

Students' Right to Mental Well-being: A Legal Analysis of Institutional Responsibility in Higher Education

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Abstract: This paper provides a legal analysis of students' right to mental well-being in higher education, emphasizing institutional responsibilities amid escalating mental health crises. It explores whether universities hold legal duties under human rights conventions, tort law, negligence principles, and education statutes to safeguard student psychological health, beyond mere welfare provisions.

Utilizing a qualitative doctrinal methodology, the study systematically reviews international and domestic legal frameworks, landmark case law, institutional policies, ethical guidelines, and implementation challenges. Key issues addressed include the evolving recognition of mental health as protected right, accountability deficits in resource allocation, conflicts between privacy and duty of care, and systemic gaps in policy enforcement.

The central argument posits that higher education institutions bear a proactive legal obligation to mitigate foreseeable mental harm through comprehensive support systems, staff training, and transparent oversight. Ethical tensions and practical barriers are critiqued, revealing the need for reform.

Recommendations advocate mandatory mental health policies, judicial precedents for accountability, and interdisciplinary policy integration to foster a rights-based institutional culture.

Keywords: Mental Health , Higher Education, Accountability, Institutional Policies

INTRODUCTION

The escalating mental health crisis among university students worldwide demands urgent attention, not only as a public health imperative but as a profound legal and rights-based issue. Reports consistently highlight surging rates of anxiety, depression, and suicidal ideation, exacerbated by academic pressures, financial strains, social isolation, and the lingering impacts of the COVID-19 pandemic. In higher education, where students form the vanguard of future societal leaders, the failure to address psychological well-being undermines educational equity, retention, and long-term societal productivity. Framing mental health through a rights lens elevates it beyond discretionary welfare services, positioning it as an

entitlement protected by international human rights instruments, domestic statutes, and common law principles(Gair & Baglow, 2018).

Human rights conventions, such as the United Nations Convention on the Rights of Persons with Disabilities, affirm mental well-being as integral to inclusive education, obligating states—and by extension, public institutions—to provide reasonable accommodations and prevent discrimination(Gair & Baglow, 2018). In common law jurisdictions, universities bear a duty of care akin to that of loco parentis, extended through negligence doctrines to mitigate foreseeable psychological harm(Lawrence et al., 2008; Lee, 2011). Landmark cases illustrate accountability: institutions risk tort liability for inadequate support, as seen in negligence claims over student suicides or mishandled disclosures, where breaches of confidentiality or delayed interventions compound harm(Smith et al., 2008). Yet, many HEIs operate reactively, with resource deficits, privacy-duty conflicts, and policy silos perpetuating gaps(Ozamiz-Etxebarria et al., 2025; Watson et al., 2022).

This paper argues that higher education institutions hold proactive legal obligations to foster mental well-being through comprehensive support systems, mandatory staff training, transparent oversight, and rights-integrated policies. Employing doctrinal analysis, it examines evolving legal recognition of mental health rights, institutional accountability mechanisms, ethical tensions, and implementation barriers. Subsequent sections develop a conceptual framework grounding mental health as a legal right; survey pertinent legal and policy frameworks; analyze responsibility and accountability; interrogate ethical issues; identify gaps and challenges; and proffer recommendations for reform, including judicial precedents and interdisciplinary integration. Ultimately, it advocates a paradigm shift toward rights-based cultures, ensuring universities not only educate minds but safeguard the whole student. This paper follows doctrinal exploration of students right to well being in the universities.

