset and is flagged as an analysis to be completed before a revised version of this paper is submitted.

Big Five Personality Test: measures five broad personality dimensions - Openness, Conscientiousness, Extraversion, Agreeableness and Neuroticism ('OCEAN') used here to explore descriptive associations with depression scores.[17]

A. Ethical Protocol

Administration followed standard protocols for anonymous survey research involving human participants, including informed consent, voluntary participation, and confidentiality of individual responses; no identifying information was collected or retained.

B. Limitations

Four limitations should be read into every finding in Part III. **First**, the sample (n = 30) is drawn from a single institution by convenience sampling and is not representative of postgraduate law students, or students generally, in India; prevalence figures below describe this cohort only. **Second**, the design is cross-sectional and self-report, which permits description of association but not causal inference between personality traits and depression severity. **Third**, no inferential statistics (correlation coefficients, regression, significance testing) were computed on the study's own data; the associations described in Part III.C are therefore reported as descriptive/observational patterns in the sample, not as statistically established relationships, pending further analysis. **Fourth**, the absence of a comparison group (e.g. students outside the law faculty, or a normative population sample) means the severity distribution cannot be benchmarked against a baseline within this study.

[16]Aaron T Beck and Robert A Steer, Beck Depression Inventory Manual (Psychological Corporation 1987); see also Yuan-Pang Wang and Clarice Gorenstein, 'A Systematic Review of the Utility of the Beck Depression Inventory for Detecting Depression in Medical Settings' (2013) 33(7) Clinical Psychology Review 943, noting that recommended cut-off scores vary by clinical setting and population.
[17]Robert R McCrae and Paul T Costa, 'A Contemplated Revision of the NEO Five-Factor Inventory' (2004) 36(3) Personality and Individual Differences 587.

IV. EMPIRICAL FINDINGS

A. PHQ-9 Results

Minimal: 10% (3 students); Mild: 40% (12 students); Moderate: 33.3% (10 students); Moderately Severe: 10% (3 students); Severe: 6.7% (2 students). On the PHQ-9, exactly half of the sample (50%) scored in the moderate-to-severe range (moderate, moderately severe and severe combined).

B. Beck Depression Inventory Results

Normal ups and downs: 30% (9 students); Mild mood disturbance: 26.7% (8 students); Borderline clinical depression: 6.7% (2 students); Moderate depression: 26.7% (8 students); Severe depression: 10% (3 students). Combining the borderline, moderate and severe categories, 43.4% of the sample scored at or above the threshold of borderline clinical depression on the BDI - this is the source of the '43%' figure referenced in the Conclusion, and is reported here as a BDI-specific statistic rather than a general finding, given that it does not match the PHQ-9 moderate-to-severe proportion (50%) reported above.

C. Big Five Personality Test - Descriptive Associations

Descriptive review of the personality data alongside depression scores shows elevated neuroticism and openness scores among students with higher depression severity, and comparatively lower depression scores among students with higher extraversion scores — a pattern broadly consistent with the wider literature, in which neuroticism is repeatedly identified as the strongest personality predictor of psychological distress[18] and social engagement is associated with lower depressive symptoms. As noted in Part III.B above, these associations are descriptive rather than statistically tested within this dataset, and should be read as hypotheses for confirmatory analysis rather than established findings.

[18]Rekha Rajesh and JMA Patel, 'Big Five Personality Factors and Mental Health among the Students of Annamalai University' (2017) 8(12) International Journal of Recent Scientific Research 22367; 'Association of "Big Five" Personality with Perceived Stress in Medical Postgraduates: A Cross-Sectional Study' (2021) 7(1) Journal of Medical Sciences and Health 15, reporting a positive correlation between neuroticism and perceived stress ($r = +0.607$, $p < 0.001$) in a comparable postgraduate sample.

D. Gender-Based Distribution

Female students in the sample showed a slightly higher rate of severe depression than male students (2 of 20 female students compared with 0 of 10 male students), while moderate depression was the most frequently observed category across both genders. Given the small cell sizes involved (a difference of two individuals), this should be treated as an observation for further study rather than a statistically robust gender effect; it is nonetheless directionally consistent with broader literature reporting gender differences in depression prevalence among university students.[19]

V. PSYCHO-LEGAL INTERSECTIONS

The empirical findings, read cautiously in light of the limitations set out in Part III.B, intersect with constitutional and statutory obligations in three respects. **First**, under Article 21, the proportion of students scoring in the moderate-to-severe range on validated depression instruments raises a live question as to whether the institution has discharged its duty to secure conditions consistent with a dignified life, as elaborated in *Francis Coralie Mullin*. **Second**, under Article 14, unequal access to institutional mental health support for instance, the absence of a dedicated counsellor or Student Services Centre of the kind envisaged by the UGC's 2022–2023 guidelines may constitute unequal treatment of students with differing support needs. **Third**, the presence of severe depressive symptoms in a small but real proportion of the sample engages section 115 of the MHCA directly: any student presenting with suicidal ideation or a suicide attempt is, by statutory presumption, to be treated as a person under severe stress entitled to care and treatment, not discipline or exclusion, and the institution's obligations under section 18 (accessible, quality, non-discriminatory mental healthcare) apply with particular force to that population.

