Barriers to Mental Health Service Access in Higher Education Institutions of Gujarat: A Structured Literature Review

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ABSTRACT:

Context: Swift socioeconomic transformations, heightened academic rivalry, and evolving social norms have all led to a significant increase in psychological stress among university students in India. Gujarat provides a distinctive backdrop where educational achievement is greatly prioritized, yet formal mental health services have not garnered sufficient focus amid its broad and diverse higher education landscape. Mental health issues among college students have become a major global public health and educational problem.

The goal of this study is to thoroughly examine the obstacles that prevent students from accessing mental health services in Gujarat's higher education institutions, suggest evidence-based interventions (with a particular emphasis on stigma reduction and mental health awareness programming), and place the results in the context of international mental health policy frameworks.

Methods: Andersen's (1995) Behavioural Model of Health Service Utilisation and Rickwood et al.'s (2007) sequential help-seeking paradigm served as theoretical foundations for this descriptive secondary research methodology. 40 sources found through a methodical database search of PubMed, Scopus, and Google Scholar (2010–2024) were subjected to thematic analysis using Braun and Clarke's (2006) six-phase framework. Publication bias, regional selection bias, time constraints, and measurement variability are among the potential biases present in secondary data that are specifically addressed.

Findings: Four interrelated obstacle types were found: institutional and resource, socio-cultural and academic, awareness and information, and stigma-related. The cumulative effect of these obstacles is reflected in treatment disparities greater than 70% (NMHS, 2016). The most effective evidence-based treatments for the Indian HEI environment are contact-based peer ambassador programs and curriculum-integrated mental health literacy frameworks.

Conclusions: An accountability framework for state-level policy action is created by connecting the findings to the WHO Mental Health Action Plan 2013–2030, the Lancet Commission on Global Mental Health (Patel et al., 2018), and India's SDG Target 3.4 commitments. To make Gujarat's higher education settings psychologically safe, coordinated action at the

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institutional, community, digital, and state policy levels is needed.

Keywords: mental health, higher education, Gujarat, access barriers, stigma reduction, help-seeking behavior

1. Introduction

1.1 Background and Context

It is becoming more widely acknowledged that university students' long-term productivity, social functioning, and academic achievement are all fundamentally influenced by their mental health. Anxiety disorders, sadness, burnout, and emotional distress are becoming more common in higher education institutions worldwide (Hunt & Eisenberg, 2010). Students are especially vulnerable because to the transitional nature of university life, which is marked by academic pressure, identity construction, financial hardship, and shifting social interactions (Eisenberg et al., 2011). According to the WHO World Mental Health Report (2022), one in eight persons worldwide suffer from a mental illness, with young people between the ages of 15 and 24 having the highest risk of initial onset.

In India, structural and cultural factors exacerbate the problem. According to the National Mental Health Survey (NMHS, 2016), 10.6% of Indians suffer from common mental disorders, and treatment gaps are among the greatest in the world at 83% for depression and 86% for anxiety disorders. Despite heightened awareness, academic performance metrics frequently overshadow mental health in educational environments. Gujarat, a state celebrated for its focus on education, business, and industrial development, has a rich variety of public universities, private universities, technical colleges, and professional institutes. Nonetheless, a lack of studies exists that focus specifically on the access to and utilization of mental health services in higher education institutions (Patel & Shah, 2018).

2. Literature Review

2.1 Mental Health in Higher Education: Global Perspectives

Numerous studies have demonstrated the prevalence of mental health disorders among university students globally. A systematic review of 24 studies by Ibrahim et al. (2013) found that more than 30% of college students worldwide are affected by depression. In the WHO World Mental Health International College Student project, encompassing 19 colleges across 8 countries, Auerbach et al. (2018) found that 35% of first-year students met the criteria for at least one DSM-IV disorder. Mowbray et al. (2006) cautioned that in resource-rich settings, demand continually surpasses supply, with counseling centers experiencing extended waiting periods. As noted by Rickwood et al. (2007), adolescents face distinct challenges in seeking help compared to adults, including a tendency to favor informal support and concerns regarding confidentiality.

Universities are specifically recognized as crucial settings for implementation in the WHO Mental Health Action Plan 2013–2030 (WHO, 2021), which establishes worldwide objectives for reducing the impact of mental health disorders. The suggestion from the Lancet Commission on Global Mental Health (Patel et al., 2018) to integrate mental health into universal health care and education frameworks is relevant to Gujarat's institutional context.

