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3 1 **Community stakeholders' perspectives on youth mental health in India: Problems,**
4 2 **challenges and recommendations**
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34 32 **Running title:** Stakeholders' perspectives on YMH in India
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Abstract

Background: India has a large youth population whose mental health needs must be addressed. This includes promotion of positive mental health, with early detection and effective intervention for mental health disorders. Understanding the perspectives of community stakeholders working with youth is pivotal to this effort. Current study aimed to bring together a group of community stakeholders (e.g., parents, teachers, policy makers) to understand their perspectives on youth mental health problems, challenges in provision of care, and to provide recommendations to address these concerns at national level.

Materials and methods: The study was conducted across two sites in India: Chennai and New Delhi. Three group meetings were conducted involving 52 participants, including governmental, non-governmental and community representatives working with youth. The proceedings were manually recorded, transcribed, and analysed using thematic analysis method.

Results: Many youth mental health problems were similar across the two sites. The commonest drivers of mental health problems were reported to be academic pressure, substance use and problematic internet/social media use. Stigma and lack of awareness were identified as the most important challenges acting as barriers to seeking mental health help by youth. Prioritizing youth mental health as a national program along with strong political will were the major recommendations suggested by the stakeholders.

Conclusion: Initial findings suggest that prioritizing youth mental health programs in India would be advantageous. Inclusive and collaborative approach, involving community stakeholders working with youth in providing services that promote mental health and early access to care will help in developing healthy young citizens.

Keywords: youth mental health, stakeholders, perspectives, India

1. Introduction

The youth population is a critical human resource for any country. India has the world's highest number of youth between 10 and 24 years of age (Engelman, Levy, Luchsinger, Merrick, & Rosen, 2014), accounting for 373 million (30.9%) of the 1,210 million of India's population with every third person belonging to this age group (Sunitha & Gururaj, 2014). This demographic reality is particularly relevant because most of the mental health problems diagnosed in adulthood in fact begin in adolescence (Kessler et al., 2007): half of the lifetime diagnosable psychiatric disorders start by age 14, a number that increases to three fourths by age 24 (Kessler et al., 2005). Major physiological, psychological and behavioural changes occur in the youth with changing patterns of social interactions and relationships and could lead to significant stress on young people and those around them.

Globally, at least 20 per cent of young people are likely to experience some form of mental illness such as depression, mood disturbances, substance abuse, suicidal behaviours, and eating disorders (World Health Organization, 2011). These statistics translate to a huge population of young people at-risk of experiencing mental health problems in India. These indicate significant and mounting morbidity, mortality, individual and societal costs. The limited availability of resources for the treatment of mental disorders in general and for young people in particular, compounded by the stigma of mental disorders marks youth mental health as a major health problem in India currently, and over the coming decades (Trani et al., 2015).

Internationally there has recently been a great upsurge of interest in early intervention for various mental illnesses, particularly psychoses (Nordentoft, Rasmussen, Melau, Hjorthøj, & Thorup, 2014; Shoemaker, Tully, Niendam, & Peterson, 2015). Early interventions in psychoses has led to a growing worldwide interest in early and timely care for young people with all mental disorders (Birchwood & Singh, 2013; Cotton et al., 2016; Csillag et al., 2016; Jacobs, 2016; Malla et al., 2016; Nolin, Malla, Tibbo, Norman, & Abdel-Baki, 2016; Patton et al., 2016). Involving multiple stakeholders in youth mental health: teachers in schools/colleges, general practitioners, and various governmental and non-governmental organizations who work closely with the youth in the community is critical to this effort (Axelrod et al., 2002; Malla, Iyer, et al., 2019; Malla, Margoob, et al., 2019; Svirydzienka, Ronzoni, & Dogra, 2017). However there is a dearth of published literature on assessing the views of diverse stakeholders on youth mental health in developing countries (broadly) and/or in India (more specifically).

The objective of the current research was therefore to explore the perspectives of community stakeholders engaged with young people experiencing mental health problems including psychoses, identify barriers to the delivery of mental health care and solicit suggestions to improve youth mental health services in India. It was envisioned that information from this inquiry would inform the development of interventions which can improve the health, wellbeing and functioning, and reduce the burden of mental illness for young persons, particularly in India and other low- and middle- income countries (LAMICs).

