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Youth Mental Health in India: Policy Gaps, Accessibility, and the Role of Educational Institutions

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Abstract: Youth mental health has emerged as a critical public health and social work concern in India, a country home to the world's largest adolescent population. Epidemiological evidence indicates that mental disorders affect approximately 7.3 per cent of adolescents aged 13-17 years, while suicide has become one of the leading causes of death among young people, with the National Crime Records Bureau (NCRB) documenting a steady rise in student suicides over the past decade (Gururaj et al., 2016; Careers360, 2025). Despite the passage of the landmark Mental Healthcare Act, 2017, which grants a legally enforceable right to mental healthcare, implementation remains uneven, and the mental health workforce continues to be severely constrained, with India recording fewer than one psychiatrist per 100,000 people (Malhotra, 2023; PMC, 2022). This paper, prepared from a social work perspective, examines the scale of the youth mental health crisis in India, critically analyses gaps in existing policy and legislative frameworks, identifies structural and socio-cultural barriers to accessing care, and evaluates the emerging role of educational institutions-schools, colleges, and universities-as frontline sites for prevention, early identification, and referral. The paper draws on secondary data from national surveys, government reports, and peer-reviewed literature. It concludes with recommendations for strengthening school- and college-based mental health infrastructure, integrating medical social workers into educational settings, and aligning policy implementation with the lived realities of Indian youth.

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

Keywords: *Youth Mental Health; India; Mental Healthcare Act 2017; Educational Institutions; Social Work; Accessibility*

1. Introduction

India's demographic profile is often described as a potential dividend, with young people between the ages of 10 and 24 constituting roughly a fifth of the country's population (Malhotra & Patra, 2014; The India Forum, 2024). This demographic weight, however, carries a corresponding public health responsibility, since adolescence and early adulthood are developmentally sensitive periods during which most lifetime mental disorders first emerge. International evidence cited in Indian literature suggests that roughly half of all adult mental disorders begin by the mid-teens and three-quarters by the mid-twenties (Kessler et al., 2007, as cited in The India Forum, 2024). For a country carrying an estimated 15 per cent of the global mental health burden (Deloitte, 2022), the mental well-being of its youth is not a peripheral concern but a determinant of national productivity, social stability, and human development.

For medical and psychiatric social workers, youth mental health sits at the intersection of clinical practice, policy advocacy, and community intervention. Social work education in India, delivered largely through Master of Social Work (MSW) programmes, has traditionally positioned psychiatric social work as a core specialisation. Yet the profession's engagement with youth-focused mental health policy particularly the practical gaps between legislative intent and ground-level accessibility remains underexplored in conference and practice literature. This paper attempts to address that gap by bringing together epidemiological data, policy analysis, and a review of institutional interventions, with specific attention to what these mean for social work practice in educational settings.

2. Objectives of the Study

- To examine the prevalence and magnitude of mental health difficulties, including suicide, among young people in India.
- To critically analyse the existing legal and policy framework governing youth mental health, including its implementation gaps.
- To identify structural, financial, and socio-cultural barriers to accessing mental healthcare among Indian youth.

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

- To evaluate the role of schools, colleges, and universities as sites for prevention, early intervention, and referral.
- To draw implications for social work practice and propose recommendations for strengthening institutional mental health support.

3. Methodology

This paper adopts a descriptive-analytical approach based on secondary sources. Data have been drawn from the National Mental Health Survey of India, 2015-16 (NMHS), reports of the National Crime Records Bureau (NCRB), the Mental Healthcare Act, 2017, government budget documents, circulars of the Central Board of Secondary Education (CBSE) and the University Grants Commission (UGC), and peer-reviewed literature published in journals such as the Indian Journal of Psychiatry, the Indian Journal of Medical Research, and BJPsych International. Given the review nature of the study, no primary data collection was undertaken; the analysis instead synthesises existing evidence to construct a policy-practice picture relevant to social work education and intervention.

4. Youth Mental Health in India: The Scale of the Problem

According to the National Mental Health Survey of India, 2015-16 (NMHS), conducted by the National Institute of Mental Health and Neurosciences (NIMHANS), 7.3 per cent of adolescents aged 13 to 17 years experienced a diagnosable mental disorder, with prevalence distributed roughly equally between boys and girls (Gururaj et al., 2016). The same survey found that mental disorders were nearly twice as common in urban metropolitan areas (13.5 per cent) as in rural areas (6.9 per cent), pointing to a distinct urban mental health burden linked to academic pressure, competitive examinations, and social isolation (Gururaj et al., 2016; PMC, 2019). Among young adults aged 18 to 29 years, the NMHS estimated a current prevalence of mental disorders at 7.39 per cent and a lifetime prevalence of 9.54 per cent, excluding tobacco use disorders (Indian Journal of Medical Research, 2018). More recent state-level modelling under the Global Burden of Disease Study (2021) found that adolescent mental disorder prevalence ranged from 10.5 per cent in Goa to 16.1 per cent in Manipur, and that mental disorders have risen from the seventh to the first-ranked cause of health loss among Indian adolescents since 1990 (The India Forum, 2024).

