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Review

India's policy and programmatic response to mental health of young people: A narrative review

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ABSTRACT

India's response to meet the mental health needs of 252 million young people between 15 and 24 years is guided by the Mental Healthcare Act 2017 (MHCA), which advocates a rights-based approach to receiving mental healthcare, the National Mental Health Policy 2014, and the National Mental Health Program operational since 1982.

We undertook a comprehensive narrative review of policies, programs, and legislations across five ministries of the Government of India—Health and Family Welfare, Education, Women and Child Development, Youth Affairs and Sports, and Social Justice and Empowerment—over the last ten years to map their approach and identify enablers and barriers for promoting youth mental health in India. Our work builds on the previous reviews on children and adolescents' mental health in India and captures the rapidly advancing policy landscape amidst the new challenges and opportunities presented by the COVID-19 pandemic, especially the increasing acceptability of digital health interventions including tele-consultations.

We note that all the five ministries recognized mental health as an important aspect of overall development and well-being of young people. However, their approach is fragmented and a comprehensive approach to youth mental health is missing in the Indian context. Having said that, many enablers for integration of preventive, promotive, and curative mental health interventions exist especially as mental health is increasingly being recognized as an integral part of the comprehensive primary healthcare. However, much needs to be done in terms of strategic planning for screening, early detection and treatment, and developing strong referral systems between community, schools and mental healthcare services. Effective implementation of MHCA, sustainable intersectoral integration of mental health across youth-oriented services, empowerment of young people, and judicious use of digital technology hold the key to reimagining the approach to advance young people's mental health in India.

1. Introduction

The transition from childhood to adulthood in the age group of 15–24 years is marked by enormous changes physically, physiologically, psychologically, and socially (World Health Organization, 2014). Throughout this phase, young people strive to establish their autonomy in various domains of life including achieving excellence in academics and career, developing independent personal relationships, navigating interpersonal relationships with parents, peers, romantic and sexual partners and overall social and financial independence. Their mental health is influenced further by developmental changes including a higher appetite for risky behaviors, increased exposure to substance use and violence, increasing influence of sociocultural values, gender norms and social media as compared to in childhood, and perceived and actual access to resources and support (Paulus et al., 2021; United Nations Children's Fund, 2021). Considering that three-fourths of all lifetime mental health problems first appear by the mid-twenties (Kessler et al., 2007), it is critical for countries to develop a strong and comprehensive response to address the mental health of their young people.

India has a huge demographic dividend with 252 million young people aged 15–24 years, equal to a fifth of its total population (Ministry of Health and Family Welfare, 2019) and mental health conditions are

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among the leading causes of years lived with disabilities in this age-group (Dandona et al., 2018). The National Mental Health Survey 2015–2016, indicates that as many as 7.3 percent adolescents and 10.6 percent of young adults suffer from mental health problems; the prevalence in the urban metropolitan areas is two-fold higher (Gautham et al., 2020; Gururaj et al., 2016a). With one in every seven young people in India feeling depressed or having little interest in doing things (United Nations Children's Fund, 2021), the number of young people requiring support may be even higher. There exists a very high treatment gap for mental health problems in India averaging to 83 percent in the general population (Gururaj et al., 2016b) perpetuated by a range of systemic challenges including the severe dearth of a skilled mental health workforce and poor availability of mental health services close to communities. India has only 9,000 psychiatrists, 1,000 clinical psychologists, 2,000 psychiatric nurses, 1,000 psychiatric social workers, and just 49 child psychiatrists for a country of more than 1.2 billion population (Math et al., 2019; World Health Organization, 2017).

Help-seeking for mental health problems is also driven by individual and social attitudes towards mental health symptoms and problems, and towards people with mental health problems (Avasthi et al., 2013). In addition to social stigma associated with mental health problems and their treatments, low levels of awreness, poor living conditions, lack of support from family and peers all impede timely and appropriate help-seeking in India (Sanghvi and Mehrotra, 2021; United Nations Children's Fund, 2021). Many young people may also consider it as a weakness to seek help for their mental health problems, further delaying support and care (Gaiha et al., 2020; Gundi et al., 2020; United Nations Children's Fund, 2021).