2. Materials and methods

2.1 Site and period of study

As part of a larger research project (Warwick-India-Canada or WIC collaborative), the current study was conducted across two sites in India, the All India Institute of Medical Sciences (AIIMS), New Delhi and the Schizophrenia Research Foundation (SCARF), Chennai, to represent North and South India, respectively. The data collection was done between July and December 2017. Both sites obtained prior Institutional Ethical Committee (IEC) approval before initiating the study.

2.2 Participants

Identification and selection of the stakeholders for the meeting was done through the following steps: 1. All the departments and organizations working in the interface of youth and health were identified including youth organizations and religious leaders; 2. Key personal from these places were listed by the researchers; 2. All of them were contacted through either electronic communication or telephone and a background note on the subject describing in detail the purpose of the meeting was sent to them along with the invitation to participate; and 4. All the stakeholders who have accepted the invitation to take part in the meeting were grouped such that representatives from all the departments and organizations were present in all the meetings.

A total of three meetings (one at AIIMS and 2 at SCARF) were conducted with 52 participants representing different organizations (**Table 1**). Each meeting was attended by 15-18 stakeholders - Government and NGO sectors, health, education, development and policy planning.

2.3 Group meetings

Before the stakeholders meetings, we conducted a review of literature and held discussion with local experts on the subject of youth mental health. These experts, largely from AIIMS and SCARF, comprised a multi-disciplinary team of psychiatrists, psychologists, social workers and family members of persons living with a severe mental illness. Based on this, we decided on a set of five open-ended questions as the framework for the stakeholders meetings.

1. What are the common mental health problems of youth?
2. What are the barriers to seeking help for these?
3. What are the common sources of support for such problems?
4. How can better and easy access to help/care be facilitated?
5. What are the means to address the issues of youth mental health problems, specially psychoses?

Written informed consent was obtained from all participants. Confidentiality of responses was assured by replacing participants' names with an interview code, and removing any personal identifiers.

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5 2 Each meeting lasted approximately 2 hours. It was largely held in English with a mix of
6 3 the regional languages Tamil and Hindi. All participants were comfortably seated in a
7 4 way that would facilitate group discussion. Two moderators facilitated the meetings and
8 5 steered the discussion according to the agenda developed based on the objectives. Four
9 6 note-takers were present during each meeting and each manually took detailed notes on
10 7 the discussion. The note-takers were trained in the process of note taking before the
11 8 meetings. All the information shared by the stakeholders were written down in verbatim
12 9 by the note takers using paper and pencil. When in doubt, the participants were requested
13 10 to repeat or reword their information before note taking.
14 11

15 12
16 12 Following the introduction and orientation about the meetings, moderators initiated the
17 13 discussion on the five questions identified. The stakeholders were encouraged to discuss
18 14 without interruption unless participants deviated from the subject. At the end of each
19 15 specific question, time was given to voice their concerns and discuss relevant issues
20 16 which had not yet been taken up.
21 17

22 17 23 18 *2.5 Data analysis* 24 19

25 20 After the three stakeholder group meetings, the detailed notes made by note-takers were
26 21 collected and compiled. The investigators went through the responses to the five
27 22 questions and collated all information (**Supplementary Table 1**). The common, most
28 23 important issues in response to the five questions were identified.
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3. Results

Data obtained were grouped under three themes – 1) Common mental health problems in youth 2) Challenges identified in the delivery of youth mental health and 3) Recommendations to improve youth mental health (**Table 2**).

3.1 Common mental health problems in youth

Majority of the participants believed that youth today faced a lot of pressure in coping with daily living. One major stress was meeting high parental expectations. Young people were expected to excel in all academic and extracurricular activities.

“There are so many things that a student should participate in school... Like exam, assignments, homework, and other activities like sports, swimming- it is hard to balance all of it. Children are “pressured to be the best” at home and school”

(Ms. SM,, a parent and service user)

Many stakeholders opined that the use of gadgets and technological devices such as phones, tablets laptops had increased to almost a state of ‘dependence’. This in turn, seems to result in a decline in academic performance, poor concentration, and sleep disturbances. Also, ‘Internet addiction’ was been identified as one of the major concerns among the youth. Many youth own a mobile phone irrespective of their socioeconomic status. The low cost of internet access has further facilitated the continued use of social media among the youth.

