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Between Books and Battles: A Legal and Judicial Safeguard for Mental Health in India's Education System

Naziya Rashid[a] Isbah Qureshi[b]

[a]Research Scholar, School of Law, University of Kashmir, Kashmir, India [b]Research Scholar, School of Law, University of Kashmir, Kashmir, India

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Education is meant to liberate, not burden the learner, its success lies not in grades or rankings, but in the holistic growth of human beings capable of living with dignity, confidence, and purpose.[1]

The importance of mental health, which was formerly stigmatised and ignored, has been more recognised as a key component of human flourishing in recent years, particularly in educational settings. Previously seen as an afterthought, mental health is now fundamental to achieving one's full potential in school and in life. Despite constitutional and legislative recognition, the country's educational system continued to disregard and disintegrate mental health, putting students at risk of experiencing stress, anxiety, depression, and burnout as a result of financial instability, intense competition, and a lack of institutional support. This study examines India's mental health legislation and its progress towards establishing a rights-based system. This study takes a step-by-step look at the development's most important stages, including the constitutional jurisprudence that guarantees everyone the right to mental health care, the Mental Health Act of 2017, which provides a comprehensive legislative framework, and the 2025 interim directives issued by the Indian Supreme Court, which mark a first in judicial activism about students' psychological welfare. To fill what it called a 'legislative and regulatory vacuum' in preventing student suicides, the Bench, which consisted of Justices Vikram Nath and Sandeep Mehta, used its exceptional powers under Article 141 of the Constitution. By establishing mental wellness as a judicially enforceable constitutional entitlement within academic

[1] *Sukhdeb Singh Saha v State of Andhra Pradesh* Crim App No 3177/2025

environments, the Court's fifteen-point regulatory framework safeguards student mental health in India and represents a fundamental transformation in constitutional interpretation. This is in accordance with Article 21 of the Constitution. In addition to outlining a comprehensive, workable plan for schools everywhere, the recently rendered decision establishes the crucial legal notion of 'institutional culpability,' which makes school administrators liable for their carelessness when it comes to student suicides and self-harm.

Keywords: *mental health, students' welfare, guidelines.*

INTRODUCTION

A growing awareness of mental health problems, human rights concerns, and the need for comprehensive treatment systems has led to a sea shift in India's mental health laws in the last few years. The complex web of constitutional safeguards, legislative acts, and court rulings in India's mental health system works together to guarantee that people with mental illness get the treatment and care they need while also protecting their rights. In 2025, the Supreme Court issued extensive interim directives that rethought the connection between educational institutions and the psychological well-being of students in response to the tragic circumstances in *Sukdeb Saha v State of Andhra Pradesh*. This marked a turning point in the judicial resolution of this crisis. Over 35% of the population is below the age of 25; the student demographic constitutes a critical segment of mental health policy. According to the National Crime Records Bureau (NCRB), more than 13,000 students die by suicide annually, reflecting a systemic failure of institutional support mechanisms.[2]

All of these things come together to form a strong rights-based approach, which is a big change from the colonial era's custodial model, which confined and regulated people with mental health problems instead of treating them. The constitutional foundation for mental health law in India rests primarily on Article 21 of the Constitution, which guarantees the right to life and personal liberty.[3] In a series of landmark decisions pertaining to mental health law, the Supreme Court has repeatedly construed this clause broadly to include the right to health and dignity.[4] The *Sukhdeb Saha* case took this expansive interpretation to a new level when the Court acknowledged that protecting students' mental health is a fundamental

[2] National Crime Records Bureau, *Accidental Deaths and Suicides in India* NCRB (2023)
[3] Constitution of India 1950, art 21
[4] *Francis Coralie Mullin v Administrator, Union Territory of Delhi & Ors* AIR 1981 SC 746; *Bandhua Mukti Morchav Union of India* (1984) 3 SCC 161

right to life and dignity guaranteed by the Constitution. This is especially true in schools, where students are at a higher risk of experiencing psychological distress.[5]

Additionally, Article 14's guarantee of equality before the law and Article 15's prohibition of discrimination provide further constitutional underpinnings for mental health rights.[6] The *Sukdeb Saha* guidelines put these constitutional principles into action by requiring additional safeguards for vulnerable student groups, such as LGBTQ+ students, students with disabilities, and members of the Scheduled Castes and the Scheduled Tribes. This is because mental health issues frequently coexist with other types of social vulnerability.