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

The most alarming indicator of this crisis is suicide. NCRB data show that India recorded 171,418 suicide deaths in 2023, the highest suicide rate in 56 years of official record-keeping (Centre for Mental Health Law and Policy [CMHLP], 2026). Within this total, student suicides have followed a troubling decade-long upward trajectory: from 8,032 in 2014 to 13,892 in 2023, a 73 per cent increase with students accounting for 8.1 per cent of all suicide deaths in 2023, the highest share recorded in ten years (Careers360, 2025). The age groups of 15-29 years consistently account for the largest share of suicide deaths nationally (CMHLP, 2026). Maharashtra, Madhya Pradesh, Uttar Pradesh, and Tamil Nadu have consistently reported the highest absolute numbers of student suicides, and clusters of suicides have been documented in coaching hubs such as Kota, known for concentrated competitive examination preparation (Abhijita et al., 2024). "Failure in examination" has been officially recorded as a precipitating cause in over a thousand student suicide deaths annually, underscoring the acute academic pressure embedded in the Indian education system (Careers360, 2023, 2025).

Community and school-based studies suggest even higher rates of psychological distress than the NMHS figures capture. A systematic review found that while 6.5 per cent of the general community showed psychiatric disorders, prevalence rose to 23.3 per cent among school-going children and adolescents specifically, with individual regional studies reporting rates as high as 33 per cent in some school-based samples (Malhotra & Patra, 2014, as cited in PMC, 2022). This divergence suggests that school and college environments rather than being neutral backdrops may themselves be sites where academic, social, and family pressures converge to produce measurable psychological distress, reinforcing the case for institution-based intervention rather than purely clinic-based response.

5. Policy and Legislative Landscape: Achievements and Gaps

5.1 *The Mental Healthcare Act, 2017*

India's most significant legislative intervention in this field is the Mental Healthcare Act, 2017 (MHCA), passed by Parliament in March 2017 and brought into force on 29 May 2018, replacing the custodial and outdated Mental Health Act of 1987 (Wikipedia, 2017; Chadda, 2020). The Act was designed to align Indian law with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) and, notably, decriminalised attempted suicide by effectively removing it from the ambit of Section 309 of the Indian Penal Code (Wikipedia, 2017). Scholars

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

have described the MHCA as the first legislation globally to grant a justiciable right to mental healthcare to an entire national population, an achievement not matched even by the United Kingdom despite its ratification of the same UN convention (Duffy & Kelly, 2018).

Despite this rights-based framing, five years into implementation, reviews note that the Act remains heavily oriented toward institutional and hospital-based rights of persons already diagnosed with mental illness, with comparatively little emphasis on community-based continuity of care or family caregiver support (Malhotra, 2023; PMC, 2019). The Act does not contain youth- or education-specific provisions, meaning that its protections such as advance directives, nominated representatives, and rights during admission apply primarily once a person has entered the formal mental health system, rather than addressing prevention or early identification among school- and college-going populations who have not yet been formally diagnosed.

5.2 *National Mental Health Programme and Budgetary Allocation*

A persistent and well-documented gap lies in financial commitment. The National Mental Health Programme (NMHP), India's principal vehicle for delivering mental health services through the general health system, received a budget allocation of only Rs 40 crore in both 2020-21 and 2021-22, a figure that remained flat even as the burden of mental illness rose; in 2019-20, actual expenditure under the programme was reported at a mere Rs 2.51 crore against the sanctioned outlay (Careers360, 2021). Even after the announcement of the National Tele Mental Health Programme in the 2022 Union Budget, overall mental health funding grew by only 12.2 per cent against a 16.6 per cent rise in total health spending, and mental health's share of the health budget actually declined from approximately 0.8 per cent to 0.77 per cent (Deloitte, 2022). Analysts have noted that nearly all of the incremental mental health funding in recent years has been directed toward centrally administered institutes such as NIMHANS rather than toward strengthening the NMHP's district-level and community outreach components (Deloitte, 2022). This pattern of underfunding relative to burden India shoulders roughly 15 per cent of the world's mental health burden but allocates well under one per cent of its health budget to mental health constitutes one of the most fundamental structural gaps limiting youth access to care (Deloitte, 2022).