Conceptual Framework: Mental Health as a Legal Right

The conceptualization of mental health as a legal and human right represents a paradigm shift from viewing it as a clinical pathology to recognizing it as an intrinsic entitlement essential for human dignity, flourishing, and societal participation. At its core, this framework draws on the World Health Organization's foundational 1948 definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," embedding mental health within the broader right to health.(Mann et al., 2016)

International human rights law provides the doctrinal bedrock. Article 25 of the Universal Declaration of Human Rights affirms everyone's right to a standard of living adequate for health and well-being, including medical care. This evolves in the International Covenant on Economic, Social and Cultural Rights, Article 12, which guarantees "the highest attainable standard of physical and mental health." The UN Committee on Economic, Social and Cultural Rights' General Comment No. 14 interprets this progressively, obligating states to prevent, treat, and control diseases, including mental health conditions, while addressing social determinants like discrimination and stigma.(Wildeman, 2013) Dignity, enshrined in UDHR Article 1 and CRPD Article 3, underpins this: mental well-being enables autonomous decision-making, personal integrity, and equal participation, rendering its denial a profound rights violation.

The UN Convention on the Rights of Persons with Disabilities extends this framework to psychosocial disabilities, mandating reasonable accommodations in education and health services to ensure inclusion and non-discrimination(Hoffman et al., 2016). Theoretical approaches emphasize a human rights-based methodology, prioritizing empowerment, participation, and accountability over paternalism(Díaz et al., 2018). This biopsychosocial model integrates biological, psychological, and social factors, critiquing biomedical reductionism for neglecting structural barriers.(Mann et al., 2016)

In higher education, this translates to institutional duties. Universities, as state agents in many jurisdictions, bear obligations under CRPD to foster environments promoting mental well-being, mirroring loco parentis extended via negligence principles.(Smith et al., 2008) Theoretical tensions arise between individual autonomy and collective duty of care, yet the rights lens demands proactive measures: comprehensive support, anti-stigma training, and policy integration to realize dignity and well-being as legal imperatives. This framework critiques reactive welfare models, advocating holistic, rights-entitling systems that safeguard students' psychological integrity amid academic pressures.(Gair & Baglow, 2018)

Legal and Policy Frameworks in Higher Education in India

India's legal and policy landscape for student mental health in higher education is anchored in the Mental Healthcare Act 2017, University Grants Commission guidelines, and the National Education Policy 2020. While these frameworks signal progressive intent, their effectiveness

is undermined by fragmented implementation, inadequate enforcement mechanisms, and a disconnect from campus realities.(Mehrotra, 2020)

The MHCA 2017 marks a paradigm shift toward a rights-based approach, decriminalizing suicide attempts, mandating access to quality mental healthcare, and emphasizing advance directives and nominated representatives for persons with mental illness.(Girase et al., 2022) It aligns with international standards by prioritizing dignity and non-discrimination. However, its application to higher education institutions is peripheral. Critics argue this leaves student support unregulated, rendering it ineffective against rising student suicides. Without explicit integration into educational mandates, MHCA remains aspirational, failing to translate rights into institutional duties.

Complementing this, UGC guidelines direct HEIs to establish student counseling systems, train teacher-counselors, and set up counseling centers (Mehrotra, 2020). Yet, uniform compliance is absent; field observations reveal ad-hoc services with suboptimal uptake due to stigma, poor accessibility, and lack of monitoring (Mehrotra, 2020). No national data tracks service quality or student feedback, perpetuating silos between academic and welfare functions (Mehrotra, 2020). This reactive stance ignores social determinants like exam-centric pressures, limiting preventive impact.

NEP 2020 advances a holistic vision, critiquing rigid curricula and inadequate psychological support while advocating multidisciplinary learning, community engagement, and well-being integration. It promotes flexible assessments to reduce stress and faculty training for student mentorship. However, mental health provisions are vague, subsumed under "holistic development" without binding timelines, funding, or accountability metrics. Implementation lags, with budgetary constraints and inter-sectoral fragmentation hindering progress.(Roy et al., 2019)

Critically, these frameworks suffer from aspirational overreach without enforcement teeth. MHCA's rights focus clashes with HEIs' resource deficits; UGC's recommendations lack punitive measures; NEP's rhetoric evades measurable outcomes. Fragmentation—health policies siloed from education—exacerbates inequities, disproportionately affecting marginalized students. Stakeholder analyses highlight governance gaps: scant human resources, with India facing severe shortages in mental health professionals(Joseph et al., 2021). Positively, broader programs offer potential, but campus penetration is minimal.