In light of the current mental health crisis in India, especially among students, the recent involvement of the judiciary has been of paramount importance. In response to the disturbing increase in student suicides, particularly in areas known for their coaching programs, the court has gone beyond its usual role and issued comprehensive operational instructions that schools are required to adhere to. In this new paradigm, courts are not content to just interpret current laws but are instead actively developing all-encompassing systems to safeguard mental health in certain institutional contexts.

Indian mental health legislation has progressed from a medical-legal framework to a comprehensive social protection system, as shown by the incorporation of the rights-based approach of the Mental Healthcare Act 2017 and the institutional accountability mechanisms of the *Sukhdeb Saha* recommendations. While tackling educational pressure, societal stigma, and resource restrictions, this transition matches wider worldwide trends in mental health policy and helps solve India's unique difficulties.[7]

HISTORICAL EVOLUTION AND LEGISLATIVE FRAMEWORK

The Indian Lunacy Act 1912: The earliest comprehensive mental health legislation in India was the Indian Lunacy Act, 1912, which remained in force for over seven decades.[8] Legislation enacted during the colonial period mirrored the prevailing custodial system, which prioritised the administration and confinement of those labelled as 'lunatics' above their treatment and rehabilitation. Despite its widespread criticism for its paternalistic

[5] *Sukhdeb Singh Saha v State of Andhra Pradesh* Crim App No 3177/2025
[6] Constitution of India 1950, arts 14-15
[7] *National Mental Health Policy of India* (Ministry of Health and Family Welfare 2014)
[8] Ministry of Health and Family Welfare, 'National Mental Health Policy of India' (Government of India2014).

attitude and neglect of patient rights, the Act laid the groundwork for mental health certification, admission to mental institutions, and the administration of their assets.

The Mental Health Act 1987: The Mental Health Act, 1987, marked a significant departure from the purely custodial approach of its predecessor.[9] Voluntary admission processes, the creation of Mental Health Authorities, and options for community treatment were among the progressive measures introduced by the 1987 Act, which was enacted in reaction to the rising awareness of human rights concerns and the need for updated mental health law. The Act laid out processes for the admission, treatment, and release of individuals with mental illness and provided a wide definition of mental disorder.[10] The 1987 Act was criticised for several shortcomings, such as its lack of protection against abuse, its inadequate focus on community mental health care, and its limited provisions for informed consent. Delays in implementing the Act were caused by insufficient infrastructure and limited resources.

The Mental Healthcare Act 2017: When it comes to mental health laws in India, the 2017 Mental Healthcare Act is the most all-encompassing overhaul yet. Many groups and individuals were involved in the decision to pass the law, including those working in mental health, the judicial system, and disability rights. It represents a change in thinking towards a rights-based approach, which emphasises respect, independence, and belonging to one's community.[11]

Key Provisions of the Mental Healthcare Act 2017 —

Definitions and Scope: Extensive definitions of mental health illnesses are included in the 2017 Act, reflecting current knowledge of these diseases. An illness of the mind is 'a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgement, behaviour, capacity to recognise reality or ability to meet the ordinary demands of life, but does not include mental retardation.' Distinct disability laws deal with issues like intellectual disability, which is strangely absent from this description.[12] To further guarantee thorough coverage of the regulatory framework, the Act also establishes the notion