Indian society accords a higher priority to family needs and social reputation (as compared to individual preferences), thereby placing a high value on fulfilling expected social and gender norms, adopting conforming behaviors such as being obedient and self-reliant, avoiding confrontations or social humiliation, preserving dignity, and exceling academically and vocationally (Gaiha et al., 2020; Maulik et al., 2019). Such an emphasis on familial and societal cohesion while seeming to de-priortise individual needs, facilitates the interconnected collective care which promotes families to support and provide care for the family members suffering from physical or mental health problems. Sociocultural and religious beliefs about the cause of mental health problems such as supernatural reasons, possession by evil spirits, or payback for past sins also influence choices about coping strategies and treatment-seeking and a preference for religious or faith-based healers over, or in addition to biomedical or psychosocial interventions (Avasthi et al., 2013; Sarkar and Punnoose, 2017). Alongside biomedical care, varieties of healthcare practices including Indian systems of medicine (Ayurveda, Siddha, Unani, Yoga, Naturopathy, and Homoeopathy), and faith-based healing co-exist inducing growing acceptance for medical pluralism for mental health in India (Biswal et al., 2017).

In the last ten years, several legislations, policies, and programs across health, education, and other sectors have put mental health into a sharper focus as a public health priority. Several reviews have described these initiatives to varying extent, albeit with a larger focus on initiatives within the health sector and are more relevant to the pre-COVID-19 pandemic context. These reviews have highlighted several limitations, including a general lack of comprehensive and transdisciplinary approach to the design and implementation of youth mental health interventions, limited availability of data on epidemiological indicators, and impact evaluation of existing policies and programs (Kumar, 2021; Mahajan et al., 2019; Mehrotra, 2020), along with limited opportunities for inclusion of the perspectives of young people in the program and intervention designs (Hameed et al., 2019; Roy et al., 2019).

Indian youth reported significant increases in symptoms of anxiety, depression, anger, stress, loneliness, and even death by suicides during COVID-19 pandemic, owing to disruptions in the routine way of life, prolonged home confinement, limited access to education, recreation, and peers, uncertainties and concerns about income and family health, enduring losses, and dealing with grief (Panchal et al., 2021; Saurabh and Ranjan, 2020). While physical access to health and mental health services was severely limited for long periods, especially during the intensive lockdowns, the pandemic also ushered in a rapid shift towards increasing acceptability, usage, and reliance on digital interventions and devices for accessing many services including health and education. This was accompanied by rapidly evolving policy and programmatic imperatives for the use of digital interventions such as telemedicine, telepsychiatry, tele-consultations, and use of health apps (Anand et al., 2021; Dandona and Sagar, 2021; Guriya Sengupta et al., 2021). Acknowledging the unmet needs for mental health and a shift towards greater acceptability of employing digital health interventions for mental health, the Government of India announced the launch of a new National Tele-Mental Health Program in January 2022 (Ministry of Finance, 2022). These rapidly evolving changes present an immediate need to examine the landscape and outline the implications for addressing youth mental health needs in the Indian context.

This review seeks to answer the broad question – What is the current landscape of various policies and programs impacting young people's mental health as implemented by the different ministries and departments of the Government in India and what untapped opportunities exist to provide a comprehensive response to meet youth mental health needs? This is addressed by (a) identifying the relevant policies, legislations, and programs for youth health, mental health, social welfare, education, and digital health; and (b) discussing the enablers and barriers for promoting mental health services for young people in India. The findings are relevant to various stakeholders including young people, policymakers, program developers and managers, service providers, as well as researchers and academicians involved in advancing interventions for youth mental health in India.