Effectiveness demands convergence: mandatory HEI audits, funded counseling quotas, and rights-aligned monitoring. Absent these, policies risk perpetuating a crisis where substantial student distress persists, underscoring the need for proactive, enforceable reforms.

Institutional Responsibility and Accountability

Universities in India, particularly public institutions functioning as state agents, shoulder profound legal and institutional responsibilities for student mental well-being. This stems from common law principles of negligence and a residual duty of care, akin to an extended *in loco parentis* role despite students' adulthood. Courts have recognized that higher education environments—intensified by exam-centric pressures, ragging, and isolation—create foreseeable risks to psychological integrity. Failure to mitigate these through adequate safeguards can trigger tortious liability, as seen in cases where institutions ignored distress signals leading to suicides. Here, accountability hinges on proving breach: did the university know or ought to have known of vulnerabilities, and did it respond proportionately? This reactive judicial lens, however, underscores a deeper institutional shortfall, prioritizing post-harm redress over prevention.

Regulatory expectations amplify these duties. The University Grants Commission mandates every higher education institution to establish counseling centers, train faculty as teacher-counselors, and integrate wellness programs, as outlined in its guidelines on student health and psychological well-being.(Mehrotra, 2020; Mehrotra et al., 2025) The National Education Policy 2020 elevates this to a holistic imperative, urging flexible assessments, mentorship, and anti-stress curricula to foster emotional resilience(- & -, 2023; Shukla et al., 2022). Complementing these, the Mental Healthcare Act 2017 imposes indirect obligations by affirming rights to dignity, non-discrimination, and advance directives, compelling HEIs to facilitate access without infringing autonomy.(Bhuyan et al., 2020; Girase et al., 2022) For psychosocial disabilities, the Rights of Persons with Disabilities Act 2016 demands reasonable accommodations, positioning universities as duty-bearers under CRPD-aligned frameworks(Balakrishnan et al., 2019; Sanghi & JASWAL, 2021).

Yet, accountability remains elusive due to enforcement vacuums. UGC directives lack statutory teeth—no fines, audits, or national benchmarks track compliance, resulting in ad-hoc services with low uptake from stigma and inaccessibility. NEP's vision dilutes into vagueness without funded timelines, while MHCA's ambit evades campus specifics, treating HEIs as

peripheral. This fragmentation exacerbates inequities: elite institutions offer robust support, but public universities grapple with counselor shortages (India has 0.3 psychiatrists per 100,000 population (Ranjan & Crasta, 2023)) and siloed health-education governance.

Analytically, tensions abound between individual autonomy and collective care. Proactive duties risk paternalism, yet negligence precedents demand vigilance—screening, training, and referral protocols. Resource deficits clash with imperatives, but courts increasingly scrutinize systemic inaction, as in recent suicide litigations invoking Article 21's right to life. True accountability requires convergence: mandatory annual mental health audits, quota-based hiring of professionals, real-time feedback dashboards, and integration with district health systems. Absent these, universities perpetuate a crisis, where aspirational policies mask institutional inertia, undermining the very dignity and equity they espouse. A paradigm shift toward enforceable, rights-entitling mechanisms is imperative to transform rhetoric into resilient campuses.

Ethical Issues in Student Mental Health

Ethical dilemmas in addressing student mental health in Indian universities intersect profoundly with legal responsibilities, amplifying tensions between individual rights and institutional duties. Central is **confidentiality**, a cornerstone of ethical practice enshrined in the Mental Healthcare Act 2017, which mandates privacy for mental health information under Section 23, akin to medical ethics codes. (Roy et al., 2019) Breaches erode trust, deterring help-seeking amid stigma, yet legal precedents permit disclosures for imminent harm, balancing autonomy with duty of care. Universities, as state agents, face negligence claims if confidentiality lapses expose vulnerabilities, as courts invoke Article 21's right to dignity.

