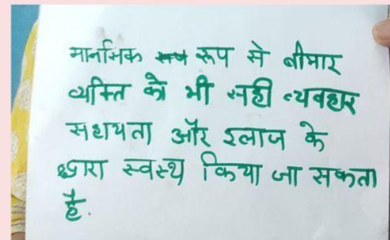
DE MONTFORT UNIVERSITY LEICESTER

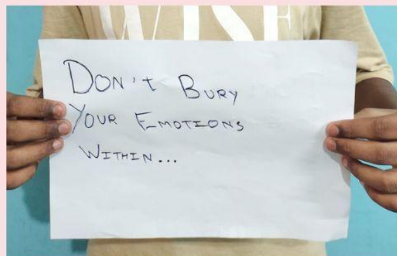
PHRN

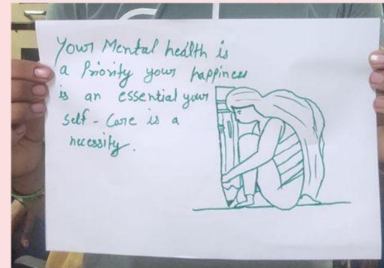
MENTAL HEALTH LITERACY

Project Report



MENTAL HEALTH





DECEMBER 30, 2024

PUBLIC HEALTH RESOURCE SOCIETY
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Public Health Resource Society

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Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
ANM	Auxiliary Nursing Midwife
AS	Assam
ASHA	Accredited Social Health Activist
CMD	Common Mental Disorder
CSO	Civil Society Organization
CT	Chhattisgarh
DMHP	District Mental Health Programme
FLW	Frontline Worker
GJ	Gujrat
ICDS	Integrated Child Development Services
JH	Jharkhand
KL	Kerala
LMIC	Low Middle Income Country
MCD	Municipal Corporation Delhi
MDM	Mid-Day Meal
MHCA	National Mental Healthcare Act
MHL	Mental Health Literacy
MHLq	Mental Health Literacy questionnaire
MeHeLP	Mental Health Literacy Project
MP	Madhya Pradesh
MN	Manipur
NIMHANS	National Institute for Mental Health and Neurosciences
NMHP	National Mental Health Programme
NMHS	National Mental Health Survey
OBC	Other Backward Caste
PB	Punjab
PDS	Public Distribution System
PLA	Participatory, Learning, and Action
PMMVY	Pradhan Mantri Matru Vandana Yojana

RJ	Rajasthan
SC	Scheduled Caste
ST	Scheduled Tribe
TN	Tamil Nadu
UP	Uttar Pradesh
WB	West Bengal
WHO	World Health Organization

Executive Summary

According to World Health Organization (WHO), in 2019, nearly a billion people, including 14% of adolescents, were suffering from mental disorders worldwide. Over 1 in 100 deaths were caused by suicide, and 58% of suicidal deaths happen before the age of 50 years [1]. According to the National Mental Health Survey (NMHS), 2016, in India, 10% of the population is affected by Common Mental Disorders (CMDs), including depression, anxiety disorders, and substance use disorders. Every 1 in 20 people in the country suffers from depression, with females between 40-49 years being affected the most. The prevalence of severe mental health disorders was found among 1.9% of the population. Disorders like schizophrenia, mood swings, and stress-related disorders were more prevalent in urban areas, attributed to factors such as fast-paced lifestyle, stress, limited support systems, economic instability, etc. [3]. The state of Delhi has the highest prevalence of schizophrenia and eating disorders among other states of the country. A report published by the Indian Express in 2012 indicated that in Delhi, the prevalence of mental health issues is rising especially among the economically deprived groups [19]. One of the significant barriers to mental health care and well-being is the stigma associated with the condition. In India, nearly 80% of individuals suffering from mental illnesses do not receive any treatment due to stigmatization [3]. Though the existing policies and programmes prioritize the mental health of adolescents and youth, there is still a need to improve access to mental health information, resources, and services [17]. NMHS, 2016, shows that the current mental health programmes in India are hampered by the lack of valid, reliable, timely, sensitive, and specific outcome indicators for mental health developed by routine data-gathering methods [3].

Public Health Resource Society (PHRS) undertook the Mental Health Literacy (MHL) project with support from De Montfort University (DMU), Leicester. Through this project, PHRS strived to build the capacities of frontline workers, and public health professionals/teams on MHL and engaged with the community through participatory methods to develop their understanding of MHL. An assessment was also undertaken to understand the level of MHL among adolescents and young adults. The project was undertaken in New Seemapuri, Shahdara, Delhi.

The project helped develop an understanding of MHL among public health professionals. It promoted open conversations on mental health in the community and demonstrated the deeply ingrained beliefs in society and the need for sustainable involvement through a participatory method. Workshops, community campaigns, games, activities, and storytelling proved to be instrumental in igniting conversations on deeply stigmatized topics like mental health.

The study with adolescents and young adults in urban slums of East Delhi revealed quite a few gaps in literacy on mental health with misconceptions, myths, and misinformation still being much prevalent. While most participants demonstrated a high level of awareness of MHL, however, a significant proportion continues to stigmatize the condition. For instance, 52.4% of our study population were in agreement with the sentence that ‘people with mental illness do not have a strong mind.’ When stated ‘Mental illness is caused by black magic or possession’, although most participants (36.9%) were in disagreement, a significant number (24.24%) agreed to it. On the other hand, a good level of literacy was seen for statements like- ‘Physical exercise helps to improve mental health’ and ‘a healthy diet helps to improve mental health.’ The study also noted that societal expectations, cultural norms, peer pressure, and body image issues have a major impact on the mental health of adolescents and young adults of New Seemapuri. Anxiety, social isolation, self-consciousness, bullying, and emotional distress were found very common in the community. While many try to cope by indulging in various activities or asking for help, others remain traumatized and feel inadequate.

The project has provided scope for expansion through new themes around mental health that can be projectized, e.g., working on issues of domestic violence, social media impact of mental health/ self-imaging, and post-partum depression, among others. Finally, we understood that in order to better understand the state of mental health and guide interventions, mental health policies and services need to be data-driven as well as participatory. There is a need to build a more supportive, informed, and stigma-free society for those affected by mental health issues.

1. Introduction

1.1 About the Project

The Mental Health Literacy (MHL) project has been undertaken by the Public Health Resource Society, (PHRS), New Delhi upon invitation from the De Montfort University (DMU), Leicester. It is one of the components of DMU's successful MeHeLP India project to engage public health professionals and policymakers through a national (Pan India) public health organization for knowledge exchange and impact by developing a sustainable mental health literacy programme.

1.1.1 Context

MeHeLP India project (https://www.mehelp.in/) is a highly collaborative, international cross-disciplinary partnership that examines the applicability and promotion of mental health literacy in urban and rural communities using participatory theatre, storytelling practices, and short films through a multi-center study in Kerala (India). The MeHeLP project is the first of its kind in India, funded by UKRI - Economic and Social Research Council (ESRC), the Arts and Humanities Research Council (AHRC), and the Global Challenges Research Fund (GCRF). It has resulted in a collaborative, international, interdisciplinary research partnership project between Indian and UK-based scholars, theatre, and filmmakers.

MeHeLP has produced one the largest data sets of interviews ever collected on mental health in a Low and Middle-Income Country (LMIC) with mental health service users, carers, and community members. The notion of 'mental health literacy' has been proposed as a way of improving mental health problem recognition, service utilization, and reducing stigma. The findings indicate that the issue may be better understood in terms of multiple mental health literacies that people deploy in different circumstances.

In this context, the MHL project implemented by PHRS has engaged with public health officials, professionals, students, community members, frontline health workers, and Civil Society Organizations (CSOs) for planning and delivering public health services. The objectives of this project were:

1. To build the capacities of frontline workers, and public health professionals/teams on mental health literacy (MHL).
2. To engage with the community through participatory methods to develop their understanding of MHL.