2. Methods

Identification of key legislations, policies, and programs for this review was guided by an initial mapping of key stakeholders relevant to youth mental health in India and consultations with a Technical Advisory Group (TAG). The TAG comprised of 16 experts who engaged with the larger youth mental health landscaping exercise at PATH, in their personal and voluntary capacities, and primarily through virtual meetings. Members of the TAG represent expertise across youth health, mental health, mental health services, lived experience of mental health problems including young people, national public health programs, research and academics, and digital health ecosystem in India and globally. Relevant documents were further identified through 1) website search across the official websites of five ministries of the Government of India - Ministry of Health and Family Welfare, Ministry of Education, Ministry of Youth Affairs and Sports, Ministry of Women and Child Development, and Ministry of Social Justice and Empowerment, 2) internet search via Google and Google Scholar using keywords related to young people's mental health in India to identify relevant journal papers and grey literature including protocols, operational framework, guidelines, implementation and evaluation reports on the policies, programs and legislations included in this review, and 3) cross-referencing from recently published reviews on young people's health and mental health.

Initiatives originating from the five ministries as written directives in the past ten years that were relevant to young people's mental health were included in the review. In addition, considering their focus on mental health, the National Mental Health Program, implemented since 1982 and the District Mental Health Program, implemented since 1996 were also included. Abandoned or concluded initiatives, or those not relevant to young people's mental health were excluded from the review. Qualitative method of document analysis was applied to address the second objective of appraising the enablers and barriers for the betterment of youth mental health in India. We used the systematic 'READ approach', a step-by-step guide for document analysis (Dalglish et al., 2020). READ is an acronym from Ready materials, Extract data, Analyze

data and Distil findings, which is commonly used in health policy research for its flexible, iterative, and reflective nature to ensure representativeness and credibility of data extracted.

2.1. Ready materials

The purposive selection of policy and program documents identified through website and internet searches was undertaken through a broad search of keywords related to young people, health, mental health, school health, digital health including mHealth and telemedicine followed by rapid reading to identify relevant documents and the relevant sections for detailed reading and data extraction.

2.2. Extract data

A Microsoft Excel-based tool was prepared for data extraction from the selected documents identified in the previous step. BG, RP, SV, and AS reviewed the documents and identified and extracted content related to the specific goals and objectives of the policy, program, or legislation, scope of the initiative and actionable indicators more broadly while emphasizing youth mental health-specific thematic areas mentioned along with descriptions of how these thematic areas are addressed, and specific recommendations and provisions for convergence and linkages across other policies and programs. All the extracted data was first checked for quality by BG and subsequently by RP. The discrepancies, if any, while interpretating the data were resolved by internal discussion and consensus building.

2.3. Analyze data

We undertook a relational content analysis of extracted data in corroboration with the relevant literature on impact evaluation. This allowed us to examine how concepts in different policies and programs were related to or distracted from each other. This was followed by an exploration of the cross-cutting relationships and intersections between the selected programmatic initiatives to uncover the enablers and barriers impacting mental health of young people in India.

2.4. Distil findings

The findings were summarized thematically and presented in a narrative style to cover the characteristics, synergies, disparities, and best practices that exist across different health policies and programs, along with the implications for transforming the existing best practices into scalable interventions including digital interventions, and development of future policy, practice, and research.

3. Results

A total of 20 initiatives (legislations, policies, and programs) were identified through the website and internet searches. Four of these were excluded as they did not meet the inclusion criteria – The Information Technology Act 2000, Rehabilitation Council of India Act 1992, Rashtriya Bal Swasthya Karyakram 2013, and National AIDS Prevention and Control Policy 2002. Eventually, 16 government initiatives, as outlined in Table 1, were considered for final review and analysis.

3.1. Current policy and programmatic landscape

Several of the initiatives reviewed across the five ministries—Health and Family Welfare, Education, Women and Child Development, Youth Affairs and Sports, and Social Justice and Empowerment—have recognized mental health as an important aspect of overall development and well-being of young people (Table 1 and Fig. 1).

Table 1
Policies and programs impacting mental health of young people in India.