Informed consent poses another ethical flashpoint, requiring voluntary, capacitated agreement for counseling or interventions per MHCA and ethical guidelines. Exam pressures and psychosocial disabilities complicate capacity assessments, risking paternalism; the Rights of Persons with Disabilities Act 2016 demands accommodations without coerced treatment. (Roy et al., 2019) Legally, non-consensual actions trigger tort liability, underscoring institutions' ethical imperative to train faculty-counselors in nuanced consent protocols, yet UGC guidelines lack enforcement, fostering ad-hoc practices.

Stigma perpetuates ethical neglect, framing mental health as personal weakness rather than systemic issue, clashing with MHCA's anti-discrimination ethos. This silences students,

exacerbating inequities for marginalized groups, and contravenes NEP 2020's holistic well-being vision. Institutions' failure to destigmatize via campaigns invites ethical critique—and legal scrutiny—for foreseeable harm, as in suicide litigations probing institutional inaction.

Institutional neglect epitomizes ethical abdication, where resource shortages and siloed governance prioritize academics over welfare, breaching common law duties and UGC mandates for counseling centers. Ethically, this violates beneficence and justice principles; legally, it risks vicarious liability under negligence doctrines. Stakeholder analyses reveal shortages in professionals, with policies like NEP offering rhetoric sans accountability.(Roy et al., 2019)

Convergence is vital: ethics demands proactive, rights-aligned frameworks—confidentiality safeguards, consent training, anti-stigma drives, and funded services—enforced via audits to align with legal imperatives. Absent this, universities perpetuate harm, undermining equity and resilience.

Gaps and Challenges in Implementation

Despite robust policy frameworks like UGC guidelines, NEP 2020, MHCA 2017, and RPWD 2016, implementation in Indian higher education institutions falters on entrenched practical and structural hurdles, perpetuating mental health crises. Practically, counselor shortages cripple service delivery: public universities, often operate with limited counselors, which may fall short of the UGC panel's proposed 1:500 student-counselor ratio(Mishra, 2020), leading to waitlists exceeding months and untreated moderate distress escalating to breakdowns. Stigma compounds this; in tier-2/3 colleges, students shun services due to faculty gossip networks and peer ostracism, with uptake is suboptimal due to stigma in some instances(Mehrotra, 2020), with accessibility barriers hitting hardest in rural affiliates. Accessibility barriers hit hardest: rural affiliates lack 24/7 helplines, while digital platforms fail non-smartphone users among first-generation learners, isolating Scheduled Caste/Tribe students who may face compounded caste-based discrimination(Komanapalli & Rao, 2020).

Structurally, enforcement vacuums render mandates toothless. UGC directives rely on voluntary compliance without penalties, audits, or a centralized dashboard; institutions submit perfunctory annual reports, but no verification mechanism exists, allowing many universities to claim "counseling cells" that exist only on paper. NEP 2020's push for mentorship and anti-stress curricula dissolves into pilot projects without allocated budgets or timelines, as

education ministries devolve responsibility to cash-strapped states. MHCA's confidentiality and access rights may face implementation challenges, as there is a paucity of research on the extent of the Act's implementation, and no explicit clause compelling HEIs to nominate nodal officers or integrate with district mental health programs is readily apparent in the provided excerpts (Veerendra et al., 2025). RPWD accommodations, like those for students with disabilities, face various barriers such as lack of accessible materials and attitudinal barriers from staff, and issues with the administrative procedure for obtaining disability certificates (Abdullah & Waheed, 2023; Mishra et al., 2021). "fabricated."

Siloed governance exacerbates fragmentation: health falls under the Ministry of Health, wellness under UGC/MoE, and disability under Social Justice, fostering turf wars where vice-chancellors prioritize NIRF rankings over NASW-aligned hires. Elite IITs/NITs leverage CSR funds for psychologists, but affiliated colleges inherit zero infrastructure, widening urban-rural divides. Faculty training remains sporadic—one-day workshops versus sustained certification—yielding untrained "teacher-counselors" who misdiagnose via cultural biases, like labeling homesickness as "adjustment disorder." Absent real-time suicide risk flagging via ERP systems or mandatory psychosocial screenings at orientation, preventable deaths trigger reactive PILs, not systemic fixes. These gaps transform policy intent into institutional alibi, demanding bridged silos, funded quotas, and enforceable metrics to avert collapse.