[9] Mental Health Act 1987
[10] Mental Health Act 1987, s 2
[11] Mental Healthcare Act 2017
[12] Mental Healthcare Act 2017, s 2(s)

of 'Mental health establishment,' which includes a wide variety of establishments offering mental health services.[13]

Rights-Based Framework: Individuals with mental illness are granted special protections under the 2017 Act. The right to non-discrimination and equality, the right to access one's own medical data, the right to privacy, and the right to communicate with one's personal contacts are all part of the extensive list of rights enumerated in Section 18. The previous laws had a paternalistic attitude, but these measures are a huge step forward.[14]

Rights Framework and Decriminalization Provisions: In addition, the Act legalises the practice of making advance directives, which enable people to state their treatment choices in the case that they are unable to do so because of a mental condition. This is a significant step in the right direction for mental health treatment as it acknowledges the agency and autonomy of people with mental illness.[15]

Decriminalisation of Suicide: The decriminalisation of suicide attempts is one of the most noteworthy improvements implemented by the 2017 Act. In subsection 115, 'any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the Indian Penal Code.[16] In *Common Cause v Union of India*,[17] a constitutional bench of the apex upheld passive euthanasia, and observed that, given international developments, there was a need to reconsider the decriminalisation of suicide. The judgment cited Section 115 of the MHCA, which stipulates that, rather than justifying punitive action under Section 309 of the Indian Penal Code (which criminalises suicide), we must presume that a person who tries suicide is under significant hardship. Section 115 represents a paradigm shift in suicide cases and the treatment of someone forced to take such drastic measures, the decision said. Instead of punitive punishments, it prioritised providing care, therapy, and rehabilitation to someone who tries suicide. Aligning Indian law with the modern understanding of suicidal behaviour, this clause acknowledges suicide attempts as signs of mental suffering rather than criminal crimes.[18] Many people who

[13] Mental Healthcare Act 2017, s s 2(i)
[14] Mental Healthcare Act 2017, s 18
[15] Mental Healthcare Act 2017, s 5
[16] Mental Healthcare Act 2017, s 115
[17] *Common Cause (A Regd. Society) v Union of India* AIR 2018 SC 1665
[18] Bhumika Modh, 'Right to Mental Health in India: A Judicial Perspective' (2025) 2(1) IJSSR <https://doi.org/10.70558/IJSSR.2025.v2.i1.30276> accessed 07 November 2025

work to alleviate the stigma that surrounds mental illness have expressed their gratitude to the decriminalisation provision. Still, there are obstacles to implementation, especially when it comes to making sure that police departments respond appropriately to suicide attempts.[19]

Community Mental Health Services: Realising that institutional treatment ought to be the rare exception rather than the norm, the 2017 Act recognises the importance of community-based mental health services and places a substantial focus on them. Every individual with a mental disease has the right to live in the community, as stated in Section 23, and the least restrictive choice for treatment is a mental health facility.[20] The Act requires the establishment of community mental health services and programs, including halfway homes, sheltered accommodation, and supported accommodation facilities.[21] Due to insufficient preparation and limited resources, however, the execution of these measures has been sluggish.

Admission and Treatment Procedures: Various forms of admission to institutions for mental health are defined in detail under the Act. Priority is given to voluntary admission, and measures are in place to ensure that no one is refused treatment because they want to be admitted voluntarily. Psychologists and other mental health experts must conduct assessments and conduct frequent reviews for supported admissions, those in which the patient lacks the ability but does not oppose admission.[22] When a patient does not have the mental ability to consent to admission, the necessary authorisation from a Mental Health Review Board is sought, and separate admission procedures are put in place. Striking a balance between therapeutic needs and safeguarding individual liberty and autonomy is the goal of these rules.[23]

CONSTITUTIONAL DIMENSIONS AND JUDICIAL INTERPRETATION

Fundamental Rights and Mental Health: Mental health rights are well-established in the constitutional framework, thanks to several provisions for basic rights that have been interpreted by the courts. Case law has established that people with mental illness have an absolute right to be free from discrimination in all areas of life, including but not limited to