5.3 National Education Policy 2020: A Contradictory Signal

The National Education Policy (NEP), 2020 rhetorically emphasises holistic development, life skills, and student well-being, and its early childhood education provisions explicitly reference nutritional and developmental needs (PressReader, 2020). However, a significant and under-

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

discussed policy contradiction lies in NEP 2020's restructuring of postgraduate professional education: the discontinuation of the M.Phil. programmes in Clinical Psychology and Psychiatric Social Work, both of which served as the principal training and licensure pathway for specialist mental health professionals recognised under the Rehabilitation Council of India (PMC, 2024). Critics have argued that this decision, taken without a clearly articulated alternative pipeline, threatens to further shrink India's already inadequate specialist mental health workforce at precisely the moment when demand for youth-focused mental health professionals is rising (PMC, 2024). This illustrates a broader pattern in Indian mental health policy: aspirational, rights-based, or well-being-oriented language at the level of policy text, coexisting with structural and budgetary decisions that constrain the workforce and infrastructure needed to operationalise those aspirations.

6. Accessibility Barriers

6.1 *Workforce Shortage*

India's mental health workforce shortage is severe and well-documented. Estimates place the availability of trained psychiatrists at roughly 0.75 per 100,000 population, compared to over eight per 100,000 in high-income countries, while the combined availability of psychiatrists, clinical psychologists, and psychiatric social workers together remains below one professional per 100,000 population (PMC, 2022; PMC, 2018). Some assessments place India's overall psychiatrist deficits at around 77 per cent relative to epidemiological need, with more than a third of the population living in areas where the deficit exceeds 90 per cent (Thirunavukarasu & Thirunavukarasu, 2010). This workforce is also unevenly distributed, concentrated disproportionately in major cities and tertiary institutions, leaving rural and semi-urban youth reliant on general practitioners or informal, non-qualified providers as their first point of contact for psychological distress (PMC, 2018).

6.2 *The Treatment Gap and Stigma*

Even where services technically exist, most young people with diagnosable mental health conditions in India do not receive treatment. The treatment gap for common mental disorders has been estimated at around 85 per cent nationally, and situational analyses in states such as Haryana describe a treatment gap as high as 95 per cent, with only one in twenty affected individuals accessing any form of care (Duffy & Kelly, 2018; PMC, 2023). Stigma both public stigmas

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

directed at those with mental illness and internalised self-stigma remains the most consistently identified barrier to help-seeking among students, alongside low mental health literacy, fear of being labelled, and concern about confidentiality within close-knit family and community structures (PMC, 2023; PMC, 2021). Systematic reviews of stigma-reduction interventions in India note that while community-based and school-based awareness programmes show some promise, evidence remains limited and geographically uneven (Kaur et al., 2021).

6.3 *Economic and Geographic Barriers*

Cost of consultation, travel time to reach urban specialist centres, and loss of daily wages or study time act as compounding barriers, particularly for first-generation learners and students from economically disadvantaged backgrounds. NCRB data corroborate this socio-economic dimension: nationally, 66 per cent of all suicide deaths in 2023 occurred among individuals in the lowest income category, earning one lakh rupees or less annually, reinforcing that mental health vulnerability in India cannot be separated from poverty and precarity (CMHLP, 2026). For students specifically, education-status breakdowns of suicide data show that the highest proportion of suicide deaths occurs among those with only secondary-level education (23.9 per cent), suggesting that the transition years around board examinations are especially high-risk (Careers360, 2023).

7. The Role of Educational Institutions

Given that formal healthcare infrastructure alone cannot close India's mental health treatment gap, schools, colleges, and universities have increasingly been positioned as frontline institutions for prevention, early identification, and referral. Several national initiatives illustrate this shift.

7.1 *Manodarpan*

Launched in July 2020 by the then Ministry of Human Resource Development as part of the Aatmanirbhar Bharat Abhiyan, Manodarpan was designed to provide psychosocial support to students, teachers, and parents coping with the disruptions of the COVID-19 pandemic (Careers360, 2020). The initiative established a national toll-free tele-counselling helpline staffed by a pool of counsellors and psychologists, an interactive web portal offering advisories on stress management, and provisions for integrating mental health content into the school curriculum (Careers360, 2020; Deccan Herald, 2020). While Manodarpan represented an important symbolic

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

and infrastructural step, its counsellor-to-student ratio and reach relative to India's school-going population of over 250 million remain limited.

7.2 *Tele-MANAS and School Integration*

The National Tele Mental Health Programme (Tele-MANAS), launched on 10 October 2022, offers a free, confidential, 24x7 helpline operating through 53 dedicated cells across states and union territories in 20 languages; by recent counts it had handled over 23 lakh calls since launch (Tribune News Service, 2026). The Central Board of Secondary Education (CBSE) has since directed all affiliated schools to prominently display Tele-MANAS helpline numbers and QR codes near counsellor rooms, notice boards, and libraries, and to incorporate mental health awareness into newsletters, student handbooks, assemblies, and parent-teacher meetings, alongside capacity-building for school counsellors and wellness coordinators (Tribune News Service, 2026). This represents a deliberate policy attempt to embed a national tele-mental health infrastructure into the everyday institutional life of schools rather than leaving it as a standalone helpline.