1.1.2 Project Design

The project was undertaken in New Seemapuri, Shahdara, East Delhi, India within the urban slum community. The project was designed to create an understanding of mental health literacy among youth and adolescents in this urban community, public health professionals, and public health frontline workers. The key interventions carried out were as follows:

1. Workshops on mental health literacy with public health professionals from Public Health Resource Society
2. Workshops on mental health literacy with public health professionals, students, adolescents, and young adults

3. Development of a Participatory Learning Action (PLA) module on mental health literacy for the community and public health workforce
4. Assess the level of MHL among adolescents and young adults between 15 – 24 years in the selected area,
5. Initiate conversation on MHL at the community level through a participatory approach using structured PLA modules.
6. Conduct campaigns on MHL among women, youth, and adolescents in the community

1.2 Literature Review

Despite its growing recognition, mental health is still overlooked and an under-prioritized section in the healthcare system. According to World Health Organization (WHO), in 2019, nearly a billion people, including 14% of adolescents, were suffering from mental disorders worldwide. Over 1 in 100 deaths were caused by suicide, and 58% of suicidal deaths happen before the age of 50 years [1]. This huge burden of mental illnesses is often underestimated due to the lack of awareness regarding the connection between mental illness and other health conditions [2]. Mental disorders are one of the major causes of disability, causing 1 in 6 years lived with disability [1]. It elevates the risk for both communicable and non-communicable diseases, as well as intentional and unintentional injuries. On the other hand, many health conditions complicate help-seeking and treatments, thus increasing the risk for mental disorders. [2]

According to the National Mental Health Survey (NMHS), 2016, in India, 10% of the population is affected by Common Mental Disorders (CMDs), including depression, anxiety disorders, and substance use disorders. Every 1 in 20 people in the country suffers from depression, with females between 40-49 years being affected the most. The prevalence of severe mental health disorders was found among 1.9% of the population. Disorders like schizophrenia, mood swings, and stress-related disorders were more prevalent in urban areas, attributed to factors such as fast-paced lifestyle, stress, limited support systems, economic instability, etc. [3]. Figure 1.1 shows the prevalence of mental disorder in 12 Indian states, namely, Assam, Uttar Pradesh, Gujrat, Rajasthan, Jharkhand, Kerala, Chhattisgarh, Tamil Nadu, West Bengal, Punjab, Madhya Pradesh, and Manipur.

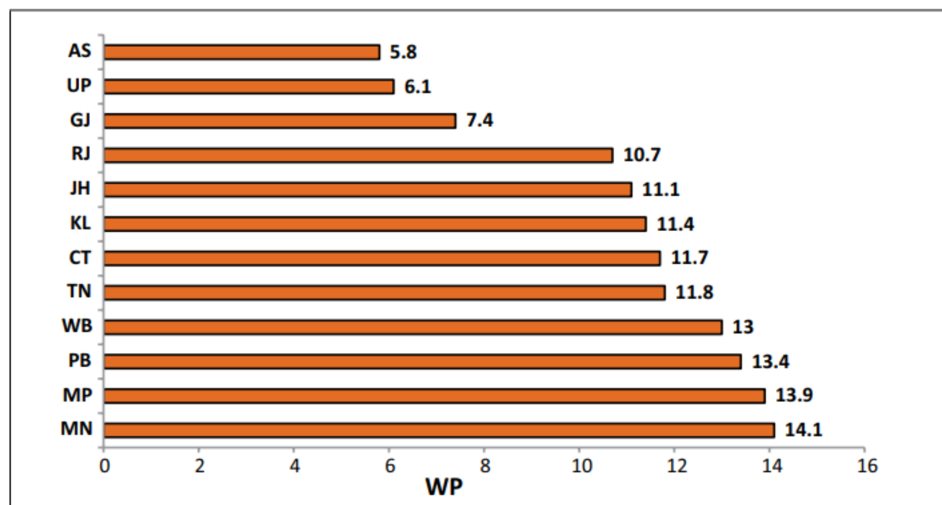


Figure 1.1: Prevalence of mental disorders in different States (%) *(Source- NMHS 2015-16)*

Adolescence is a unique period of social and emotional development. According to WHO, one in every seven adolescents experience some kind of mental disorder worldwide. Depression, anxiety, and behavioural disorders are some of the leading mental health issues in this age category [4]. A study conducted among adolescents and young adults between 15 to 24 years in Himachal Pradesh showed that some of the major mental health conditions among them are depression (6.9%), anxiety (15.5%), tobacco abuse (7.6%), alcohol abuse (7.2%), and suicidal ideation (5.5%) [3][5]. Factors such as abuse, bullying, peer pressure, substance abuse, teenage pregnancy, etc. can affect the mental health of adolescents. NMHS, 2016 shows that nearly 9.8 million young Indians aged between 13-17 years are in need of active interventions for mental health conditions [3].

One of the significant barriers to mental health care and well-being is the stigma associated with the condition. For an individual, stigma can cause anxiety and avoidance of mental health care causing delays in treatment-seeking [6]. For families, it can create shame and isolation, which makes it more difficult for them to get support and services [7]. For the society at large, stigma can lead to misallocation of resources with mental health services being often overlooked [8][9]. In India, nearly 80% of individuals suffering from mental illnesses do not receive any treatment due to stigmatization [3]. A study conducted among 445 participants from the South Indian district of Udupi, found the prevalence of stigma toward mentally ill people was 74.61% [10].

A study conducted by Fox et al. (2012) shows that internalized stigma or self-stigma is associated with delays in treatment-seeking [11]. Self-stigma occurs when an individual internalizes the public attitudes, discriminations, and prejudices against them and experiences adverse consequences [12]. The fear of being stigmatized, outcast, and misjudged, increases the risk of postponing or avoiding getting care for mental health issues resulting in intensification of the disease. Delays in receiving help can also feed a vicious cycle of pessimism, loneliness, and self-blame [9].

Treatment compliance/adherence is an important factor in determining the success of medical intervention for mental illness. A study conducted in India with 883 patients with mental disorders, found that only 35.7% of participants showed treatment compliance, with women having higher levels of treatment non-adherence [13]. Attitudes towards mental disorders/treatment, inadequate aftercare environment, and resource shortages are essential factors affecting treatment adherence in mental healthcare [14].

The National Mental Health Programme (NMHP) was launched in India in 1982 to ensure the availability and accessibility of minimum mental healthcare for all, particularly to the most vulnerable and underprivileged sections of the population. In 1996, the District Mental Health Programme (DMHP) was launched as part of NMHP for early detection and treatment of mental health conditions, to increase public awareness on mental health, and to train healthcare workers on identifying mentally ill persons [15]. In 2014, the National Mental Health Policy was launched with the vision of universal access to mental health care and reducing distress and disability, with a special focus on vulnerable populations. In 2017, the National Mental Healthcare Act (MHCA) was amended to "provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto".

Though the existing policies and programmes prioritize the mental health of adolescents and youth, there is still a need to improve access to mental health information, resources, and services [17]. NMHS, 2016, shows that the current mental health programmes in India are hampered by the lack of valid,

reliable, timely, sensitive, and specific outcome indicators for mental health developed through routine data-gathering methods. Additionally, there is a paucity of mental health specialists in India. Among the 12 state surveys during NMHS, the availability of psychiatrists (per lakh population) varied from 0.05 in Madhya Pradesh to 1.2 in Kerala [3]. Figure 1.2 gives a detailed representation of the same.

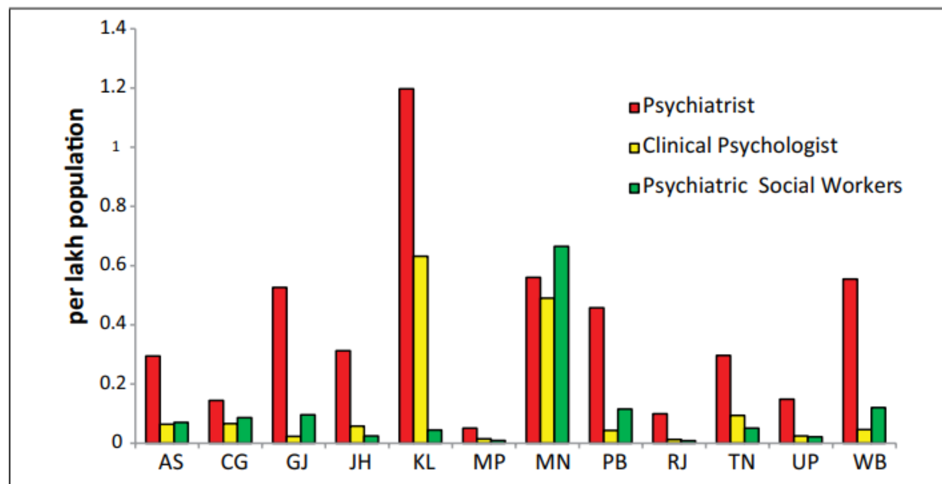


Figure 1.2: Mental health specialist human resources in NMHS States (per lakh population) *(Source-NMHS 2015-16)*

The state of Delhi has the highest prevalence of schizophrenia and eating disorders among other states of the country [19]. A report published by the Indian Express in 2012 indicated that in Delhi, the prevalence of mental health issues is rising especially among the economically deprived groups [19]. The ever-growing burden of mental health can be effectively addressed when communities are empowered with knowledge about mental health. A participatory community-based approach to treating mental health conditions can prove to be beneficial in the Indian context since care-seeking is influenced by traditional beliefs and practices [18]. NMHS recommends the involvement of non-specialist professionals in mental health care. With grass root level health functionaries like Accredited Social Health Activist (ASHA), Auxiliary Nursing Midwife (ANM), and health workers contributing significantly to the workforce density, there is a need to increase their engagement in mental health programmes through the development of skill-enhancing initiatives [3].