	Policies, programs, or legislations	Year of launch	Themes relevant to young people's mental health covered in the policies, programs, or legislations
Ministry of Health and Family Welfare (MoHFW)			
1	National Mental Health Program (NMHP) ("National Mental Health Program," n.d.)	1982	Prevention and treatment of people with mental health problems and their rehabilitation. Promotion of positive mental health by improving human and material resources.
2	District Mental Health Program (DMHP) ("National Mental Health Program," n.d.)	1996	Community-based mental health services, early detection and treatment, awareness generation, basic psychiatric care, and integration of mental health within public health system.
3	National Mental Health Policy (New Pathways New Hope National Mental Health Policy, 2014)	2014	Universal access to mental health care across lifespan, emphasis on suicide prevention, children of people with mental health problems, recommends expansion of DMHP to cover all the districts in the country.
4	Rashtriya Kishor Swasthya Karyakram (RKSK, National Adolescent Health Program) ("Adolescent Health, National Health Mission," 2014)	2014	Peer education program for improving awareness about adolescent health problems including mental health and substance abuse at school and community, observing 'Adolescent Health Days' at village level, convening 'Adolescent Friendly Club' monthly meetings at sub-center (covering five villages) and facility-based counseling and healthcare support through 'Adolescent Friendly Health Clinics'.
5	Mental Healthcare Act (MHCA, 2017)	2017	Decriminalization of suicides, promotes rights-based approach to access mental health services for people with mental health problems, medical insurance for the treatment of mental health problems on the same basis as the treatment of physical ailments.
6	National Health Policy ("NHP," 2017)	2017	Improving health services for young people in general, developing sustainable networks for community to strengthen mental health services, universal health coverage, addressing tobacco and substance use.
7	School Health Program (Ayushman Bharat) ("School Health & Wellness Programme, National Health Mission," 2020)	2018	It is a joint program with the Ministry of Education encompassing physical and mental fitness by promoting healthy behavior, yoga and meditation, safe use of internet and digital literacy.
			The curriculum and training material for teachers designated as the Health and Wellness Ambassadors in schools includes – (1) emotional well-being and

(continued on next page)

Table 1 (*continued*)

	Policies, programs, or legislations	Year of launch	Themes relevant to young people's mental health covered in the policies, programs, or legislations
			mental health, (2) interpersonal relationships, (3) gender equality, values, and responsible citizenship, (4) prevention and management of substance misuse, (5) safety against violence and injuries. Health and Wellness Ambassadors are equipped with SAATHIYA SALAH app for peer education.
8	Guidelines for Tele-medicine Services in Ayushman Bharat – Health and Wellness Centres (HWC) ("Telemedicine guidelines for HWC," 2019)	2020	A low-cost 'Hub and Spoke Telemedicine Model' from HWCs (Spokes) for providing specialized care for cardiac, gynecological, and pediatric problems primarily and expanding it to include basic screening and management of non-communicable diseases including mental health problems.
9	Telepsychiatry Operational Guidelines ("Telepsychiatry," 2020)	2020	Jointly developed by National Institute of Mental Health and Neurosciences (NIMHANS) Bengaluru, Indian Psychiatric Society, and Telemedicine Society of India as specific guidance to psychiatrists in setting up, implementation, administration, and provision of telepsychiatry services. These guidelines complement the Telemedicine Operational Guidelines prepared by the Board of Governors, Medical Council of India, in partnership with the National Institution for Transforming India (NITI Aayog) and released by MoHFW in 2020.
10	National Digital Health Mission ("Official webiste of Ayushman Bharat Digital Mission," 2022)	2020	Envisaged to develop the 'DigiDoctor' platform for including information on doctors from across the country to streamline telemedicine and telepsychiatry services.
Ministry of Youth Affairs and Sports			
11	National Youth Policy (NYP, 2014)	2014	Emotional well-being, awareness generation around mental health problems including substance use disorders, maintaining healthy lifestyles, awareness about health, nutrition, and preventive care, targeted disease control programs through National Service Scheme (NSS) and Nehru Yuva Kendra Sangathan (NYKS).
Ministry of Education (Formerly the Ministry of Human Resource Development)			
12	Adolescent Education Program (AEP) ("Adolescent Education Program," 2005)	2005	It is a joint initiative with the MoHFW. Age-appropriate life skills-based education in schools, basic information and services on reproductive and sexual health, HIV prevention, prevention of substance abuse.
13	National Education Policy (NEP) ("National Education Policy," 2020)	2020	Universal access to education, prevention of substance abuse, mental health training through school curriculum, association of counselors or well-trained social workers with schools.
Ministry of Women and Child Development (WCD)			
14	Rajiv Gandhi Scheme for Empowerment of Adolescent Girls – SABLA ("SABLA," 2010)	2011	Life skills education comprising coping with stress, responding to peer pressure and confidence building, counseling and age-appropriate knowledge on family welfare, reproductive and sexual health.
15	The Protection of Children from Sexual Offences Act ("POCSO," 2012)	2012	Protection of children below 18 years from offences of sexual assault, sexual harassment, and pornography.
Ministry of Social Justice and Empowerment			
16	The Rights of Persons with Disabilities Act ("RPWD Act," 2016)	2016	Right to free education for children (6–18 years) with disability, imprisonment sanctioned for sexually exploiting children with disability.