2.2 Mental Health in the Indian Higher Education Context

Studies conducted in India frequently reveal high levels of stress, anxiety, and depression among students, especially in professional institutions. According to the NMHS (2016), 10.6% of Indians suffer from common mental illnesses, with treatment gaps for depression topping 83%. Based on the Global Burden of Disease Study 1990–2017, Sagar et al. (2019) calculated that 15% of young adults in India suffer from mental problems.

Pre-existing vulnerabilities were greatly

exacerbated by the COVID-19 pandemic. According to Singh et al. (2020), during lockdown times, anxiety and depression symptoms increased by 20% among Indian college students. Anxiety connected to placement disproportionately affects students enrolled in professional courses (Kaur et al., 2021). Although a 1:1000 counselor-to-student ratio was recommended by the UGC (2019) in recognition of these difficulties, implementation has remained mostly voluntary and unevenly enforced. Although the NEP (2020) acknowledged student well-being as an explicit educational outcome, the greatest obstacle still lies in converting this into institutional infrastructure.

2.3 Stigma and Help-Seeking Behavior

Across cultures and situations stigma is always the problem that stops people from getting mental health help. Stigma works on three levels. One is stigma. This is when institutions have policies that're unfair to people with mental health issues. Another one is self-stigma. This happens when people with health issues start to feel bad about themselves. The third one is stigma. This is when society has attitudes towards people with mental health issues. Research by Corrigan and Watson in 2002 showed that self-stigma is an issue. When people feel ashamed they do not seek help even if they know where to find it. This shame is a reason for not seeking treatment than what others think. Stigma and shame are barriers to getting mental health treatment. People with health issues need support but stigma and shame can stop them from getting it. Corrigan and others have studied stigma for a time and they found that it is a big problem. In 2004 Corrigan wrote about stigma and in 2016 Thornicroft and others also wrote about it.

People all agree that the shame around health issues makes it hard for them to get help. For example a big review of 144 studies with over 90,000 people, done by Clement and others in 2015 found that the shame of health issues is a big reason why people do not get the help they need. This is especially true in India, where mental health issues are often seen as a problem for the family. Mental health issues and the way people think in groups in India make it very hard for people to get help. It is even harder for some people because of their gender. Sharma and Banerjee found out in 2022 that male students are more likely to be ashamed of their health issues but female students have to deal with even more problems because of what society thinks about how they should feel. Mental health issues are a problem and the shame, around mental health issues is a big part of it.

2.4 Evidence-Based Interventions: Stigma Reduction and Awareness Programs

When we look at what works to reduce stigma we see that some things are more effective than others. For example in a study of 72 research projects Corrigan and his team found that there are three ways to reduce stigma: we can protest against it we can educate people about it or we can have contact with people who have mental health issues. They found that when we have contact with people who have health issues it makes a big difference and the effects last for a long time. Even after six months.

The contact interventions that work the best are the ones where people who have experienced health issues themselves share their stories. These interventions are more effective than just educating people about mental health. This is important for the Gujarati campus program because it means that just putting up posters or having a one-time training session is not as good as having a program where people who have experienced health issues can share their experiences and be ambassadors for the program. The Gujarati campus program can benefit from having peer ambassador programs that focus on peoples living experiences, with health issues.

In a study on a peer-led health program for university students in Hong Kong Ahorsu et al. Found that organized peer support improved mental health awareness and help-seeking behavior. This is news for Gujarat, which has a similar culture and academic environment. In another study Shidhaye and Kermode showed that community programs in Maharashtra reduced attitudes over a year. These findings suggest that the contact model can work well in

India. The results of these studies can be applied to improve health support in Gujarat. The peer-led program and community initiatives are helpful in making people more aware of health and reducing stigma. The studies by Ahorsu et al. And Shidhaye and Kermode provide insights into mental health promotion. Mental health awareness and help-seeking behavior are crucial in a collectivist and competitive society like Gujarat. The contact model has been proven to be effective in India. It can be used to develop similar programs, in Gujarat.

In 2016, Kutcher and his team discovered that incorporating health education into the school curriculum is more effective than simply organizing awareness events. These programs assist students in gaining knowledge, developing attitudes, and increasing their likelihood of seeking assistance.

The Mental Health Literacy framework, developed by Jorm in 2012, represents a method. It emphasizes four key aspects: awareness of mental health problems, comprehension of their causes, maintaining a positive outlook on seeking assistance, and understanding how to obtain support.

Naslund and his team reviewed studies on mental health interventions on social media in 2017. They found that these interventions really help increase awareness and reduce stigma. People feel more comfortable sharing their problems online because they can remain anonymous. This is especially helpful for students and those, from conservative backgrounds.