2. Activities Undertaken

2.1 Workshop with public health professionals

2.1.1 Training of PHRS staff on MHL

The project started with a five-day workshop with public health professionals from PHRS. A two-hour online session each day was organized from 11th December 2023 till 15th December 2023. The training session was facilitated by Prof Raghu Raghavan, Prof Brian Brown, and Dr Deepika Saini from DMU. The workshop was attended by 10-12 PHRS professionals. It focused on the following key aspects.

- Understanding the basics of mental health, MHL, and cultural approach to mental health
- The signs and symptoms, triggers, and diagnosis of various mental health disorders. These included CMDs and Severe Mental Health Disorders (SMDs); and the biopsychosocial model of mental illness
- Mental health stigma and its harmful effects
- Various self-help and professional-help approaches for mental well-being.

PHRS staff engaged in online training sessions of MHL

2.1.2 Workshop with public health students from Dr B R Ambedkar University, Delhi

A one-day workshop was conducted on mental health literacy at Dr. B. R. Ambedkar University, Delhi on 22nd May 2024. The session was attended by 27 public health students and was facilitated by Dr Rupa Prasad and Ms Rishita Maiti from PHRS. Interactive discussions were held on topics of mental health disorders, cultural beliefs and stigma surrounding the condition, and the importance of self-care. Group activities were also conducted in the form of case study assessments, role plays, and poster-making to understand the perspectives and learnings of the public health students.

MPH students from Dr. B. R. Amdebkar University posing for post-session photographs

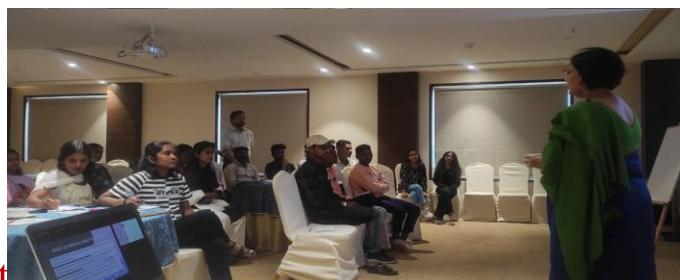
2.1.3 Workshop with public health professionals/CSO from different states of India

A session on MHL was undertaken by PHRS at Bhopal on 24th July 2024. Public health professions from different CSOs such as Terre Des Hommes, Chaupal, PRERAK, Paryavaran Mitra, Vacha, Pratham, MUSKAAN, Vikas Samvaad, TISS, ADHAR, PRASOON, Synergy Sansthan, etc, attended the session. It followed an interactive discussion on- the basics of mental health, various CMDs and SMDs, mental health stigma, and self-care approaches.

Session on MHL with different CSOs

2.1.4 Workshop with adolescents and young adults

A session with adolescents and young adults was undertaken by PHRS on 24th July 2024 at Bhopal. Most of them were working in the community through various NGOs. The group participated in various activities and games related to mental health. The participants shared their experiences, and cases of mental health issues they come across in the field. The group also shared various self-care activities they undertake to take care of their mental health.



2.2 Assessment of MHL among community members of New Seemapuri

A study was undertaken in the urban slum community of Delhi to assess the knowledge, awareness, and practice related to mental health. The data was collected in two phases – Phase 1 (March-April 2024) and Phase 2 (July 2024).

2.2.1 Methodology

Selection of district and slum: For the selection of the district and the slums for the study, a facilitating organization in Delhi was contacted. Based on the discussion with the facilitating organization, the study was conducted in the Seemapuri slum (block B&D) of Shahdara district in East Delhi.

Participants: Adolescents and youth in the age group of 15-24 years.

Sample size: During the first phase, 272 participants and during the second phase 186 participants responded to the MHLq, leading to a total of 458 participants.

Sampling method: Purposive sampling

Data collection tool: For quantitative data collection, the standard Mental Health Literacy questionnaire (MHLq) developed by DMU has been used. The tool was translated into Hindi.

For qualitative data collection, a checklist for participants between 15-19 years and 20-24 years was been developed.

Data Management and Analysis: The data collection was carried out by the research team. For the qualitative data analysis, detailed notes of the interviews were transcribed and analyzed using thematic analysis.

Ethical consideration: Ethical clearance was taken from the Institutional Ethics Committee of Public Health Resource Society. Participant information sheets and informed consent forms in the local language were used. The form was shared with the participants/ read out to the participants. Thereafter, written consent was taken. After every interview, a summary of the interview was read back to the participants to ensure validation. No risks were perceived to the respondents of the study. Confidentiality was maintained throughout data collection, analysis, and documentation. Participation was voluntary with the right of the respondents to withdraw at any stage. Due acknowledgment has been given to all persons (participants and others) involved in this research.

2.2.2 Study Site Description

New Seemapuri is located in East Delhi stretching approximately 7-8 square kilometers. The locality is divided into six blocks (A to F). Each block has 9 to 15 *galis* (streets), with approximately 52 households in each *gali*. The residents of New Seemapuri practice different religions with the predominant being Hinduism in blocks A to D, followed by Islam being followed mostly by residents of blocks E and F. The region has three mosques and a few temples. Most of the residents belong to the category of scheduled caste (Balmiki), followed by the general caste. A wide cadre of the population belonged to migrants from Uttar Pradesh, Bihar, and Bangladesh mostly located in the E and F block.

Most people belonging to the older generation have education level till secondary school in the area, while the younger generation has mostly completed a graduation degree. However, it was informed that girls are more inclined towards an educational career while boys who reside in E and F blocks have been victims of drug abuse and are unemployed. The area has functional community institutions like Anganwadi centers and government schools. New Seemapuri has a total of 27 Aanganwadi centers and two government schools- one primary school in B block and one higher secondary school in C block.

27 Aanganwadi workers, 16 ASHA workers, and 2 ANMs are working in the area. Schemes such as ICDS (Integrated Child Development Services), MDM (Mid-Day Meal), PDS (Public Distribution System), and PMMVY (Pradhan Mantri Matru Vandana Yojna) are functional in New Seemapuri.

The locality has one Mohalla clinic. A dispensary was located at B block of New Seemapuri which was demolished in 2018. Due to this, people face difficulties in case of emergencies and have to travel approximately 3-4 km to the nearest emergency hospital. There are three emergency hospitals- GTB Hospital, Swami Dayanand Hospital (general hospital), and IHBAS Hospital (mental health hospital) near New Seemapuri.

The main source of drinking water is piped tap water supplied from Jal Board. Though there were no complaints of water scarcity, it had been informed that there was a frequent supply of non-potable/dirty water during winters. All the households have bathrooms and toilets. One public washroom is available in the area. The area has good road connectivity and is easily accessible through public transportation- autos, e-rickshaws, and buses. 1-2 ration stores (PDS) are available in each block. The stores are functional and accessible to everyone. The PDS supplies only rice and wheat.

Most people belonging to the SC category are engaged in sanitation and waste management work in the MCD (Municipal Corporation Delhi) department. Very few work in private/ corporate companies. Among working women, most are engaged as house-help.

Some NGOs/institutions that provide social services in the area are Jan Sandesh, ASHA DEEP Foundation, Jivisha, Pardarshita, Mobile Creches, and Chetanalaya. These organizations are mostly working for the empowerment of the marginalized sections through self-reliance, education, and upskilling their livelihood options.