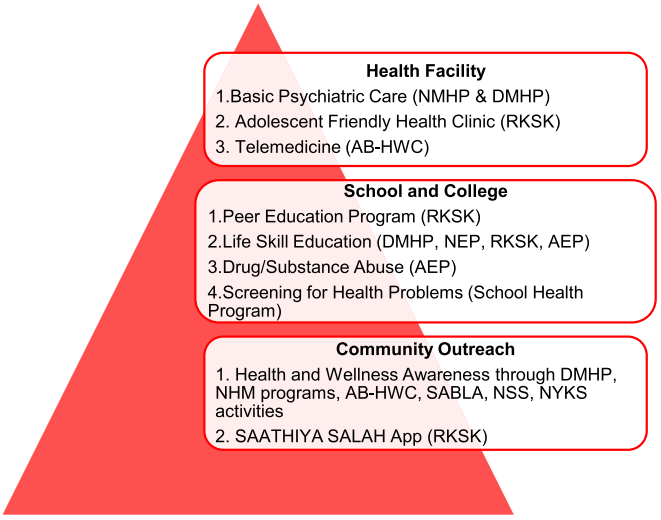

Fig. 1. Key programmatic initiatives across five key ministries that can support young people's mental health in India.
Notes: DMHP = District Mental Health Program, RKSK = Rashtriya Kishor Swasthya Karyakram, AB-HWC = Ayushman Bharat Health and Wellness Centre, NEP=National Education Policy, AEP = Adolescent Education Program, SABLA = Adolescent Girl Scheme, NSS=National Service Scheme.

3.1.1. *Health*

The *National Mental Health Policy 2014*, *National Health Policy 2017*, and *Mental Healthcare Act 2017* (MHCA) have included a clear intent for providing universal access to quality mental health services through preventive, promotive, curative, and rehabilitative services across the lifespan. They lay emphasis on addressing the social determinants of mental health, tobacco and substance abuse, and reducing social stigma associated with mental health problems. They also promote leveraging of digital technology especially, to improve access to specialists. Further, MHCA decriminalizes suicide and mandates the government to provide care, treatment, and rehabilitation services for persons who attempted suicide.

The *National Mental Health Program (NMHP)* is being implemented by the Ministry of Health and Family Welfare (MoHFW) through the three-tier public healthcare delivery system since 1982. The *District Mental*

Health Program (DMHP), launched in 1996 (under the NMHP), provided an added emphasis on improving access to mental health services at sub-district level through facility and community-based outreach. The DMHP is essentially oriented to provide care for adults, and is operational in 704 districts presently (Ministry of Health and Family Welfare, 2022). However, in the absence of systematic routine monitoring and information on the number of people receiving care for mental health problems, the extent of DMHP's functionality at ground level has not been comprehensively assessed (International Council for Market Research, 2009; Murthy and Isaac, 2016; NIMHANS, 2003; Policy Group, 2012). Recently, to further the integration of basic mental healthcare within comprehensive primary healthcare services, the Ayushman Bharat *Health and Wellness Centre (HWC)* scheme has included mental health as a component of its expanded service package. Presently, specific operational guidelines and training manuals to enhance the capacity of medical officers, community health officers (CHOs) and community health workers (CHWs) are developed for the wide-scale implementation of the mental health service package ("Comprehensive Primary Health Care," n.d.).