“School and college students are more vulnerable to internet addition, they spend most of the times on internet and cell phone.. they neglect other areas of life such as, relationships, work, family and leisure pursuits. Eventually it leads to academic decline and social isolation”

(Mrs. S, Vice principal, college)

Depression and anxiety were the most common mental disorders affecting youth, followed by substance abuse and relationship problems. Suicide and self-harm behaviour are other serious concerns. They were concerned that Chennai city had a large number of youth suicides, many related to exams (Vijayakumar & Phillips, 2016). Poor performance in exams led to deep disappointment, a sense of failure and fear of not having met parental expectations.

“Youth experiment with alcohol/drugs to avoid the feeling of sadness or depression and get into trouble. They express their depression through hostile, risk taking behaviour like self-harm. Such behaviours lead to the deeper problem..... They face major problems in handling relationship with friends and family.”

(Mr. V, Media representative)

3.2 Challenges in the delivery of mental health care to youth

Delivering youth mental health services itself was identified as a challenge due to lack of awareness and social stigma. Stigma was the most prominent barrier to access services and was thought to be widely prevalent in all sections of society, including schools and colleges. Many schools refuse to acknowledge the extent of mental health problems in students, fearing that this would place the school in bad light. Students too hesitate to seek help due to stigma and fear of being labelled - even if a student counsellor is available.

"Many students and their parents have asked me if they can see me outside the school since they do not want others to know about it"

(Ms. S, School Student Counsellor)

Stakeholders also expressed the view that parents were at times unable to detect early signs of mental disorders, attributing these to adolescent behaviours. This coupled with denial led to delay in seeking help. The view that teachers need to be more aware and discrete was expressed often.

"Teachers are the first contact of the student in identifying change in students behaviour... one student was referred for 'de-addiction treatment' as the hostel warden saw a beer bottle in that student's room... so that particular student was accused in front of all other students and referred for treatment"

(Dr. T, De-addiction counsellor)

Many teachers were thought not be well informed on this subject and schools were reported to not have student counsellors. Moreover, there was lack of information on the kind of services available for such problems.

3.3 Recommendations to improve youth mental health

It was felt that strong political will and action was needed to prioritize youth mental health, for example through a national program addressing the various barriers observed in delivering youth mental health services.

Stakeholders also advocated for policy level change in order to sensitize schools and colleges about mental health. While there is a Department of Youth at the Central Government, this department needs to be sensitized to the issue of mental health. In recent years, some of the IITs (Indian Institute of Technology) have started evolving programmes to reduce/prevent suicides in students.

A key idea expressed by stakeholders was that better awareness of mental health would make young people seek help promptly.

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3 1 *“College students experience distress, but unfortunately they aren’t getting the help...
4 2 they don’t know from where to seek help, they think their symptoms of distress are just a
5 3 part of stress of college”*

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(Mrs. P, Student counsellor)

6 There was consensus that government agencies needed to legislate for the need for
7 student counsellors in all schools and colleges, and that the training of teachers should
8 include mental health training. Media was seen as an important tool to increase mental
9 health awareness with broad societal impacts, including among young people
10 themselves. This included print and electronic media. Social media used extensively by
11 the youth should be harnessed to increase mental health literacy.
12

For Peer Review

1 4. Discussion

2 The aim of the current study was to understand the perspectives of community
3 stakeholders working with youth in India in relation to youth mental health. The study was
4 carried out at New Delhi and Chennai, representing the northern and southern parts of
5 India.

6
7 Our findings suggest that the most common mental health issues seen in youth relate to
8 academic pressure, substance use and problematic internet/social media use. Stress
9 arising from academic pressures is often serious leading to a plethora of distressing
10 symptoms such as anxiety, depression and even suicide. Internet/gadget addiction and
11 relationship issues were identified as the major behavioural issues in young people.

12
13 High, sometimes unrealistic expectations from parents as articulated by stakeholders
14 serve to compound the stress faced by the students. This is in keeping with increasing
15 number of suicides that a non-governmental organization, SNEHA, in Chennai
16 successfully lobbied with the state education department to have a supplementary exam
17 which failed students can take before the next academic year began (Vijayakumar &
18 Phillips, 2016).