[19] Lakshmi Vijayakumar, 'Challenges and opportunities in suicide prevention in South-East Asia' (2017) 6(1) WHO South-East Asia Journal of Public Health <https://doi.org/10.4103/2224-3151.206161> accessed 07 November 2025
[20] Mental Healthcare Act 2017, s 23
[21] Mental Healthcare Act 2017, s 21
[22] Mental Healthcare Act 2017, s 89
[23] Mental Healthcare Act 2017, s 86

work, education, and social assistance, as guaranteed by Article 14.[24] Individuals with mental illness are disproportionately affected by the needless limitations placed on them in institutional settings, making the freedom of speech, association, and mobility guaranteed by Article 19 all the more important. The Supreme Court has made it clear that there must be a good reason to restrict fundamental liberties, and that mental illness alone is not enough.[25]

According to Article 21 of the Indian Constitution, mental health is a fundamental aspect of the right to life. No one has the right to a life devoid of dignity, autonomy, and well-being; this Court has made it clear time and time again in its decisions that this does not entail a life of bare survival.[26] Mental health is central to this vision.

Landmark Judicial Decisions: The evolution of India's mental health legislation has been influenced by a number of seminal court rulings. The Supreme Court's decision in *Sheela Barse v State of Maharashtra* set significant precedents for the care of vulnerable populations, such as those with mental illness, by addressing concerns of custodial abuse and the rights of those in protective custody.[27]

Many people who participate in prostitution also suffer from mental health disorders; the case of *Gaurav Jain v Union of India* brought attention to these concerns and laid forth guidelines on how to help these people recover.[28] More recently, in *Common Cause v Union of India*, the Supreme Court recognised passive euthanasia and living wills, which have implications for advance directives under mental health legislation.[29]

In *Shatrughan Chauhan v Union of India*[30] and *Navtej Singh Johar v Union of India*,[31] under Article 21 of the Indian Constitution, the court clearly recognised the need to protect mental integrity, psychological autonomy, and the right to be free from humiliating treatment as fundamental aspects of human dignity. In addition to these rulings from the courts, the Mental Healthcare Act of 2017 established a serious and watchful framework to combat the rising tide of student mental health problems.

[24] *State of Maharashtra v Indian Medical Association & Ors* AIR 2002 SC 302
[25] Constitution of India 1950, art 19
[26] Constitution of India 1950, art 21
[27] *Sheela Barse v State of Maharashtra* AIROnline 1987 SC 483
[28] *Gaurav Jain v Union of India & Ors* AIR1997 SC 3021
[29] *Common Cause (A Regd. Society) v Union of India* AIR 2018 SC 1665
[30] *Shatrughan Chauhan & Anr v Union of India & Ors* (2014) 3 SCC 1
[31] *Navtej Singh Johar & Ors v Union of India Thru Secretary Ministry of Law and Justice* AIR 2018 SC 4321

Right to Health Jurisprudence: There are major ramifications for mental health legislation from the Supreme Court's right to health jurisprudence. The Court's decision in *Paschim Banga Khet Mazdoor Samity v State of West Bengal* affirmed the provision of healthcare services by the state as a positive responsibility under Article 21, which guarantees the right to life.[32]

The courts have expanded this line of precedent to include mental health treatments, holding that the government must provide easy access to inexpensive mental health care. Legal precedent in the case *State of Punjab v Ram Lubhaya Bagga* established that all residents, even those suffering from mental illness, had a right to receive medical treatment from the state.[33]

COMPARATIVE PERSPECTIVES AND INTERNATIONAL STANDARDS

International Human Rights Framework: International human rights norms, including the 2007 ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) by India, are essential for making sense of the country's laws pertaining to mental health. All people, including those with psychosocial disorders, should have the same access to basic freedoms and human rights as everyone else, according to the UN Convention on the Rights of Persons with Disabilities.[34]