The *Rashtriya Kishor Swasthya Karyakram (RKSK, National Adolescent Health Program*), launched in 2014, aims to empower adolescents to realize their full potential by making informed decisions about their well-being and health, including mental health. The community intervention comprises peer education and quarterly observing of Adolescent Health Day. A dedicated resource kit and an app called *SAATHIYA SALAH* have been developed as job-aids for peer educators and adolescents primarily, which is also recommended for use by teachers designated as Health and Wellness Ambassadors. The app also includes a helpline (1800-233-1250) to directly connect with a counselor. The RKSK also has a facility-based intervention to provide medical advice and counseling by doctors and skilled counselors at Adolescent Friendly Health Clinics (AFHCs).

The recent initiatives such as the *National Digital Health Mission* 2020 (NDHM), *Telemedicine Practice Guidelines* 2020, and *Telepsychiatry Practice Guidelines 2020* have recognized the use of text, audio, and video modes of consultation in normal day-to-day clinical practice including for psychiatric consultations, with specific guidelines pertaining to legality, consultation process, prescription guidelines and documentation of telepsychiatric consultations. In April 2021, the Government of India launched the *Mental Health and Normalcy Augmentation System* (MANAS) app for the population aged 15–35 years ("MANAS Mitra | Principal Scientific Adviser," 2021). This initiative is aimed to integrate the health and wellness efforts of various government ministries across all age groups from 0 to 70 years and made available in many languages.

3.1.2. Education, Women and Child Development, Youth Affairs, and Social Welfare

The *National Youth Policy* (2014), the *National Education Policy (NEP),* 2020, and the *Scheme for Adolescent Girls (SABLA), 2010*, aim for holistic development of young people and recommend integration of mental health with existing programs such as the Integrated Child Development Services (ICDS), Nehru Yuva Kendra Sangathan (NYKS), and National Service Scheme (NSS) for children and adolescents in schools and colleges. They emphasize health promotion, life skills education, vocational training, and community services for personality development and increasing awareness about substance use and the ensuing ill-effects. The NEP has additionally recommended mental health checkups along with regular health checkups under the School Health Program, and introduction of well-trained social workers and counsellors in the school ecosystem. It also calls for inclusion of mental health and social-emotional learning in teacher education reforms.

The Ministry of Education, in collaboration with the National AIDS Control Organization, has launched the *Adolescent Education Program (AEP)* in schools and *Red Ribbon Clubs* in colleges to raise awareness on prevention of HIV/AIDS and to impart age-appropriate knowledge about sexually transmitted diseases and substance abuse with an added focus on young people's mental health problems. The Ministry of Social Justice and Empowerment has launched *KIRAN* (1800-599-0019) in 2020, India's first national 24x7 mental health helpline, that offers early screening, psychological support, psychological crisis management, and facilitates referrals to mental health specialists.

3.2. Enablers for improved youth mental health

Presently, mental health is recognized as an integral part of comprehensive primary care through HWCs and the National Health Mission, indicating a clear intent, potential platform and pathway for creating synergies and shared responsibilities between different health and mental health programs. A convergent approach can be envisioned across the policies and programs from these five ministries to promote young people's access to basic mental health services based on the common intenstions and recommendations. Advancing community-level awareness on youth mental health; prevention of self-harm, violence, substance abuse, and injuries; destigmatization of mental health problems; addressing sociocultural determinants including repressive gender and sociocultural norms; and addressing sexual and reproductive health needs have been emphasised to some extent by programs across the ministries. Screening and early detection of health problems at schools and providing access to care, has been prioritised by the RKSK and the School Health Program, which also includes mental health. Integrating suicide prevention initiatives across health, education, and youth development programs has gained an additional impetus, following the enabling mandate of the MHCA which decriminalizes suicides. The National Mental Health Policy 2014 has also emphasized steps for preventing suicides such as responsible media reporting, addressing substance misuse, and restricting access to means of suicide.