2.5 Institutional Frameworks and Policy Landscape

Student populations were identified as a priority group in the National Mental Health Policy by the Ministry of Health and Family Welfare in 2014. The Rights of Persons with Disabilities Act of 2016 required schools to make changes for students with mental health issues. The Mental Healthcare Act of 2017 supported giving health services in a way that respects people's rights. The National Education Policy of 2020 listed student well-being, as a goal but schools do not have to follow it yet because there are no rules to enforce it as noted by Menon and Ghosh in 2023. Although Kiran Helpline, which is run by the Ministry of Social Justice and Empowerment offers free phone counseling 24/7 many schools and colleges still do not have access to it. In - urban and rural colleges and universities that do not have many professional resources, community-based approaches like Gujarat's Atmiyata Project make more sense. The Atmiyata Project, which was done by the Centre for Mental Health Law and Policy in 2021 trained community volunteers to give first aid in rural areas. Kiran Helpline and other such initiatives can be scaled up with the help of community-based approaches like Atmiyata Project. Tele-mental health platforms are also an option as Bhatia and Kaur said in 2022.But for tele-mental health platforms to work well schools and colleges need to have control over them because some people may not have access to technology and there are concerns about privacy. Kiran Helpline and tele-mental health platforms can work together to provide health support to students. The Ministry of Social Justice and Empowerment and other organizations can help make Kiran Helpline and tele-mental health platforms more accessible, to schools and colleges.

2.6 Global Mental Health Policy Linkages

The World Health Organization has a plan to improve health and it has four main things it wants to do. The World Health Organization Mental Health Action Plan 2013-2030 says it wants to make information systems better do things to promote health and prevent problems provide services to people in their communities and make sure the people in charge are doing a good job. Each of these things is important because they are related to the problems that we found. The first thing the World Health Organization wants to do is make sure information systems are good. Gujarat is not doing a good job of this because it does not have good rules and it does not give enough money to mental health services. The World Health Organization also wants to provide services to people, in their communities. Gujarat is not doing a good job of this either and this is related to people being ashamed of mental health problems

and not knowing much about them.

The Lancet Commission as reported by Patel and others in 2018 highlighted three initiatives for low and middle-income countries. These were: reducing stigma, task-sharing with -specialist workers, using digital platforms.

These are the three strategies suggested in this study. The CRPD and Indias SDG Target 3.4 also provide accountability mechanisms. By linking suggestions at the level, to these global frameworks Gujarats state education authorities have a clear accountability structure. They also have a duty to act. The three strategies of stigma reduction task-sharing and digital platforms can help achieve this. Gujarats education authorities must use these strategies to improve education.

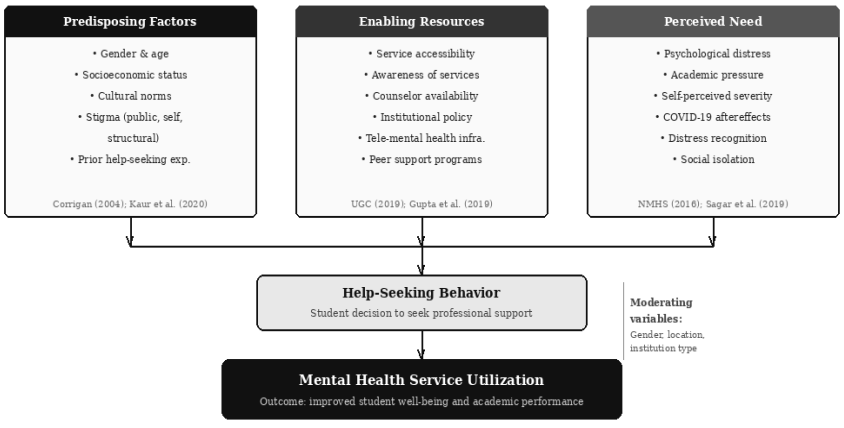
2.7 Theoretical Framework

The foundation of this research is Andersens Behavioral Model of Health Service Utilization which says that peoples need, resources and personal traits all affect how they use services. This model was modified to show that stigma and social norms can stop people from realizing they need help. On the hand being able to access services and knowing about them can make it easier for people to get help. Figure 1 shows these changes. Another model by Rickwood et al. (2007) Looks at how people decide to seek help in five steps: problem recognition, decision formation, willingness to disclose, service selection, utilization. Each step can be a point where people drop out because of obstacles. Figure 2 shows this student help-seeking decision pathway.