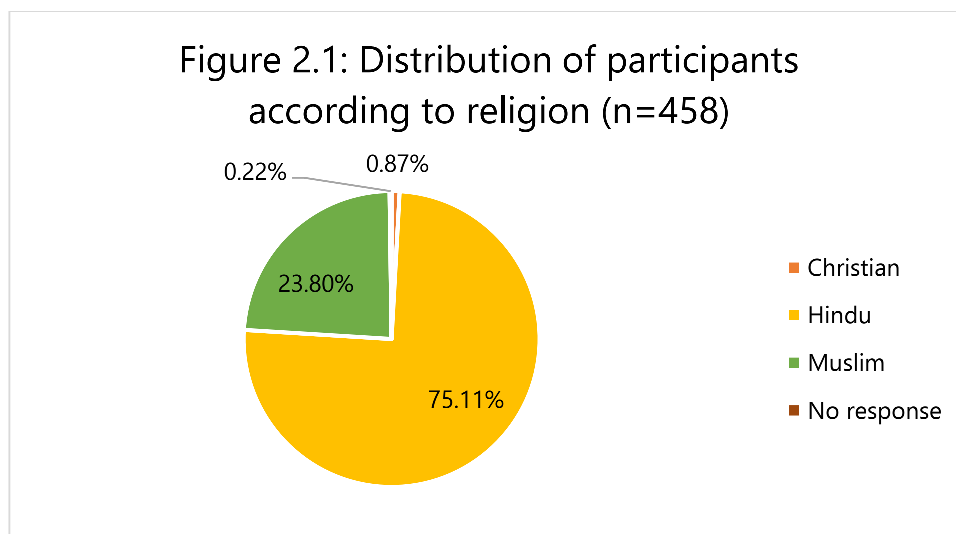
2.2.3 Findings

Demographic characteristics of the respondents

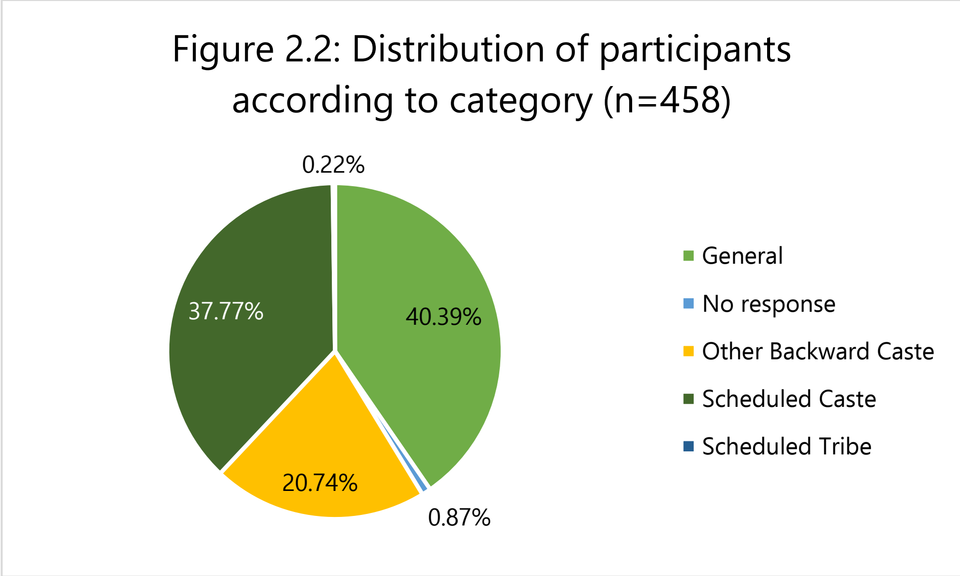
A total of 458 respondents between 15 to 24 years participated in the study from B and D blocks of New Seemapuri.

Age and gender: The mean age of participants was 18.88 years. Out of the study participants, 240 were female, 214 were male, and 4 were transgenders.

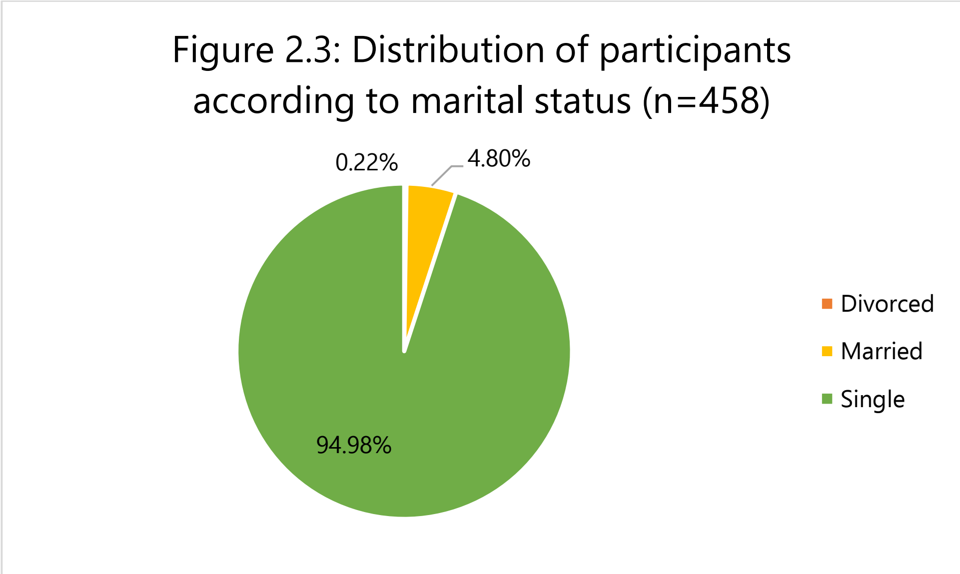
Religion: Around 75% of respondents followed Hinduism, 25.80% followed Islam, and 0.87% followed Christianity [Figure 2.1].



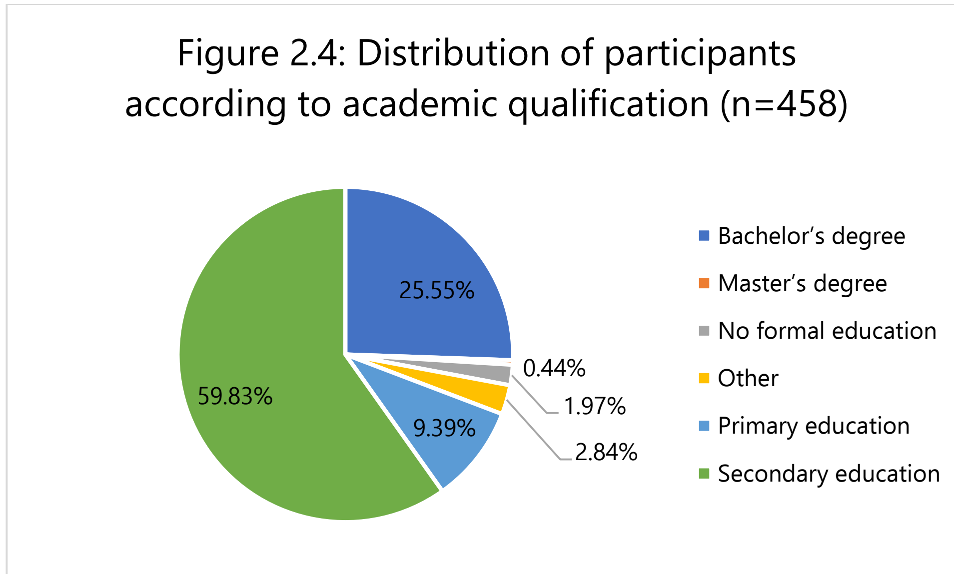
Category: Most of the respondents belonged to the General category (40.39%) and Scheduled Caste (SC) category (37.77%). 20.74% identified as Other Backward caste (OBC) and 0.22% as Scheduled Tribe (ST) [Figure 2.2].



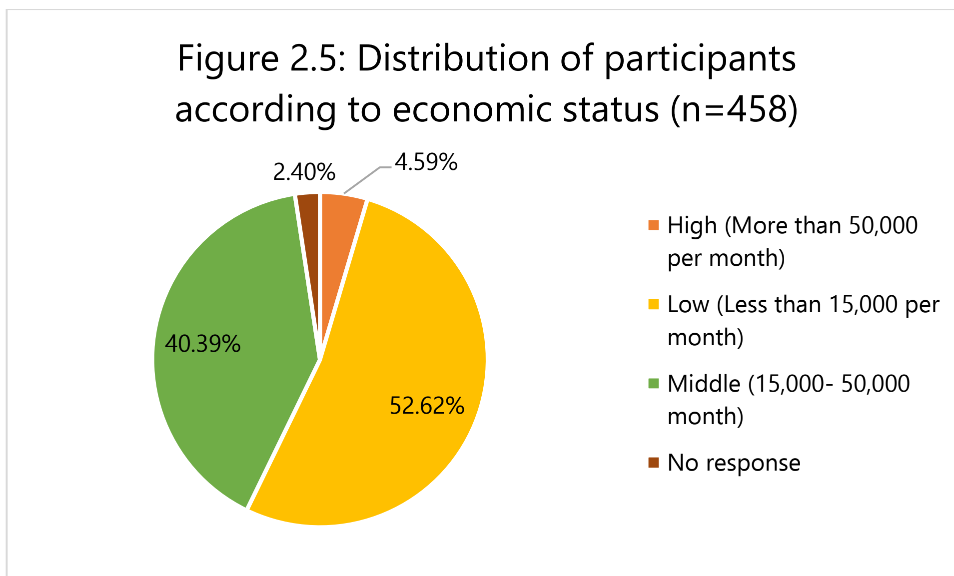
Most of the study participants were single (94.98%) and 4.80% were married. A small proportion (0.22%) were divorced. [Figure 2.3].