According to the United Nations Convention on the Rights of Persons with Disabilities (Article 12), governments must assist disabled people in exercising their legal rights rather than making decisions on their behalf. Concerning mental health laws, this has ramifications, especially in relation to guardianship procedures and consent to treatment.[35]

International Frameworks and Comparative Analysis —

WHO Mental Health Legislation Guidelines: The World Health Organisation has issued recommendations for mental health law that highlight certain important aspects. These include the following: informed consent, the least restrictive environment, independent

[32] *Paschim Banga Khet Mazdoor Samity & Ors v State of West Bengal & Anr* (1996) 4 SCT 28
[33] *State of Punjab & Ors v Ram Lubhaya Bagga Etc.* AIR 1998 SC 1703
[34] United Nations Convention on the Rights of Persons with Disabilities 2008
[35] United Nations Convention on the Rights of Persons with Disabilities 2008, art 12

review procedures, and voluntary treatment as the preferred alternative.[36] The World Health Organisation (WHO) has developed ten basic principles for mental health-care law:[37]

1. Promotion of Mental Health and Prevention of Mental Disorders;
2. Access to Basic Mental Healthcare;
3. Following Internationally Accepted Principles for Mental Health Assessments;
4. Provision of the Least Restrictive type of Mental Healthcare;
5. Self-determination;
6. Right to be Assisted in the Exercise of Self-determination;
7. Availability of the Review Procedure;
8. Automatic Periodic Review Mechanism;
9. Qualified Decision-maker;
10. Respect for the Rule of Law.

Many of these concepts are included in India's 2017 Act, although there are still obstacles to their implementation. While India's laws are forward-thinking, their execution is sluggish when compared to the WHO standards, which place an emphasis on community-based care and deinstitutionalisation. The rights-based approach in India mirrors the World Health Organisation's (WHO) standards, which place a focus on protecting human rights and reducing stigma.

Comparative Analysis with Other Jurisdictions: The mental health laws of India may be better understood by comparing them to those of other countries. The Mental Health Act 1983 (as modified) of the United Kingdom offers a comprehensive framework for the protection of rights and the guarantee of treatment, with robust procedures for independent evaluation. However, Indian law does not follow the contentious model of the United Kingdom's approach, which places a focus on community treatment orders.[38]

The mental health laws of Australia may teach India a thing or two about how to improve its own system, thanks to its focus on recovery-oriented treatment and consumer engagement. Supported decision-making, rather than substitute decision-making, is the emphasis in

[36] World Health Organization, 'WHO Resource Book on Mental Health, Human Rights and Legislation'(WHO 2005).
[37] Melvyn Freeman and Soumitra Pathare, *WHO resource book on mental health, human rights and legislation : stop exclusion, dare to care* (WHO 2010)
[38] Mental Health Act 1983, s 20

Australia, which is in line with the objectives of the UNCRPD and might guide changes to the laws in India.[39] Nevertheless, there was still a need for a regulatory framework and a constructive legal approach, particularly for students who endure psychological pressures while migrating in search of better educational institutions, despite the existence of these frameworks on a constitutional, legislative, and international level.

Considering this sorry state of affairs, the Hon'ble Supreme Court had also in mind an earlier pending matter of *Amit Kumar v Union of India*[40], the court here also was dealing with a case of student suicide and termed the ongoing issue as a *suicide epidemic* of educational institutions. In a detailed discussion of the matter, the court requested interim rules along the same lines as those given out in the case of *Vishaka v State of Rajasthan*, which served as the foundation for the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act 2013. Consequently, until the legislative and regulatory void is filled, the courts have also sought to establish some guidelines in this area.[41]

RECENT JUDICIAL DEVELOPMENTS: THE SUKHDEB SAHA GUIDELINES (2025) - A NEW LEASE OF HOPE

Supreme Court Guidelines on Student Mental Health: In the case of *Sukhdeb Saha v State of Andhra Pradesh & Ors*, the Supreme Court of India released extensive recommendations for the mental health of students in July 2025, marking a watershed moment in the history of mental health law. Following an invocation of Article 141, the Court issued a landmark decision outlining fifteen mandatory standards for schools throughout the country. These standards will be legally enforceable in all 50 states.