19
20 The stakeholders recommended screening for mental disorders among the youth in
21 educational institutions. Some Indian studies have found a high prevalence of depression
22 among youth. A study from south India found 22.45% of students depressed as per the
23 Becks Depression Inventory (Trivedi et al., 2016). This is also linked to the meagre help
24 available in educational institutions for such emotional problems. Very few have in house
25 counsellors and many of those are inadequately trained to deal with such issues (Kodad
26 & Kazi, 2014).

27
28 Lack of awareness about mental health issues and stigma in seeking care were major
29 barriers to help seeking. Another Indian study (Srivastava, Chatterjee, & Bhat,
30 2016) reported similar findings. A review of 144 studies in Britain found that ethnic
31 minorities and youth were disproportionately deterred by stigma in seeking help for mental
32 health problems (Clement et al., 2015), underscoring the need to address stigma in order
33 to promote help seeking among youth.

34
35 Factors intrinsic to the health systems also seem to be contributory to youth either
36 declining or failing to seek care. This appears to be a universal concern regardless of the
37 structure, funding or orientation of the health system. Many LAMICs do not have
38 specialist departments/teams to deal with youth mental health issues. At the same time,
39 fragmentation and compartmentalization of child and adolescent mental healthcare from
40 adult care services, which is very evident in the western world, does not seem to exist in
41 LAMICs (Ono, Friedlander, & Salih, 2019; Singh et al., 2010).

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43 Our community stakeholders expressed broader concerns, not restricted only to clinical
44 issues. Recommendations like policy decisions explicitly prioritizing youth mental health
45 and introduction of positive mental health programmes in schools and colleges can be
46 addressed only through a larger, high-level coordinated action with various government

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3 1 and non-government institutions along with strong implementation drive, monitoring and
4 2 evaluation. This calls for new and novel frameworks beyond 'traditional' mental health
5 3 services to develop and translate youth mental health into practice (Kutcher, Davidson, &
6 4 Manion, 2009)

7 5
8 6 Families are an important resource in helping youth tackle their mental health issues. A
9 7 few Indian studies (Hasumi, Ahsan, Couper, Aguayo, & Jacobsen, 2012; Trivedi et al.,
10 8 2016) have found a positive correlation between increased parental involvement and
11 9 good youth mental health. Many prevention and treatment approaches that have
12 10 demonstrated effectiveness in promoting adolescent mental and behavioural health are
13 11 also family-centred.

14 12
15 13 It appears that the youth seem to prefer family and peers as the first contact for help with
16 14 their emotional problems (Griffiths, Crisp, Barney, & Reid, 2011; Morris, Silk, Steinberg,
17 15 Myers, & Robinson, 2007). Surprisingly, teachers were the last option. Although many
18 16 effective adolescent mental health programs have emphasized the role of school teachers
19 17 for early identification of mental health issues in youth, it was noted that the youth
20 18 population does not always feel comfortable sharing their problems with school teachers.
21 19 One reason for this could be students' apprehensions about confidentiality. Although
22 20 trained teachers may be able to detect early symptoms of mental illness, they may not be
23 21 perceived to possess the aptitude or be empathetic enough by students, thus preventing
24 22 or limiting rapport or trust building. The risk of being treated differently or given special
25 23 treatment (in the event of identifying as having a mental illness), even if warranted, may
26 24 be a concern for students who fear being discriminated or labelled by their peers.
27 25 Imparting persistent training on mental health might enable at least some of the teachers
28 26 to be more effective counsellors. Mental health professionals are low on the list of persons
29 27 youth wish to seek help from (Knaak, Mantler, & Szeto, 2017).

30 28
31 29 All expressed opinions in this study emphasize the need to detect early emotional
32 30 problems among youth and to have in place a care system in home and educational
33 31 environments that can facilitate early intervention. Groups like parents and teachers need
34 32 to be involved early. Strategic investments in mental health of young are critical for healthy
35 33 growth of young people and these programs need to be monitored and evaluated for their
36 34 efficacy and effectiveness using public health approaches.