Use of digital interventions for mental health, especially for improving access to specialists has been enabled by the approval and launch of the Telemedicine Practice Guidelines, 2020 and Telepsychiatry Guidelines, 2020. These have recognized the use of text, audio, and video modes of consultation in day-to-day clinical practice including for mental health consultations. In addition, the NDHM provides the framework for implementing the recommendations made in MHCA of empowering people with accurate information so as to enable informed decision-making regarding their mental health and health in general. This brings in an opportunity to leverage digital technology for developing interventions targeting young people as well as developing e-learning platforms for enhancing the capacities of mental health and non-mental health workers and professionals.

3.3. Barriers

A major challenge lies in the explicit definition of youth or young people included in the initiatives across the five sectors. For instance, the RKSK refers to individuals in the age group of 10–19 years as adolescents and within the age group of 10–24 years as young people, while the National Youth Policy defines youth as people who are 15–29 years in age. In addition, differences in target population and vulnerable subgroups exist across initiatives, such that SABLA scheme under Ministry of Women and Child Development largely focus on gender, nutrition, and empowerment of girls, whereas the initiatives under the Ministry of Education cover all children especially from minorities and marginalized communities, while the initiatives from the Ministry of Youth Affairs and Sports emphasize on the development of underprivileged youth. Further, clear actions and outputs for the interventions like improving mental health awareness, destigmatization through community outreach, and addressing social determinants of mental health are not properly defined in the policies included in this review.

An evaluation of the mental health programs in the country is long overdue. This also threatens ongoing and new initiatives which may not benefit from the experience, success, and failures of the preceding programs. A greater set of challenges arises from the continued gross deficiencies in the availability of comprehensive mental health services in

many parts of the country. The RKSK, while providing a pivot to implement youth mental health programs in schools and community settings, continues to struggle with several challenges to its own implementation such as persistent difficulty in recruitment and retention of peer educators and counselors, lack of appropriate training resources, lack of safe and friendly spaces for young people to vent, lack of interventions to provide psychosocial support, lack of functional referral linkages, insufficient training and supervision of non-mental health professionals on screening, early detection, and treatment of common mental health problems among young people.

The HWC guidelines describe mental health as a 'desirable' service as against 'essential' ultimately reflecting a continuing de-prioritization of addressing mental health problems in primary care settings. Compounding this is the challenge of providing regular and sufficient supplies of essential medicines for treatment of mental health problems at primary healthcare facilities under DMHP (Gupta and Sagar, 2018). The chronic budgetary and workforce constraints hitherto impeding the scale up of the DMHP (Gautham et al., 2020; Math et al., 2019), poise a grave reminder that such constraints can threaten the implementation of well-designed programs. In 2020 and 2021, the NMHP received only 0.06 percent and 0.05 percent of the total union health budget, respectively (Kumari, 2021; Venkatachalam, 2020). With this miniscule budget, the promise of universal mental healthcare made in MHCA 2017 will continue to remain overshadowed, especially with the added fallouts of the COVID-19 pandemic.

4. Discussion

This review paper captures a bird's-eye view of India's current multisectoral programmatic landscape of young people's mental health across five ministries of the Government of India – Health and Family Welfare, Education, Women and Child Development, Youth Affairs and Sports, and Social Justice and Empowerment. Existing policies and programs for adolescents and young people have recognized mental health as a priority for holistic youth development and well-being and recognize the need to improve young people's access to mental health information, resources and services but the approach across the sectors remains fragmented and inadequate. Key barriers such as poor awareness about mental health problems, poor attitudes towards help-seeking, and social stigma associated with mental health problems are however, not adequately prioritized (Mirza and Singh, 2019).