The rules are a major step towards resolving the student suicide epidemic in India, especially in major coaching cities like Kota, where the issue has grown to a terrifying level. These guidelines are meant to augment, not replace, the current efforts of the National Task Force on Student Mental Health. The Court has made it clear that these are temporary protections until a full framework is established.

[39] Mental Health Act 2007
[40] *Amit Kumar v Union of India & Ors* WP (C) 8474/2019
[41] *Vishaka & Ors v State of Rajasthan & Ors* AIR 1997 SC 3011

Comprehensive Framework for Educational Institutions: The fifteen rules provide a thorough structure for safeguarding students' mental health in many different ways. Important parts include a requirement that schools with 100 or more children hire licensed mental health specialists, a formula for the ideal ratio of pupils to counsellors, and a ban on detrimental practices such as academic performance-based batch segregation.

All schools are required by the rules to implement standardised mental health policies that are based on pre-existing frameworks such as the National Suicide Prevention Strategy, the MANODARPAN program, and the UMMEED Draft Guidelines. As far as mental health safeguards in schools go, this is a huge step in the right direction.

Special Provisions and Accountability –

Special Focus on Vulnerable Populations: Particular attention to marginalised and disadvantaged student groups is shown by the recommendations. Training for staff on how to connect sensitively with students from marginalised backgrounds, including students from SC, ST, OBC, EWS, LGBTQ+, disabled, and traumatised or who have attempted suicide in the past, should be a priority for all educational institutions. Modern knowledge of prejudice and mental health inequalities informs this intersectional approach. The Court has made it clear that it will not abide by any kind of retaliation against those who report incidents of sexual assault, harassment, ragging, or caste-based discrimination, and that strong reporting procedures must be in place to address these issues.

Institutional Accountability and Safety Measures: Educational institutions are held firmly accountable for their actions by the rules. The administration faces regulatory and legal ramifications when it fails to respond promptly to allegations of discrimination or harassment, particularly when this negligence leads to student suicide or self-harm. The Court's focus on environmental aspects in suicide prevention is evident in the safety measures, which include requiring residential institutions to install tamper-proof ceiling fans and restricting access to high-risk locations.

Regulatory and Monitoring Framework: District Magistrates are appointed to district-level monitoring committees by the judgment. These committees will have members from the health, education, and child protection departments. Regulations requiring private coaching centres to register and establishing student protection standards must be announced by the

states and union territories within two months. This establishes a thorough regulatory system that was previously lacking in the coaching industry. The Court also required submission of compliance affidavits within 90 days, ensuring immediate implementation and accountability. This timeline-bound approach reflects judicial recognition of the urgency of the student mental health crisis. A major shift in the court system's perspective on mental health has occurred with the release of the *Sukhdeb Saha* guidelines, which establish binding requirements for institutional accountability and expand protections to include educational environments.

CHALLENGES IN IMPLEMENTATION

The implementation of student mental health frameworks in India is obstructed by structural, cultural, and financial barriers:

Stigma and Cultural Barriers: Particularly in more traditional and rural areas, people with mental illness still face social stigma. Seventy percent of students regard getting mental health care as a sign of weakness, according to research published in the Asian Journal of Psychiatry (2021).

Lack of Infrastructure and Professionals: A country with a population of over 1.4 billion people has fewer than 10,000 clinical psychologists with licenses. There is a critical lack of campus mental health services due to this shortfall.

Fragmented Governance: There is a lack of cooperation since the Ministry of Education oversees educational institutions and the Ministry of Health and Family Welfare oversees mental health.

Financial Constraints: Public universities often lack funding to establish mental health cells or hire counsellors.