Almost 60% of participants had completed secondary education [Figure 2.4]. 25.55% had a Bachelor's degree, 9.39% finished primary education, and 1.97% of respondents did not have any formal education. 0.44% of study participants had a Master's degree.



Among the participants, 52.62% responded belonging to low economic status, having a monthly income of less than Rs 15,000 per month (176.845 USD), 40.39% belonged to middle economic status with a monthly income between Rs 15,000 to 50,000 per month (176.845 to 589.484 USD), and 4.59% of respondents belonged to high economic status having monthly income more than Rs 50,000 (589.484 USD) [Figure 2.5].



The majority of the participants were students (61.35%). 12.66% of respondents were formally/full-time employed and 9.83% were unemployed. 6.77% of respondents were homemakers, and 1.75% were employed as daily wage workers [Figure 2.6].

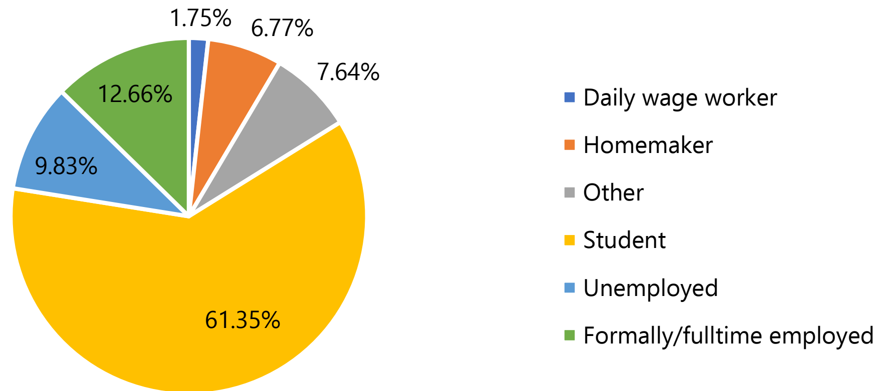


Figure 2.6: Distribution of participants according to occupation (n=458)

Awareness of mental health disorders

Among the participants, 13.54% responded that they knew individuals who were suffering from some kind of mental health problem [Figure 2.7]. Most of them were their relatives (33.85%), friends (29.23%), and themselves (10.77%). [Figure 2.8].

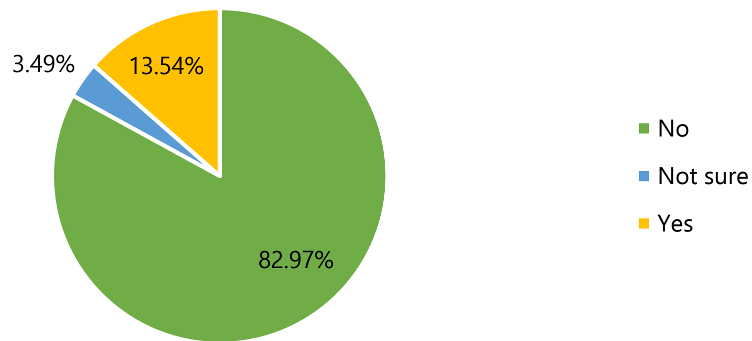
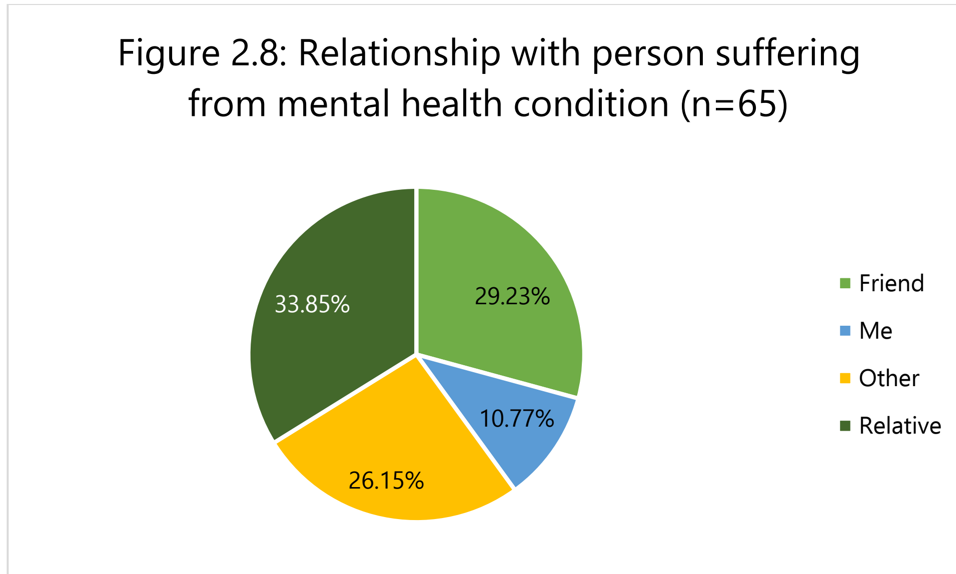


Figure 2.7: Aware of individuals suffering from mental health problem (n=458)



When asked, what kind of mental health problem the persons were suffering from, most of them identified signs of depression with some of them clinically diagnosed. A few other responses were anxiety, hallucinations, anger issues, etc.

Knowledge, attitude, and practices related to mental health

The participants were asked a series of questions related to mental health literacy with responses ranging from strongly disagree to strongly agree [Table 2.1].

Around 41% of participants disagreed with the statement that 'Mental illness does not affect people's emotions.' Most participants (53.28%) disagreed that 'Only grown-ups have mental illnesses.' Most participants (63.97%) agreed that 'Family environment will affect the mental health of the members.' 65.5% agreed with the statement that 'A person with Depression feels very unhappy.' 64.41% also agreed that 'Doing something enjoyable helps to improve mental health.' When asked if the participant would seek family help if they had mental illness, 62.23% agreed while 6.11% disagreed with it.

Among the participants, 36.03% agreed with the statement that depression is not a true mental illness

An adolescent boy, aged 18 years, expressed that he finds it challenging to open up about his problems, especially as he has no friends. He doesn't talk to his parents for the same, as he feels they may not fully understand. He realises that there's a disconnect between parents' perception regarding mental health and they don't understand the issues and challenges that he faces. This has led to a minor disagreement with his father. Occasionally, he discusses his concerns with his cousins, but only when they meet in person.

and 57.72% disagreed with 'People with mental illness should hide it from other people.' 47.48% and 68.01% of respondents agreed with the statements that 'Alcohol use may cause mental illnesses' and 'Drug addiction may cause mental illness' respectively.

27.94% of participants believed that 'Mental illness is caused by black magic or possession'. Most participants (56.55%) agreed that 'The sooner mental illnesses are identified and treated, the better' [Table 2.1].

A young man, aged 20 years, said that his younger brother is struggling with substance addiction problem, that has affected his own mental well-being. He expressed feelings of guilt and self-blame, as he believes his absence while working in Gurgaon left his brother without adequate guidance at home. His brother was admitted to rehabilitation, costing him Rs 6000 per month, but despite these efforts, his brother remains involved with drugs.