A fourth, more tentative claim can be made under Article 19(1)(a): sustained psychological distress may, as a matter of policy rather than settled doctrine, impair a student's practical capacity to participate in academic expression, debate and civic life. This is best understood as a normative argument for institutional reform rather than a presently litigable Article 19 claim, since Article 19 doctrine is concerned with state-imposed restrictions on expression rather than

[19]Compare EM Vaughan and others, 'Symptom Prevalence Differences of Depression as Measured by the Beck Depression Inventory and Patient Health Questionnaire in Adults with Overweight or Obesity and Type 2 Diabetes' (2019) 157 Diabetes Research and Clinical Practice 107880, on divergence between BDI and PHQ-9 symptom prevalence estimates more generally.

psychological capacity as such; establishing an Article 19 cause of action would require demonstrating a sufficient nexus between institutional inaction and a restriction attributable to the state or a state instrumentality. This paper flags the argument as a direction for further doctrinal work rather than asserting it as established law.

Despite the MHCA's progressive framework, the Act's promise of accessible, quality mental healthcare under section 18 remains substantially unrealised in educational contexts. Students' reluctance to seek help, driven by stigma and low institutional awareness, reflects the broader implementation barriers documented in parliamentary and scoping reviews of the Act.[20] The National Human Rights Commission has separately identified systemic gaps in MHCA implementation, including staff shortages and failure to uphold statutory mandates for community-based care, underscoring the state's constitutional and international obligations to protect the dignity and autonomy of persons with mental illness.[21] The absence of trained counsellors, regular mental health screening and structured awareness programmes in the surveyed institution, read against the UGC's 2022–2023 and 2026 guidelines discussed in Part II.B, constitutes a documented gap between regulatory expectation and institutional practice.

VI. CONCLUSION AND RECOMMENDATIONS

This study's integration of doctrinal constitutional analysis with an exploratory empirical survey reveals a gap between India's progressive mental health legal framework and its practical implementation in one educational setting. Constitutional recognition of mental health as integral to the right to life under Article 21, together with the MHCA's rights-based approach and the UGC's evolving regulatory guidance for HEIs, provides a robust legal foundation for student mental health protection. Within the surveyed cohort, 43.4% of students scored at or above the threshold of borderline clinical depression on the BDI, and 50% scored in the moderate-to-severe range on the PHQ-9; given the sample size and single-institution design set out in Part III.B, these figures should be read as indicative of a problem worth further, larger-scale investigation, not as a generalisable prevalence estimate for Indian law students.

The following recommendations are tied to specific legal and regulatory instruments identified

[20]Uvais and others (n 8); Parliamentary Standing Committee (n 9).
[21]National Human Rights Commission, Mental Health and Human Rights: In the Context of the Mental Healthcare Act 2017 (NHRC 2023).

in this paper:

1. **Institutional grievance and screening mechanisms under MHCA section 18:** institutions should establish a documented pathway by which a student's right to accessible, quality mental healthcare under section 18 can be invoked and tracked, rather than relying on informal referral.

2. **Section 115 protocols:** institutions should adopt a written protocol treating any disclosed suicide attempt or ideation as triggering the section 115 presumption of severe stress, with a care-first response and an explicit bar on disciplinary action for the attempt itself.

3. **Compliance with UGC 2022–2023 guidelines:** establishment of a functioning Student Services Centre, rather than a nominal one, with a trained counsellor and a defined caseload capacity.

4. **Preparedness for the 2026 UGC draft guidelines:** institutions should begin phasing in the counsellor-to-student ratio and monitoring committee structure proposed in the January 2026 draft guidelines ahead of any final notification.

5. **Confirmatory research:** a follow-up study with a larger, multi-institution sample, formal inferential statistics, and a documented ethics committee clearance is needed before the associations reported in Part IV.C can inform policy design with confidence.

Achieving effective mental health rights enforcement in higher education requires coordinated action across the judiciary, the legislature, the UGC and individual institutions. The path from aspirational right to lived entitlement runs, on the evidence of this paper, through specific and monitorable instruments especially section 18 and section 115 of the MHCA and the UGC's institutional guidelines rather than through constitutional recognition alone.

REFFERENCE

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