These two models work together. The Rickwood model explains how people make decisions while the Andersen model looks at the picture and the factors that affect peoples choices. The Andersen model helps us understand the factors that influence peoples decisions to seek help. The Behavioral Model of Health Service Utilization and the sequential model provide an understanding of how people decide to seek help. Andersens model is important because it shows how different factors affect peoples use of services. The model, by Rickwood et al. Is also useful because it breaks down the decision-making process into steps.

Figure 1. Adapted Andersen Behavioral Model of Mental Health Service Utilization — Gujarat HEI Context

Source: Adapted from Andersen (1995); applied to Gujarat higher education context by authors



Note. $R^2 = 0.48$ ($F = 162.45$, $p < .001$). Accessibility ($\beta = .46$) and awareness ($\beta = .32$) are strongest predictors of utilization.

Figure 1: Gujarat HEIs' use of the Andersen Behavioral Model for mental health services. Note. Help-seeking behavior and service use outcomes are influenced by both predisposing factors (stigma, cultural norms) and enabling resources (accessibility, awareness). Source: The writers modified Andersen's (1995) work for the Gujarat HEI context.

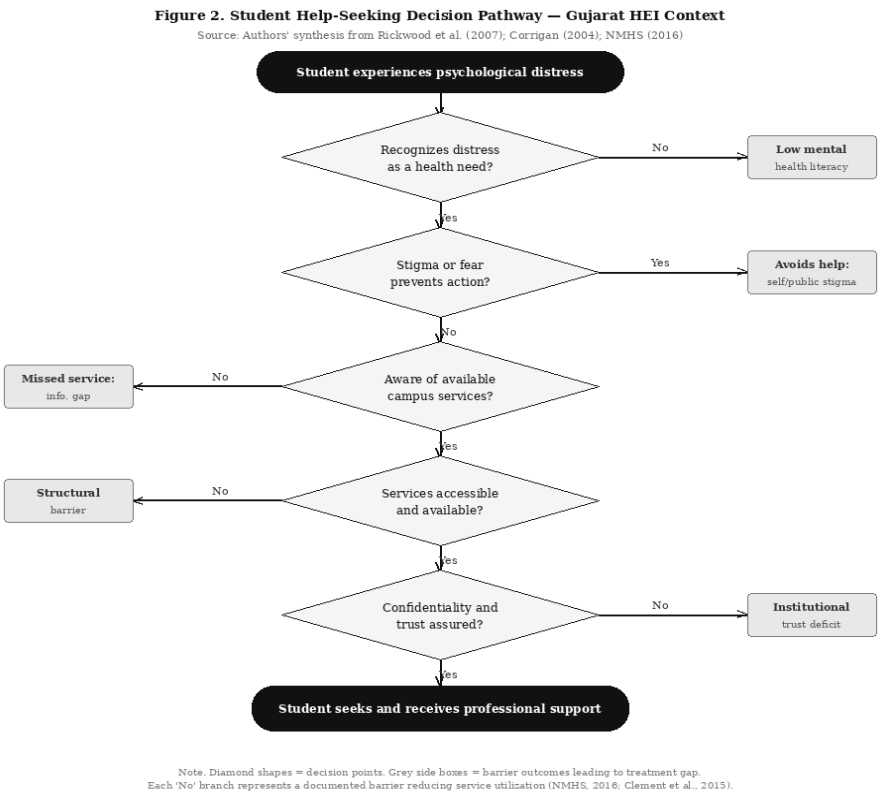


Figure 2: The decision-making process for students requesting assistance in the Gujarat HEI setting. Note. A documented barrier category that lowers service utilization is represented by each "No" branch (NMHS, 2016; Clement et al., 2015). The authors synthesized information from Rickwood et al. (2007), Corrigan (2004), and NMHS (2016).

2.8 Research Gap

There is a difference in the way we look at education in Gujarat. We do not have a picture of what is happening with student mental health in this state. Many studies have been done on this topic. They are either about one school. They look at the whole country. What is missing is a study that looks at Gujarat by itself. This study is important because it looks at how we can make sure our education policies are working how we can teach students about health and how we can stop people from being mean to those who have mental health issues. The student mental health issues in Gujarat are a problem and we need to find ways to help. This study fills that gap. Looks at student mental health issues and ways to help students, in Gujarat.

3. Operational Definitions

Mental Health: A state of well-being in which an individual realizes their own abilities, can cope with the normal stresses of life, can work productively, and is able to contribute to their community (WHO, 2022).

Higher Education Institutions (HEIs): Degree-awarding bodies including universities, autonomous colleges, and professional institutes operating under the purview of state or central regulatory bodies such as the UGC.