Table 2.1: Knowledge, attitude, and practices related to mental health

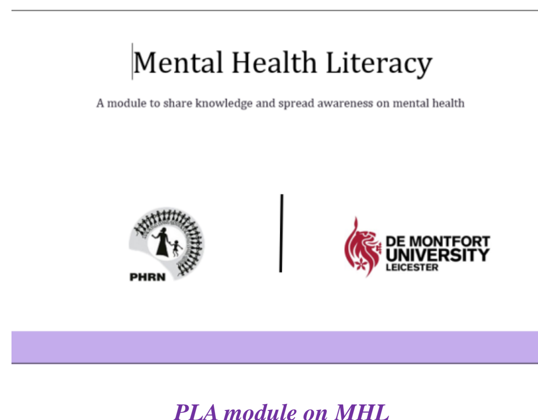
Sl. No.	Statements	n=458				
		Strongly disagree (%)	Disagree (%)	Undecided (%)	Agree (%)	Strongly agree (%)
1	Mental illness does not affect people's emotions.	9.39	41.27	9.39	31.88	8.08
2	People with mental illness do not have a strong mind.	5.02	23.36	11.35	52.4	7.86
3	Only grown-ups have mental illnesses	9.61	53.28	14.19	17.69	5.24
4	Those with mental illness should not get married.	9.83	32.97	22.27	28.6	6.33
5	Anyone can be affected by a mental illness.	6.99	13.76	8.08	57.21	13.97
6	Depression is not a true mental illness.	10.7	31.66	12.88	37.12	7.64
7	A person with mental illness remains so lifelong.	9.39	40.17	15.72	29.26	5.46
8	Person's thoughts are affected by the mental illnesses.	4.37	16.59	12.88	58.3	7.86
9	People with mental illnesses come from low-income families.	14.41	50.22	8.3	22.27	4.8
10	People with mental illness should hide it from other people.	14.85	53.28	8.73	17.25	5.9
11	If I had a mental illness, I would seek help from a traditional healer.	6.77	18.56	9.83	49.34	15.5
12	People with mental illness may find comfort from Ayurvedic medicine.	5.68	17.03	23.8	43.01	10.48
13	Mental illnesses do not affect a person's own behaviour.	12.88	47.16	13.54	22.05	4.37
14	Impairment/problems in brain functioning may cause the development of mental illnesses.	3.93	9.83	12.88	63.32	10.04
15	A person with Depression feels very unhappy	2.18	8.73	6.55	65.5	17.03

16	Alcohol use may cause mental illnesses.	4.8	20.96	11.79	48.47	13.97
17	Drug addiction may cause mental illness.	4.59	5.24	6.55	63.54	20.09
18	One of the symptoms of depression is the loss of interest or pleasure in most things.	4.59	10.26	15.5	60.92	8.73
19	A person with anxiety disorder avoids situations that may cause her/him tension.	3.49	10.7	10.48	64.41	10.92
20	High tension & pressure situations may cause mental illness.	5.9	8.73	4.8	66.59	13.97
21	Family environment will affect the mental health of the members.	2.62	10.7	5.68	63.97	17.03
22	Long-lasting symptoms are one of the important aspects to determine whether a person suffers.	3.28	11.35	19.87	57.21	8.3
23	People with mental illness can have physical symptoms/pain.	4.15	13.54	15.28	58.52	8.52
24	Physical exercise helps to improve mental health	4.37	4.8	6.33	64.85	19.65
25	Doing something enjoyable helps to improve mental health.	4.15	5.24	6.33	64.41	19.87
26	Social service or service without any expectation promotes inner satisfaction and good mental health.	4.37	13.1	12.23	60.26	10.04
27	A healthy diet helps to improve mental health	2.84	4.8	6.33	68.12	17.9
28	If a friend of mine developed a mental illness, I would advise her/him to look for a psychologist/psychiatrist.	3.49	5.24	6.33	59.39	25.55
29	If I had a mental illness, I would seek professional help (psychologist and/or psychiatrist).	2.62	6.55	6.55	61.57	22.71
30	Mental illness should be treated by taking medications prescribed by a doctor.	3.93	10.48	10.48	55.9	19.21
31	If I had a mental illness, I would seek my family's help.	4.59	6.11	5.9	62.23	21.18
32	If someone close to me has a mental illness, I think the astrologer would be able to help them.	18.78	42.14	11.79	21.83	5.46
33	Mental illness is caused by black magic or possession.	20.74	36.9	12.01	24.24	6.11
34	The sooner mental illnesses are identified and treated, the better.	3.28	1.97	3.49	56.55	34.72

2.3 Community Engagement Using Participatory Methods

2.3.1 Development and designing of PLA module

PHRS designed and developed a Participatory, Learning, and Action (PLA) module on MHL to empower communities and frontline workers with knowledge of mental health. This will eventually help them in early recognition of different mental health conditions in the population. PLA modules are designed to allow for open discussion and knowledge exchange through a series of games and activities. The module has been developed keeping in view the cultural relevance and is easily adaptable. It covers aspects of various mental health disorders, signs and symptoms to recognize them, and the stigma associated with them.



PLA module on MHL

2.3.2 PLA module transaction

The PLA module was transacted in the community in the presence of field functionaries and AWWs. The module was transacted during community meetings with women groups, adolescent groups, and youth groups in B and D blocks of New Seemapuri. The module is designed for easy facilitation of the meetings, to discuss the issues related to mental health at the community level, such that it can lead to action. Apart from assisting in analysis, the module delivers some key messages through a participatory pedagogy of storytelling, games, and activities that are interactive in nature. 2-3 community meetings with each of the groups were conducted in the two blocks of New Seemapuri. Some of the major action points that emerged during the meetings were:

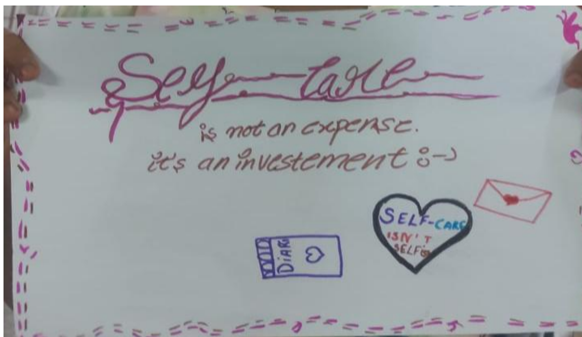
Adolescents	• We will try to spread awareness about mental health among our friends • We will try to create a good environment for those having mental health disorders so they have a sense of belonging • We will try to make those having mental health disorders feel comfortable enough to open up.
Women	• We will start the change (spread awareness) in our households first • We won't use the term '*pagal*' (mad) vaguely • We will form groups among ourselves where people can open up about their problems without any fear of judgment

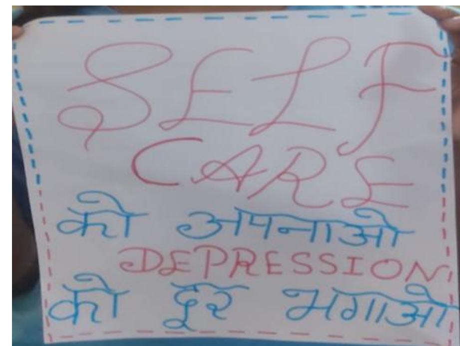
Youth	• We will not stigmatize people who are suffering from mental health disorder • We will advise people with a mental health disorder to consult a counselor.

Ongoing PLA session on MHL in the community

2.3.3 Campaign on MHL

Community-based campaigns were conducted on MHL. Women, adolescents, and youth from New Seemapuri participated in poster-making events to raise awareness about mental health issues, reduce stigma, and encourage open dialogue within the community. Many opened up about their lived experiences during the meetings which promoted mental well-being. The campaign created a more knowledgeable and caring community by empowering people to actively participate in understanding and supporting mental health. The campaigns were conducted with each of the women, adolescent, and youth groups in the two blocks of New Seemapuri.





Few posters on MHL

3. Case Study

3.1 The journey of physical transition during adolescence

A widely acknowledged characteristic during the adolescence phase is the emergence of biological, psychological, and social changes. Adolescents during this phase go through a range of experiences that affect their well-being and strain their coping mechanisms. It is also the peak time for the occurrence of various mental disorders [20]. According to WHO, globally, one in seven 10-19-year-olds experiences a mental disorder, accounting for 13% of the global burden of disease in this age group [4]. Boys are more likely to face behavioural challenges like Attention Deficit Hyperactivity Disorder (ADHD) and experience suicidal thoughts during this phase. Additionally, they are also less likely to seek help than girls [21]. While conversing with the adolescent boys of New Seemapuri in Delhi, in was noted that societal expectations, cultural norms, peer pressure, and body image issues have a major impact on their mental health. Anxiety, social isolation, self-consciousness, bullying, and emotional distress was found very common in the community. While many try to cope by indulging in various activities or asking for help, others remain traumatized and feeling inadequate.