7.3 *Higher Education and the College Counselling Gap*

At the higher education level, the University Grants Commission (UGC) has periodically issued advisories encouraging universities and colleges to establish student counselling cells and wellness centres, particularly following COVID-19-related disruptions. However, implementation across India's more than 45,000 colleges remains highly uneven, with well-resourced central and private universities typically offering dedicated counselling services while many state and rural colleges lack even a single trained counsellor. Research on college students internationally and in India consistently identifies inadequate counsellor availability, stigma, and concerns about confidentiality as key reasons students avoid formal campus mental health services even where they nominally exist (PMC, 2022; PMC, 2021).

Taken together, these initiatives indicate that Indian policy has begun to recognise educational institutions as strategic sites for mental health intervention not merely as passive settings where distressed young people happen to be present, but as active infrastructure through which prevention, psychoeducation, early screening, and referral pathways can be delivered at scale. The gap lies less in policy intent and more in the density, training, and sustained funding of the human resources counsellors, psychologists, and psychiatric social workers needed to make these institutional mandates functional.

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

8. Implications for Social Work Practice

For MSW practitioners and students, the evidence reviewed here points toward several practice and advocacy priorities. First, psychiatric and school social workers are well positioned to occupy the referral and case-coordination role that sits between educational institutions and the formal mental health system translating Tele-MANAS or Manodarpan contact into sustained, contextually appropriate follow-up care. Second, the concentration of the mental health workforce in urban tertiary centres suggests a clear rural and semi-urban practice gap that social work education can address through fieldwork placements in schools and community health centres located outside major cities. Third, given that examination-related failure and academic pressure are repeatedly cited as precipitating factors in student suicide data, social workers in educational settings have a distinct role in group-based life-skills education, peer support facilitation, and family-level psychoeducation aimed at reducing the stigma and secrecy that often surround student distress. Finally, the discontinuation of the M.Phil. in Psychiatric Social Work under NEP 2020 restructuring is a direct professional concern; sustained advocacy by social work bodies for a clearly defined, RCI-recognised postgraduate training pathway is necessary to protect the pipeline of specialists who would otherwise staff exactly the school- and college-based positions this paper argues are needed.

9. Recommendations

- Increase the National Mental Health Programme's budgetary allocation in proportion to India's share of the global mental health burden, with a specific ring-fenced component for school- and college-based services.
- Mandate a minimum ratio of trained counsellors or psychiatric social workers to students in all UGC-recognised colleges and CBSE/state-board-affiliated schools, with phased implementation and monitoring.
- Integrate structured, age-appropriate mental health literacy and life-skills curricula into the school system, building on but going beyond helpline-display circulars.
- Establish a clear, RCI-recognised postgraduate training pathway for psychiatric social work following the NEP 2020 restructuring, to safeguard the specialist workforce pipeline.

Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

- Strengthen referral linkages between Tele-MANAS, Manodarpan, district mental health programmes, and educational institutions so that helpline contact translates into continuity of care rather than a single point of support.
- Invest in rural and semi-urban mental health infrastructure to correct the urban concentration of the psychiatric and psychosocial workforce documented in national data.
- Support routine, anonymised screening and surveillance of student psychological distress in schools and colleges to enable early identification ahead of crisis points such as board and competitive examinations.

10. Conclusion

Youth mental health in India sits at a critical juncture. The country has taken genuinely significant legislative and policy steps most notably the Mental Healthcare Act, 2017 and the launch of Tele-MANAS that formally recognise mental healthcare as a right and attempt to extend services nationally. Yet these advances remain constrained by chronic underfunding, an acute shortage of trained mental health professionals, urban-rural disparities in service availability, and a policy contradiction embedded in NEP 2020's restructuring of psychiatric social work training. Rising student suicide numbers and school-based prevalence data make clear that the consequences of these gaps are not abstract but are measurable in lost lives and diminished well-being among India's youth. Educational institutions have emerged as an increasingly important, though still under-resourced, site of intervention. For the social work profession, this presents both a professional responsibility and an opportunity: to advocate for adequately staffed, well-integrated mental health infrastructure within schools and colleges, and to position psychiatric and school social workers as central, rather than peripheral, actors in India's response to its youth mental health crisis.

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Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

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Vol. 4, Issue 10 October 2026 ISSN: 2584-0142

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