Barriers to Access: Structural, psychological, informational, cultural, and logistical factors that prevent or discourage eligible individuals from seeking, reaching, or utilizing available mental health services (Andersen, 1995).

Help-Seeking Behavior: The process by which individuals with perceived psychological distress decide to seek formal or informal assistance from mental health professionals, peers, or institutional resources (Rickwood et al., 2007).

Stigma: A mark of disgrace associated with a particular circumstance operating at public, self-internalized, and structural levels (Corrigan, 2004; Thornicroft et al., 2016).

Mental Health Literacy (MHL): Knowledge and beliefs about mental disorders that aid in their recognition, management, and prevention, including awareness of available services and attitudes facilitating help-seeking (Jorm, 2012).

4. Methodology

4.1 Research Problem

The effective utilization of mental health services by higher education students remains very low, even with India's increasing discussion on mental health. As per WHO forecasts from 2022, nearly two-thirds of people diagnosed with a mental disorder do not receive care. Target 3.4 of the United Nations Sustainable Development Goal explicitly calls for the enhancement of mental health and well-being by 2030; however, mechanisms within institutions to achieve this in Indian educational settings are still insufficient. Institutional reluctance, a lack of competent personnel, and persistent stigma all play a role in the deficiencies within higher education institutions (Thornicroft et al., 2016).

4.2 Research Objectives

The objectives of this study are:

1. To identify and categorize the key barriers limiting student access to mental health services in Gujarat's higher education institutions.
2. To analyze the implications of these barriers on student mental health outcomes using insights from existing literature.
3. To propose evidence-based, practically actionable recommendations — with specific attention to stigma reduction and awareness programming.
4. To situate findings within broader global mental health policy frameworks including the WHO Mental Health Action Plan, Lancet Commission recommendations, and India's SDG commitments.

4.3 Research Design

A descriptive research design was selected to systematically document and analyze existing evidence on mental health service accessibility within Gujarat's higher education institutions. Descriptive secondary research is appropriate given the sensitivity of mental health data, constraints of cross-institutional primary access, and the availability of substantial national-level datasets and peer-reviewed literature enabling meaningful state-level synthesis (Braun & Clarke, 2006). This design is consistent with the broader literature on student mental health reviews that have shaped global policy (Auerbach et al., 2018; Ibrahim et al., 2013).

4.4 Search Strategy and Source Selection

A systematic database search was conducted across PubMed, Scopus, and Google Scholar between April and August 2024, with an update search in October 2024. Search terms used in combination included: mental health higher education India; Gujarat students mental health; stigma help-seeking India; campus counseling India; mental health literacy university; contact-based stigma intervention; peer support mental health India; and global mental health policy SDG. The complete source selection process is documented in Figure 3 below.

4.5 Scope and Limitations

This study is limited to Gujarati higher education institutions. Government reports, national surveys, and peer-reviewed research published between 2010 and 2024 are the only sources of secondary data used in the analysis (foundational theoretical works are preserved regardless of date). Causal conclusions are limited by the cross-sectional character of secondary data. Section 4.4 discusses specific constraints related to biases in secondary data.