"***I receive numerous comments for being lean*"** shared by an adolescent boy during one-on-one conversation with our field team. ***"My relatives suggest to me to eat more as I look too thin for my age with comments like 'patla hote jaa rha hai khaya karo kuch*'."("you are getting thin you should eat more") One of the most common themes that emerged our during most of our in-depth interviews was body image, physical appearance, and societal judgement. Though such comments may seem casual for most people, but can leave a deep mark on the mental health of the person. "***My peers used to bully me for being dark-skinned, calling me with names like 'kaalo (blackie)'. I used to run away from those people. I tried everything I could to change my complexion***" narrated another boy. The profound impact of societal beauty standards on young minds often leads to social isolation and overthinking, leaving them with a feeling of inadequacy. While some were victims of bullying, others faced internal turmoil and social anxiety- "***the changes in my body during puberty made me feel underconfident. I also felt social-anxiety for quite some time***." This is a common reflection of the body image toll on adolescents. However, many were trying to cope and move past the societal judgements. "***My friend tease me for having a big forehead, my family comment on my leaneness. Though I sometimes feel self-consious due to this, but I choose not to dwell on this***."

The various experiences shared by adolescent boys highlight the need for collective support from families, peers, communities, and schools during this phase of physical and emotional transition. It is crucial to create an environment for adolescents that support positive self-image and lessen the stigma for them.

3.2 Gender dynamics and mental health

Both men and women face significant health challenges. However, WHO's article on women's health describe that, sociocultural factors such as - unequal power relationships between men and women, social norms that decrease education and paid employment opportunities for women, an exclusive focus on women's reproductive roles, and potential or actual experience of physical, sexual and emotional violence, make a woman's health of particular concern [22]. This also leads to differential occurrence of psychological disorders among women. It often begins with the gender dynamics within the household. Cultural norms, family's expectations and pressures can cause a variety of emotional reactions, ranging from tension and annoyance to the feeling of powerlessness. The young women of Delhi describe how they often face the dilemma to choose between personal aspirations and the expectations from family and society.

"***I want to become an architect. But all my mother talks about is of marriage. Her only concern is- 'Beta, umar nikal jayegi, humara toh bas ek hi ladki hai'***," ("daughter, you will become old, we have only one daughter") exclaimed a young woman from New Seemapuri. Such family pressure signifies the age-old value of women being judged on the basis of their marital status. Maintaining parents' hopes while attempting to achieve one's own goals can be difficult and lead to stress, anxiety, and a host of other mental health issues. At the same time experiencing inequalities due to gender can foster emotional fatigue and resentment. While interviewing, various young women revealed how common it is for them to experience inequalities, while their male siblings enjoy freedom. The perception of inequality causes emotional isolation and a sense of being overlooked. "***I am stuck at home, doing all the chores, while my brother comes and goes as he pleases. They* (parents) *say they treat us equally, but it's not true***." Overtime, the feeling of unjust can lead to frustration and emotional numbness. "***I wanted to become cabin crew, but my parents said no. They let my brother study engineering***" shared by another young woman. Many women expressed that they were unable to share their feelings with anyone since they believed no one would 'understand' them. Some even started crying while sharing their experiences with our team. Nevertheless, not all women faced extreme discrimination. Many parents prioritized their daughter's education and aspirations and defied societal expectations- "***My parents don't pressure me to marry. They want me to focus on my education and be financially independent***."

To cope with the wide range of emotional stressors, the women adopted various coping mechanisms. While some turned to isolation and become a rebel, others practiced mindfulness activities like meditation. "***I listen to music, I meditate—it's the only way I can manage the stress***", said a young adult woman. It is essential to address the great mental health challenges posed by gender dynamics in society. Women's empowerment is one of the crucial steps toward safeguarding their emotional well-being.

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3.3 Psychological effects of social media

Social media has become a part of our lifestyle. For today's youth, social media has become a means to gain acceptance and be popular. Although social media provides many opportunities, but addiction of the same can be adverse. Cyberbullying, privacy breach, and impact on mental health are all risks associated with the usage of social media. Additionally, youth use cell phones and other forms of media in large numbers, resulting in chronic sleep loss, which has a negative influence on cognitive ability, school performance, and socio-emotional functioning [23]. We tried to explore the various social media platforms used by the adolescents and young adults in New Seempuri in Delhi and its impact on their social life.

Social media can often serve as a means of social and emotional distraction. ***"I watch Instagram reels when I am stressed as it helps me forget about my worries for a while***," said one participant. For many others, the beauty standards showcased on social media can lead to self-consciousness and self-criticism. Many of our study participants reflected an urge to meet the societal beauty norms. This often can lead to emotional strain, feelings of inadequacy, and body dysmorphia. One adolescent girl exclaimed, "***I aspire to have beauty like the influencers on Instagram. Unke jaise toh exact nhi payegi lekin thoda toh banna chahti hun***"('I cant become exactly like them but atleast a little") while another said, "***the filters make me look better, but I know it's fake***."

The social media paradox feeds into a cycle of self-doubt and emotional highs and lows to people, through validations provided by the number of likes and comments. "***It's fun to make videos, but when I don't get enough likes, I feel disappointed***" an adolescent boy exclaimed. This is a clear instance of the effect of social media on users' self-esteem and mental health by creating a sense of dependence on external validation. In turn, this can lead to anxiety, self-doubt, and feelings of self-inadequacy.

At the same time, many participants also pointed out the differences between online and offline realities. With statements like "***people on social media are fake; they show what they are not***," and "***social media creates unrealistic opinions about masculinity. Sometimes it stops you from accepting yourself***," it was evident that some of the study respondents were aware of fake representations showcased by social media. The impact of social media on mental health is multifaceted. Hence, it is crucial to encourage healthy and mindful usage of technology among the younger generations. Emotional dependence on the same can be harmful.

3.4 Stories of resilience and self-care among Delhi's youth

The modern lifestyle can often take a toll on the mental health of young people making them vulnerable. In this regard, self-care can be an essential tool to develop resilience and emotional stability. In the long term this can help in boosting the self-esteem of an individual. While interviewing through the streets of New Seemapuri, Delhi, we encountered several adolescents and young adults who are embracing self-confidence and defying the so-called 'beauty standards' of society. With statements like "I have never paid heed to societal judgments. I dress however I like to" and "I have never felt the need to pertain to societal beauty standards", we felt a sense of self-acceptance and self-worth among many of the young women we ecountered.

While many people are still affected by the extravagant lifestyle shown on social media, few understand its double-edged nature. A young content creator exclaimed, "***I like making Instagram reels. It helps me connect with people. Sometimes I fall behind in the ongoing social media trends. But then I keep reminding myself that I shall grow at my own pace***". For others, social media community has helped in overcoming insecurities. An adolescent boy mentioned being self-conscious of the physical changes he went through during his early adolescence. However, through social media he learned about similar changes among boys of his age, "***It made me realise that I am not alone in this journey***".

We also came across people who turned the traumas and challenges of life into their strength. A young woman recalled the challenges she faced post-marriage and pregnancy, "***My first pregnancy was tough because I did not know much at that time. But eventually, it made me stronger. Raising my two daughters has been a big challenge and responsibility because I want them to grow up independent***". She exclaimed her children are a source of motivation and resilience in her life. Another girl, who often used to get bullied in school due to her looks, has now learned to ignore and overcome it, "I used to cry when people commented on my complextion. But now I have overcome that because I cannot change the way I look". Her journey resonates resilience and self-acceptance.

People cope with their stresses in different ways. Some find peace through practicing their hobbies, others listen to music. "***I get stressed only during exams. I usually watch motivational videos on YouTube. They calm me***," said an adolescent boy. Others rely on entertainment, "***Music and movies are my escape***" a young woman exclaimed. By building self-confidence, personal development, and practicing self-care activities, many young individuals of Delhi are learning to overcome societal judgements and embrace themselves. Their experiences serve as inspirational reminders of the value of self-worth, the strength of resilience, and the results of choosing optimism over pressure.

4. Learnings and Challenges

1. This project helped the PHRS team to learn basic concepts of mental health and it also helped in taking forward the knowledge to other public health professionals and the community.
2. PLA proved to be an effective tool to engage with the community and empower them to take ownership of their mental health.
3. Workshops, community campaigns, and interactive group activities sparked conversations on heavily stigmatized topics like mental health.
4. The MHL project provided a limited scope for engaging with individuals to provide need-based support.
5. Workshops with public health professionals, students, and field functionaries expanded our knowledge of mental health and allowed a medium for the exchange of experiences and best practices.
6. A project on mental health requires long-term engagement with the community.
7. Community mobilization was time-consuming given that mental health topic is deeply stigmatized.
8. The project has provided scope for expansion and new themes around mental health can be projectized, e.g., working on issues of domestic violence, social media impact of mental health/ self-imaging, and post-partum depression, among others.
9. The MHLq needs further discussion and refinement to suit the context in which it is to be applied.