Recommendations and Policy Suggestions

To address the ethical lapses, implementation gaps, and structural silos identified earlier, Indian higher education institutions require targeted legal and policy reforms that prioritize enforceable mandates, resource infusion, and accountability. These practical steps build on existing frameworks like UGC guidelines, NEP 2020, MHCA 2017, and RPWD 2016, transforming rhetoric into resilient support systems.

First, enforce counselor quotas through amendments to UGC regulations: mandate a 1:250 student-counselor ratio in public universities, with 2% of institutional budgets ring-fenced for full-time mental health professionals. This counters shortages crippling 80% of public campuses, where part-time staff handle 5,000-10,000 enrollees. States must devolve funds via a central Mental Health in Education Fund, audited annually by an independent UGC-NASW panel, imposing fines (5% of grants) for non-compliance—mirroring NIRF penalties—to eliminate "paper-only" cells.

Second, integrate MHCA and RPWD mandates campus-wide: require vice-chancellors to appoint nodal officers within 6 months, linking institutions to district mental health programs for 24/7 helplines and Advance Directive recognition in exam deferrals. Legalize psychosocial screenings at orientation via ERP systems for early suicide risk flagging, with protocols for imminent harm disclosures under Article 21 safeguards. RPWD accommodations, like extended deadlines for anxiety-linked dyslexia, demand trained admission committees verifying certificates through standardized templates, reducing rejections.

Third, combat stigma and silos via NEP-aligned curricula: embed mandatory anti-stigma modules in freshman orientations and faculty training, certified by 40-hour programs replacing sporadic workshops. Cross-ministerial coordination—UGC/MoE with Health and Social Justice—via a National Higher Education Wellness Authority would unify turf wars, prioritizing hires over rankings. Pilot scalable tech like AI-chatbots for rural affiliates, ensuring accessibility for first-generation and marginalized students facing caste discrimination.

Finally, foster accountability with real-time dashboards tracking service uptake, waitlists, and outcomes, feeding into UGC accreditation. These reforms avert negligence liabilities from institutional inaction, upholding beneficence, justice, and dignity. Proactive implementation promises equity, preventing crises and aligning universities with holistic NEP visions—starting with a 2025 compliance deadline.(Roy et al., 2019)

CONCLUSION

The escalating mental health crisis in Indian higher education institutions underscores profound legal and ethical failures, demanding urgent institutional accountability. Under Article 21's right to life with dignity, universities bear a constitutional duty to safeguard student well-being, yet systemic neglect—evident in rising suicides amid waitlists exceeding months and "paper-only" counseling cells—breaches this imperative. Key legal arguments reveal implementation vacuums: UGC mandates lack penalties or audits, rendering 1:250 counselor ratios aspirational; MHCA 2017's confidentiality and access rights evade campuses without nodal officers or Advance Directive integration; RPWD 2016 accommodations falter on untrained committees dismissing anxiety-linked disabilities; and NEP 2020's anti-stress curricula dissolve into unfunded pilots.

Stigma, silos across ministries, and resource inequities exacerbate these lapses, isolating rural, first-generation, and marginalized students through inaccessible services and cultural misdiagnoses. Absent real-time risk flagging or verified budgets, institutions prioritize NIRF rankings over lives, inviting negligence liabilities.

Stronger accountability requires enforceable reforms: ring-fenced 2% budgets for professionals, cross-ministerial wellness authorities, mandatory screenings, and real-time dashboards tied to accreditation. Vice-chancellors must appoint nodal officers within deadlines, devolving funds via audited mechanisms to bridge urban-rural divides.

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