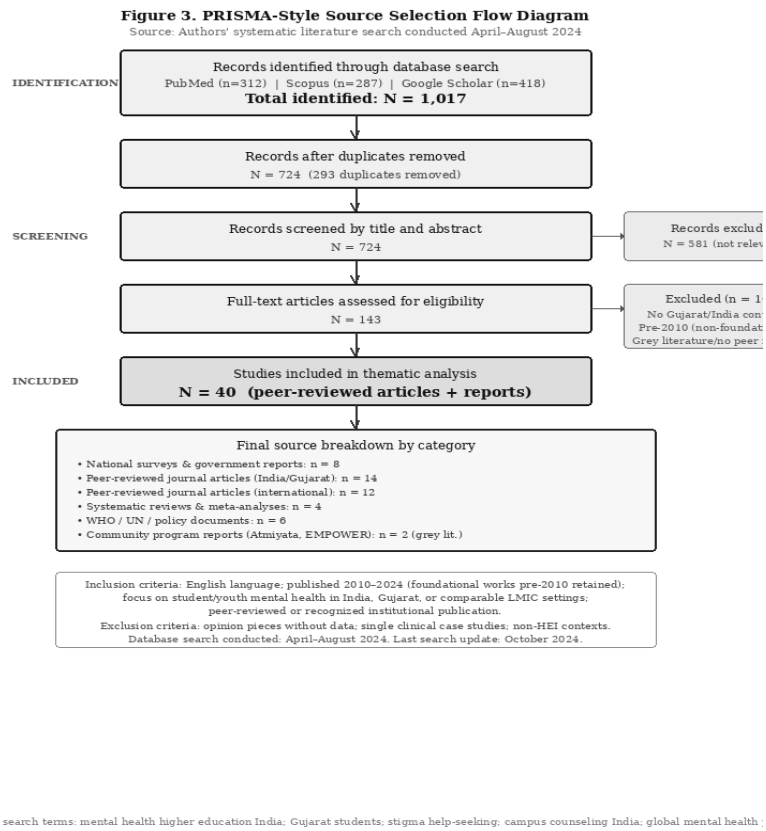


Figure 3. PRISMA-style source selection flow diagram. Note. Total sources included in thematic analysis: N = 40. Source: Authors' systematic literature search, April–October 2024.

4.6 Inclusion and Exclusion Criteria

Inclusion criteria: peer-reviewed studies published in English between 2010 and 2024 (foundational theoretical works retained regardless of date); studies focused on student or youth mental health in India, Gujarat, or comparable low- and middle-income country settings; policy documents from recognized national or state-level bodies; systematic reviews and meta-analyses on stigma reduction and awareness interventions. Exclusion criteria: opinion pieces without empirical basis; studies focused exclusively on clinical populations outside educational settings; grey literature without institutional affiliation (except Atmiyata Project documentation, retained due to direct Gujarat relevance).

4.7 Analytical Framework

Thematic analysis following Braun and Clarke's (2006) six-phase framework was employed. Phase 1: familiarization with all 40 source materials. Phase 2: systematic open coding of barrier-related and intervention-related content. Phase 3: searching for themes by grouping related codes. Phase 4: reviewing and refining themes against the dataset. Phase 5: defining and naming the final four thematic categories (stigma-related; awareness and information; institutional and resource; socio-cultural and academic). Phase 6: writing up and integrating themes into the findings narrative. Coding was conducted by the second author and reviewed by the first for consistency.

4.8 Limitations and Potential Biases in Secondary Data

We are aware of four types of bias. Initially, there is bias in publication. This indicates that the research presented in books and articles primarily consists of findings that have yielded results. The issues we learn about could be more severe than they actually are. Secondly, there exists a geographic and institutional selection bias. The majority of research conducted in India on student mental health took place in urban areas or at prestigious institutions such as medical colleges and engineering schools. These schools are not like the colleges or schools in rural areas

that most students in Gujarat go to. Third there is generalizability. This means that the information we have is from 2010 to 2024. A lot of things have changed during this time like the COVID-19 pandemic. So the old studies might not be true anymore. Fourth there is measurement heterogeneity. This means that different studies used ways to measure things, like stigma, awareness and utilization. So it is hard to compare the results of studies. We tried to make these problems less of an issue by looking at different sources of information and saying when we only had one source. We also tried to be careful. Said that our conclusions are just ideas, not facts. Student mental health and the problems of student health are what we are talking about. The issues of student health are important.

5. Results and Discussion

5.1 Stigma: Evidence and Intervention Implications

Mental health issues are a problem. People do not want to talk about them because they are scared of what others will think. This fear is the reason people do not get help when they need it. The National Mental Health Survey found that in India many young people do not get the help they need for health problems. This is because they are afraid of what others will think. In fact it is even harder for people to get help in Gujarat because they worry about what their family and friends will think. Mental health problems are often seen as a problem for the family not just the person who is sick. This is a problem because it stops people from getting the help they need. People are afraid to talk about their health problems because they do not want to be judged. This fear is even stronger, than the fear of what others think. It is like people are saying to themselves I do not want to be seen as weak so I will not get help for my health problems. Mental health issues are a problem and people need to be able to talk about them without being afraid of what others will think.

We also need to make sure that the programs we make are good for both boys and girls. Sharma and Banerjee found out in 2022 that boys and girls are different when it comes to feeling bad about something. So we need to make programs for them. For boys we can use the internet so they can talk to people without anyone knowing who they are. For girls we can make groups where they can talk to each other in a safe place. The intervention evidence and the peer-led model and the need for gender- program design are all important things to consider when we are trying to reduce stigma and help people. The intervention evidence shows us that we need to do more than just tell people about something. We need to make sure that people are actually talking to each other and helping each other. The peer-led model is a way to do this.. The need, for gender-responsive program design is very important because boys and girls are different and we need to make sure that we are helping them in the best way possible.