37 35 38 36 *Strengths and limitations*

39 37
40 38 To our knowledge, this is the first study from India that has qualitatively explored the
41 39 mental health needs of youth in two different sites in India, and involving key stakeholders
42 40 from the community, governmental and non-governmental organizations. The major
43 41 strengths of the current study are 1. Involving two representative sites from North and
44 42 South of India 2. Involving the major community stakeholders working with youth. The
45 43 limitation is that it is relatively small, our stakeholder sample may not be representative,
46 44 and it represents small sections of a large country. An important future direction worth
47 45 exploring is the participation of more youth representatives themselves.

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1 **5. Conclusion**

2 Youth mental health is a major health and social concern worldwide and in India. It is
3 important to understand the social, political and cultural aspects associated with youth
4 mental health issues in order to best address them. Identifying key stakeholders in the
5 community involved in shaping youth mental health and developing a collaborative
6 program to address youth mental health is the need of the hour.

For Peer Review

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4 **2**

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1 **Conflict of interest**

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3 The authors have no conflicts of interest to declare.
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For Peer Review

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Table 1. Key community stakeholders on youth mental health and the number of representatives participated in the three focused group discussions conducted at AIIMS, New Delhi and SCARF, Chennai

Type of stakeholder	Number of participants
Psychiatrist	8
Psychologist	6
Social worker	9
School counselor	3
School correspondent/teacher	4
Pediatrician	2
Public health	2
Government representatives (Department of Health and Family Welfare, State Mental Health Authority and District Mental Health Programme)	3
Non-Governmental Organizations (NGOs) working with youth higher education and health	4
College administrative and mental health professional dealing with youth welfare in colleges	2
Mental health service user/Family member	4
Religious head	2
Media representative covering youth affairs	3
Total	52

AIIMS – All India Institute of Medical Sciences; SCARF – Schizophrenia Research Foundation

Table 2. Summary of community stakeholders' perspectives on youth mental health

Common mental health problems identified in youth	Challenges identified in the delivery of youth mental health services	Recommendations to improve youth mental health
<ul style="list-style-type: none"> • Substance use • Stress/ academic pressure • Internet addiction • Anxiety • Depression • Body image issues • Eating disorders • Aggressive behaviors • Absenteeism • Conduct Disorders • Relationship Issues • Self-harm • Isolation • Low esteem/need external validation • Low frustration tolerance 	<ul style="list-style-type: none"> • Stigma • Lack of understanding that its mental health issue • Delay caused as family unable to distinguish between "abnormal behavior" and normal "teen" behavior • Denial by parents • Lack of awareness about available mental health resources • Lack of man power • Financial concerns • Nearly 50% of youth not in structured institutions • Poor awareness amongst teachers • No counselors in most schools • No referral channels • No incorporation of mental health in education • Lack of political will 	<ul style="list-style-type: none"> • Change should be from policy level • Introduce Mental Well Being as school curriculum • Media as main tool to create and increase mental health awareness • Should move from psychiatric centric to people centric (peoples' movement) • Improve parent and family support system • Increase numbers of trained mental health professionals • Screening tools for the early identification of mental illness in schools and colleges • Train teachers to identify mental health problems in youth • Care should be affordable and easily accessible • Incorporating school mental health into District Mental health program • Introducing mental health awareness and basics of mental illness subjects in B.Ed. course • Involve other stakeholders (NGOs, RWA, government officials) in the society to reduce stigma • Better designed school curriculums to reduce academic stress • Quick valid referral channels/directory • Provide financial support

Supplementary Table 1: Responses from the participants for the five questions asked during the meetings

Question	Response
What are the common mental health problems of youth?	Substance use, stress due to academic pressure, internet addiction, anxiety, depression, self-harm and body image issues
What are the barriers to seeking help for these?	Stigma, lack of understanding that its mental health issues, lack of awareness about available mental health resources, non-incorporation of mental health in education and lack of political will
What are the common sources of support for such problems?	Friends, internet resources and family. Very few young people seek help through the school or college counselors and teachers.
How can better and easy access to help/care be facilitated?	Train teachers to identify mental health problems in youth, improve parent and family support system, introduce Mental Well Being as school curriculum and screening tools for the early identification of mental illness in schools and colleges
What are the means to address the issues of youth mental health problems, specially psychoses?	Increase numbers of trained mental health professionals, media as main tool to create and increase mental health awareness, care should be affordable and easily accessible, incorporating school mental health into District Mental health program, should move from psychiatric centric to people centric (peoples' movement) and change should be from policy level