Absence of Accountability: The UGC Guidelines are meant to be a guide, not a rule. There will be no enforcement tools in place until there is legislative support.

RECOMMENDATIONS FOR REFORM AND IMPROVEMENT

Strengthening Implementation Mechanisms: For mental health laws to be put into practice, there has to be more cooperation across those involved, more funding, and more robust

institutional processes. The states should make it a top priority to set up Mental Health Review Boards and Mental Health Authorities that are both well-functioning and have sufficient authority and funding.

It is possible to expand the *Sukdeb Saha* recommendations' model for implementation to include more comprehensive mental health legislation implementation, such as district-level monitoring committees and required compliance reporting. To find out how well mental health laws are working and where they may be improved, there has to be a system in place for regular monitoring and review. Improving accountability and driving changes may be achieved via the engagement of service consumers and their representatives in independent monitoring organisations.

Enhancing Community Mental Health Services: Investment in community service development is crucial to achieving the goal of community-based mental health treatment outlined in the 2017 Act. Supported housing, crisis intervention programs, and community mental health teams are all part of this. Integration of mental health services with primary healthcare systems, as envisioned in the National Mental Health Programme, remains crucial for ensuring accessible care. The student mental health recommendations show how targeted interventions might improve protection for mental health in general.

The incorporation of judicial precedent with statutory language produces a flexible legal system that can respond to new situations while preserving fundamental rights and respect for human dignity. When other developing nations want to update their mental health legislation, this method may show them how to do so in a way that takes into account their unique circumstances.

Institutional Compliance: Institutional compliance is inconsistent, despite rulings like *Sukhdeb Saha v State of Andhra Pradesh* affirming that mental well-being is vital to the right to life and human dignity. The onus is on the institutions to follow the rules and put people in place to put them into action, rather than seeing the instructions as just ideas.

CONCLUSION

A landmark event in Indian constitutional law has occurred with the Supreme Court's involvement in student mental health via thorough interim guidelines, which expand the

scope of protection for basic rights to include the duties of institutions to ensure the psychological wellness of their students. Judgmental ability to read the Constitution creatively and alter the institutional system in response to complicated modern societal problems is on display in the Court's novel approach.

In addition to setting long-lasting precedent rules for the protection of mental health in institutions, the fifteen-guideline framework imposes new duties on educational institutions. This accomplishes the double goal of improving students' lives right now and advancing constitutional discussions on positive rights and institutional duties in the long run.

Issues with resources, professional ability, and cultural integration are all part of the larger systemic problems that make it difficult to put these suggestions into practice. Despite the difficulties, there are openings for fresh ways of thinking about mental health service provision, training professionals, and collaborating across institutions.

The comparative research highlights the unique features of the Indian constitutional approach to mental health protection based on rights and identifies possible uses and future directions for this approach. The cultural sensitivity, universal coverage, and thorough institutional responsibility emphasised in the recommendations should serve as examples for other varied cultures dealing with comparable problems. Beyond the immediate issues of student mental health, there are larger problems about the role of the judiciary, the duties of institutions, and the changing character of constitutional rights in modern democracies. The action by the Court highlights the possibilities and constraints of judicial activism in tackling societal structural issues.

Educational institutions, government agencies, professional organisations, and society at large must maintain their commitment to these rules to succeed in the end. The acknowledgement that safeguarding mental health requires societal accountability as a whole, not just individual or institutional actions, is reflected in this all-encompassing implementation mandate. The decision provides a starting point, but it does not finish the journey. The true test will come during implementation. Justices Nath and Mehta have provided more than just precedent; they have laid out a road map to salvation.

The real test of their decisions won't be in bureaucratic notices or compliance reports, but in whether schools can go back to their roots and help kids become confident, purposeful adults.

As rightly said in the judgment, *A line is drawn now, it is up to educators, parents, policymakers, and society to ensure that no more young lives are lost to a system that was meant to uplift them.*