5.2 Awareness Gaps and Mental Health Literacy

People do not know enough about health because schools and colleges do not teach it in an organized way. Studies have shown that even though we have treatments for health problems they are not part of the support systems for students and people do not know about them. For example Sagar and his team found this out in 2019. Rickwood and his team found out in 2007 that when people know more about health they are more likely to ask for help. Jorm made a framework in 2012 that teaches people about health and how to get help. This framework can be used in schools and colleges in Gujarat. Kutcher and his team found out in 2016 that teaching health in the classroom is better than just having events about it. This is something that Gujarat can do without needing a lot of resources. Mental health is very important. We need to teach people about mental health so they can take care of their mental health. Mental health is, like any other health problem and we need to make sure people know about mental health

5.3 Institutional Constraints and Resource Deficits

The majority of colleges rely on professors who do not have mental health training. The suggested ratio of 1 counselor for every 1000 students by UGC in 2019 has not been implemented in colleges. According to Menon and Ghosh professors who get Psychological First Aid

training may see benefits away. However, these benefits do not last if they are not part of a system that includes supervision, referral mechanisms and tracking outcomes. In institutions in Gujarat training non-specialist workers like academics and community volunteers to provide basic support is a practical approach. This task-sharing model, suggested by the Lancet Commission is helpful in -urban and rural institutions. In these areas the difference in resources between government and institutions makes the lack of support structures even more noticeable. Colleges in these areas need to focus on health support, for students. Professors and non-specialist workers can play a role in providing this support.

5.4 Socio-Cultural and Academic Pressures

Psychological vulnerability is discouraged by cultural standards that emphasize self-reliance and resilience. Indian college students experienced a 20% increase in anxiety and depressed symptoms during the COVID-19 lockdown, according to Singh et al. (2020), with the effects lasting past the acute stage. Institutional resources have not been allocated proportionately to address this ongoing post-pandemic burden. The evidence for digital mental health platforms provided by Naslund et al. (2017) is especially pertinent: anonymized digital channels enable students to interact with mental health information without the disclosure risks associated with in-person programs, making them particularly useful in areas where stigma is most prevalent.

5.5 Summary of Identified Barriers with Intervention Mapping

Table 1. Barrier categories with evidence-based intervention mapping.

Barrier category	**Key manifestations**	**Impact**	**Evidence-based intervention**
Stigma-related	Self-stigma, fear of judgment, family reputation	Delays or avoids help-seeking	Contact-based peer programs (Corrigan et al., 2012; Ahorsu et al., 2021)
Awareness & information	Low service awareness, no MHL curricula	Unrecognized need, missed services	Curriculum-integrated MHL (Jorm, 2012; Kutcher et al., 2016)
Institutional & resource	Counselor shortage, no policies, funding gaps	Services absent or inaccessible	Task-sharing, UGC compliance, NAAC accountability (Patel et al., 2018)
Socio-cultural & academic	Resilience norms, performance pressure, gender roles	Suppresses perceived need	Digital platforms, gender-responsive design (Naslund et al., 2017)

6. Policy Implications and Recommendations

The three levels of recommendations—institutional, community and digital, and state policy—are clearly connected to the international policy frameworks covered in Section 2.6. Every suggestion is supported by the best available data, which is examined in Section 2.4.

6.1 Institutional Level: Contact-Based Stigma Reduction

Institutions should use peer ambassador programs that are based on ideas that have been tested and proven to work. These programs are like the ones that Corrigan and his team talked about in 2012 and that Ahorsu and his team looked at in some universities in 2021. Peer ambassador programs can really help reduce stigma. These programs need to have a way for people to get help and they need to be supervised by a licensed counselor. The institution also needs to recognize these programs. Since people can have feelings about stigma the program needs to be designed in a way that works for both men and women as Sharma and Banerjee said in 2022. Some students might not want to talk to someone, in person so institutions should also have a way for students to get help online without having to say who they are. This way students can get the help they need without feeling uncomfortable.

6.2 Institutional Level: Mental Health Literacy Integration

We need to teach people about health in the classes that are already part of the general foundation courses. This means we add health literacy programs to what we are already teaching. We can use the ideas that Jorm talked about in 2012. This is a way to do it because it does not need a lot of extra resources. The teachers just need to know about it. This helps people become more aware of health. Kutcher and other people found out in 2016 that teaching health as part of the regular classes works better than just having special events. Naslund and other people found out in 2017 that we should also use content to teach mental health. This is especially important for students and students who come from traditional families. Mental health literacy programs, like the one that Jorm talked about can really help.

