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Community stakeholders' perspectives on youth mental health in India: Problems, challenges and recommendations

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Running title: Stakeholders' perspectives on YMH in India

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; Svirydzenka, 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 though 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 personnel from these places were listed by the researchers; 2. All of them were contacted though 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 **(Table1)**. 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.

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

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

2.5 Data analysis

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

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.
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"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.

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

(Mrs. P, Student counsellor)

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

4. Discussion

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

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

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

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

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

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

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

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

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

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

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

Strengths and limitations

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

5. Conclusion

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

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Conflict of interest

The authors have no conflicts of interest to declare.

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