5. Conclusion and Way Forward

The MHL project stands as a notable intervention aimed at addressing mental health concerns and misconceptions amongst the vulnerable population. The project strived to create an understanding of mental health in the community and thereby aided in reducing stigma around the topic.

The study with adolescents and young adults in urban slums of East Delhi revealed quite a few gaps in literacy on mental health with misconceptions, myths, and misinformation still being much prevalent. While most participants demonstrated a high level of awareness of MHL, however, a significant proportion continues to stigmatize the condition. Although most participants were aware that mental disorders affect feelings, thoughts, and behaviour, there was a notable lack of recognition of mental illness as a serious or lifelong health problem. There were differences in opinions regarding mental illnesses, with many continuing to link it to possessions and black magic. However, it was also found that the majority of respondents acknowledged the importance of self-care and family support in promoting mental wellness. Most of the participants were willing to seek professional psychological or medical help and believed that early identification and treatment of mental health conditions is useful.

The project followed a participatory approach to engage with the adolescents, youth, and women in the urban slum community in Delhi. The PLA approach placed the community at the centre of the intervention to shape the discussions and learnings in a way that is culturally appropriate and relevant to the participants. This empowered the community to take ownership of their mental health. Additionally, various workshops with public health professionals, public health students, and public health workers at the ground level proved beneficial in sharing knowledge and good practices in mental health.

Overall, the MHL project showcased the deeply ingrained traditional beliefs in society. It showed the importance and need for sustainable involvement with the community through a participatory method. Igniting conversations on topics like mental health needs active participation through community campaigns, games, activities, and storytelling. Moving forward, one of the key challenges would be to address the remaining myths and stigma around mental health disorders in society. The evidence generated through this project can be used to address broader public health initiatives and policies related to mental health. Moving forward, some of the actionable steps can be:

1. MHL is a useful tool for reducing stigma and providing knowledge on mental health. It may need further refinement to suit the context. More and more healthcare providers should be trained on MHL and enhance their capacities to identify mental health disorders.

2. MHL should also be a part of the school curriculum. This can include common mental health disorders and coping strategies for stress management.

3. There is still a strong stigma associated with mental health conditions, which hinders communication. Culturally sensitive programs that acknowledge traditional values and beliefs should be implemented.

4. In communities, peer support groups can be established to provide assistance to those with mental health issues.

5. Mental health facilities that offer affordable counseling services can be established at the community level. These can also support people to engage in yoga and other mindfulness practices.

6. Mental health policies and programmes should be data-driven. Hence, it is crucial to invest in research for a better understanding of mental health challenges in society.

7. Engaging with the public health systems and allied departments in the need of the hour to ensure mainstreaming of mental health issues and mechanisms to address these issues in different settings.

References

1. “WHO Highlights Urgent Need to Transform Mental Health and Mental Health Care.” Accessed September 17, 2024. https://www.who.int/news/item/17-06-2022-who-highlights-urgent-need-to-transform-mental-health-and-mental-health-care.
2. Prince, Martin, Vikram Patel, Shekhar Saxena, Mario Maj, Joanna Maselko, Michael R. Phillips, and Atif Rahman. “No Health without Mental Health.” *The Lancet* 370, no. 9590 (September 8, 2007): 859–77. https://doi.org/10.1016/S0140-6736(07)61238-0.
3. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, Mehta RY, Ram D, Shibukumar TM, Kokane A, Lenin Singh RK, Chavan BS, Sharma P, Ramasubramanian C, Dalal PK, Saha PK, Deuri SP, Giri AK, Kavishvar AB, Sinha VK, Thavody J, Chatterji R, Akoijam BS, Das S, Kashyap A, Ragavan VS, Singh SK, Misra R and NMHS collaborators group. National Mental Health Survey of India, 2015-16: Summary. Bengaluru, National Institute of Mental Health and Neuro Sciences, NIMHANS Publication No. 128, 2016.
4. “Mental Health of Adolescents.” Accessed September 18, 2024. https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health.
5. Banandur, Pradeep, Gururaj Gopalkrishna, Zoya Rizvi, and Gopal Beri. “Health Impacting Behaviour & Morbidity: Implications for Adolescent & Youth Health Programmes in India.” *The Indian Journal of Medical Research* 158, no. 5 & 6 (November 1, 2023): 494–504. https://doi.org/10.4103/ijmr.IJMR_2605_20.
6. Stigma and discrimination of mental health problems: workplace implications. Brohan E, Thornicroft G. *Occup Med (Lond)* 2010;60:414–415.
7. Stigma and mental health. Sartorius N. *Lancet.* 2007;370:810–811.
8. The paradox of self-stigma and mental illness. Corrigan PW, Watson AC. *Clin Psychol Sci Pract.* 2002;9:35–53.
9. Ahad, Ahmed A, Marcos Sanchez-Gonzalez, and Patricia Junquera. “Understanding and Addressing Mental Health Stigma Across Cultures for Improving Psychiatric Care: A Narrative Review.” *Cureus* 15, no. 5: e39549. Accessed September 20, 2024. https://doi.org/10.7759/cureus.39549.
10. Venkatesh, Bhumika T., Teddy Andrews, Sreemathi S. Mayya, Mannat M. Singh, and Shradha S. Parsekar. “Perception of Stigma toward Mental Illness in South India.” *Journal of Family Medicine and Primary Care* 4, no. 3 (September 2015): 449. https://doi.org/10.4103/2249-4863.161352.
11. Fox, Annie B., Brian N. Smith, and Dawne Vogt. “How and When Does Mental Illness Stigma Impact Treatment Seeking? Longitudinal Examination of Relationships between Anticipated and Internalized Stigma, Symptom Severity, and Mental Health Service Use.” *Psychiatry Research* 268 (October 2018): 15–20. https://doi.org/10.1016/j.psychres.2018.06.036.
12. Corrigan, Patrick W., and Deepa Rao. “On the Self-Stigma of Mental Illness: Stages, Disclosure, and Strategies for Change.” *Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie* 57, no. 8 (August 2012): 464–69. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3610943/.
13. 2024 Khan et al. Cureus 16(2): e54495. DOI 10.7759/cureus.54495
14. Deng, Mengjie, Shuyi Zhai, Xuan Ouyang, Zhening Liu, and Brendan Ross. “Factors Influencing Medication Adherence among Patients with Severe Mental Disorders from the Perspective of Mental Health Professionals.” *BMC Psychiatry* 22 (January 7, 2022): 22. https://doi.org/10.1186/s12888-021-03681-6.
15. “National Mental Health Programme (NMHP) :: National Health Mission.” Accessed September 20, 2024. https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1043&lid=359.
16. THE MENTAL HEALTHCARE ACT, 2017. https://www.indiacode.nic.in/bitstream/123456789/2249/1/A2017-10.pdf
17. Girase, Bhushan, Rachana Parikh, Samica Vashisht, Anushka Mullick, Vaibhao Ambhore, and Sudhir Maknikar. “India’s Policy and Programmatic Response to Mental Health of Young People: A Narrative Review.” *SSM - Mental Health* 2 (December 1, 2022): 100145. https://doi.org/10.1016/j.ssmmh.2022.100145.
18. Pranab Mahapatra, and Shekhar Seshadri. Mental health in India: evolving strategies, initiatives, and prospects. 2023
19. The Indian Express. “About 10 percent of Delhi’ s Population Suffer from Mental Illnesses: Study,” October 11, 2012. https://indianexpress.com/article/cities/delhi/about-10-per-cent-of-delhi-s-population-suff/.
20. Paus, Tomáš, Matcheri Keshavan, and Jay N. Giedd. “Why Do Many Psychiatric Disorders Emerge during Adolescence?” *Nature Reviews Neuroscience* 9, no. 12 (December 2008): 947–57. https://doi.org/10.1038/nrn2513.

21. Helland Lindborg, Tonje, Inger Kristensson Hallström, Astrid Synnøve Litland, and Helene Åvik Persson. "Adolescent Boys' Experiences of Mental Health and School Health Services - an Interview Study from Norway." *BMC Public Health* 24, no. 1 (May 31, 2024): 1464. https://doi.org/10.1186/s12889-024-18952-6.
22. "Women's Health." Accessed October 1, 2024. https://www.who.int/health-topics/women-s-health.
23. Khalaf, Abderrahman M, Abdullah A Alubied, Ahmed M Khalaf, and Abdallah A Rifaey. "The Impact of Social Media on the Mental Health of Adolescents and Young Adults: A Systematic Review." *Cureus* 15, no. 8: e42990. Accessed October 1, 2024. https://doi.org/10.7759/cureus.42990.