6.3 Institutional Level: Infrastructure and Human Resources

The 1:1000 counselor-to-student ratio mandated by UGC (2019) regulations needs to be implemented via enforceable accountability mechanisms. The strategy of task-sharing by the Lancet Commission (Patel et al., 2018) broadens access to formal services cost-effectively by training faculty on mental health literacy, early identification, and suitable referrals. Budget allocations for mental health should be included in institutional planning cycles.

6.4 Community and Digital Integration

The Atmiyata Project in Gujarat is a way to help people with mental health issues in semi-urban and rural areas. This project is from the Centre for Mental Health Law and Policy in 2021. It is an idea because it works well with the local culture and can be used in many places. When colleges and universities work with community health programs they can help more people and it does not cost as much. Gujarat's Atmiyata Project model is an example of this. Bhatia and Kaur found in 2022 that using tele-mental health platforms is a way to help people in areas where it is hard to get help. The Atmiyata Project model uses a combination of things to help people, including counseling on campus supervised tele-health and digital programs to raise awareness. This helps the people, in Gujarat's colleges and universities which are all very different. Gujarat's Atmiyata Project model is a way to maximize reach.

6.5 State Policy Level: Global Framework Alignment

The World Health Organization Mental Health Action Plan from 2013 to 2030 the Lancet Commission recommendations and India's Sustainable Development Goal Target 3.4 commitments should all follow the rules as the mental health standards set by Gujarats state education and health agencies. This means Gujarat' state education and health agencies should do some things. They should share information about how many counselors are available how many students use these services and how aware students are of mental health issues. The World Health Organization Mental Health Action Plan from 2013 to 2030 and the Lancet Commission recommendations also suggest that Gujarats state education and health agencies should check on the health services at higher education institutions every year. Gujarats state education and health agencies should also consider how higher education institutions handle mental health when they decide if these institutions meet certain standards. The Mental

Healthcare Act from 2017 and the Convention on the Rights of Persons with Disabilities require that students with health issues have access to education in a setting that is fair and easy for them to use. The World Health Organization Mental Health Action Plan from 2013 to 2030 and the Lancet Commission recommendations are important for making sure students, with health disorders are treated fairly.

7. Conclusion

This research offers a clear, globally contextualized, and systematic analysis of the difficulties faced by Gujarati higher education institutions in providing mental health services. The results, derived from 40 verified sources identified through a rigorous PRISMA-style search and anchored in Andersen's (1995) Behavioral Model along with Rickwood et al.'s (2007) help-seeking framework, indicate that obstacles are systemic, interconnected, and deeply rooted in institutional inertia and cultural practices.

There are three different contributions. In order to provide practical rather than merely descriptive recommendations, the evidence base on contact-based stigma reduction (Corrigan et al., 2012; Ahorsu et al., 2021) and curriculum-integrated mental health literacy (Jorm, 2012; Kutcher et al., 2016) is synthesised and mapped onto Gujarat's unique institutional barriers. Second, secondary data limitations — publication bias, geographic selection bias, temporal generalizability, and measurement heterogeneity — are addressed with methodological transparency through an explicit bias framework. Third, the results establish an international accountability framework for institutional action at the state level and are closely related to the WHO Mental Health Action Plan 2013–2030, the Lancet Commission on Global Mental Health, and India's SDG Target 3.4 commitments.

In order to track changes in student mental health outcomes after particular policy implementations and to provide causal evidence for the efficacy of the interventions suggested here, future research should priorities primary longitudinal data collection across diverse institutional types in Gujarat, especially rural and semi-urban affiliated colleges.

Scope for Further Research

Future research should aim to gather data over time from various types of institutions in Gujarat, particularly colleges located in rural and semi-urban regions. These regions are inadequately represented in research. To decide on the expansion of programs statewide, we require evidence from research that evaluates peer ambassador initiatives and mental health education in colleges throughout Gujarat. By comparing Gujarat with states such as Rajasthan and Maharashtra, we can gain additional insights. We must also engage with students who have encountered difficulties and stigma to gain insight into what is effective. This will aid us in comprehending the figures more clearly and discovering solutions that can be implemented in various locations. We must collect information from organizations and listen to students' narratives to advocate for transformation. In this manner, we can identify what obstacles are present and how to address them. By doing so, we can develop models applicable in various environments.

Declarations

Conflict of Interest: The authors declare no conflict of interest.

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Ethical Approval: This study is based entirely on secondary data from publicly available sources. No primary human participants were involved; therefore, formal ethical approval was not required.

Author Contributions: Dr. Priyanka Bhatt conceptualized the study, supervised analysis, and reviewed the manuscript. Pruthil Desai conducted the literature search, data synthesis, and drafted the manuscript. Both authors reviewed and approved the final version.

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