To address these barriers, a sociocultural shift is needed in the young people's proximal ecosystem, whereby culturally appropriate and sensitive interventions improve awareness about mental health problems, and facilitate an empathetic exchange about young people's mental health needs and concerns, between young people and their parents, guardians, teachers, and peers (World Health Organization, 2020). Such interventions should paritcularly engage with families, recognizing the salient role of families in providing support, encouragement, and emotional strength to young people (Avasthi et al., 2013). Young people and their parents who have experienced cultural stigmatization due to their mental health problems can also be involved in framing mental health programs (Chadda and Deb, 2013; Faregh et al., 2019; Jain and Jadhav, 2008). Inspiration from culturally revered anecdotes from religious texts and rational advice from senior generations can help in developing effective messages to promote healthier attitudes towards mental health (Khambaty and Parikh, 2017; Thatikonda, 2019). Such socio-culturally appropriate knowledge can be disseminated widely at existing community outreach platforms such as those offered in the village level convenings of Village Health, Sanitation, and Nutrition Committees of the Nation Health Mission (Health Department), Parent-Teacher-Association meetings at schools (Education Department) and the NSS and NYKS (Department of Youth Affairs).

Young people's participatory engagement to promote their own mental health is essential and it is recommended that such engagement should begin early in their adolescence and continue into adulthood (Berry et al., 2021). The differing age group focus across the different policies and programs relevant to young people's mental health and included in this review points to a potential challenge in ensuring a universal early start for mental health promotion and sustained engagement through adulthood. For instance, the NEP 2020 targets the age group 3–18 years to provide universal access to formal education, sports education, and opportunities for mental, intellectual, and social development. Correspondingly, the NYP 2014 addresses young people between 15 and 29 years of age and strives for their holistic skill development, while the SABLA scheme seeks to empower girls between 11 and 18 years, and RKSK targets young people between 10 and 19 years. To address this, an intersectoral approach is needed to identify the specific and shared responsibilities towards addressing youth mental health needs across the different target age groups, comprehensively and seamlessly.

Young people of the twenty-first century are growing up in a rapidly progressing digital world. Good internet penetration, high engagement of youth in online platforms, and the user-friendly appeal of digital health tools have created potential avenues to engage young people in using research-backed, self-help interactive Apps in local languages (Kanuri et al., 2020). Digital communication tools can be leveraged to engage young people with program implementers and policymakers to share, discuss, and mobilize the resources for policy implementation (Banandur et al., 2021; Berry et al., 2021; Liverpool et al., 2020; Middaugh et al., 2017). Today, digital means of communication provide unprecedented opportunities to advance in academics, health, career, social and civic engagement (Lupton, 2021). Youth-led innovations especially should be encouraged for co-creation, ideation, and innovative thinking through social entrepreneurship challenges and youth innovation hubs, so that young people can be directly engaged in designing the solutions they need (Desveaux et al., 2019; Singh, 2015; Tauberer, 2017).

This review highlights a key gap in terms of lack of youth-focused or youth-specific mental health services across RKSK, DMHP and HWCs. There is an urgent need to include youth-specific intervention packages within the larger framework of these programs so that youth who need help are identified at the platforms close to them such as schools and communities and the necessary support can be coordinated through the DMHP and HWCs which are primarily responsible for providing mental health services at the primary healthcare level. Another glaring gap is the relatively little emphasis on scaling up psychosocial support interventions within schools, communities, or primary healthcare settings. Evidence from both high- and low-resource settings suggest that scaling up of psychosocial interventions is possible by adopting a number of strategies such as using simplified therapies that can be delivered by non-specialist health workers (van Ginneken et al., 2013), brief therapies (Schleider and Weisz, 2017), computer-assisted or online guided therapies (Büscher et al., 2020; Christ et al., 2020; Domhardt et al., 2021), as well as adopting interventions that do not require constant specialist supervision (Wolpert et al., 2019). A pathway to systematically analyze such evidence and deliberate on their adaptation, adoption, and inclusion within the national mental health programs needs to be developed. Similarly, the current policies and programs do not provide an adequate framework to introduce early interventions to address the needs of young people who may have sub-clinical or sub-threshold symptoms. These early interventions could delay, minimize, or even prevent the onset of mental health problems (McGorry and Mei, 2018).

A major limitation in the current management of health information in India is lack of comprehensive data about the outreach and utilization of existing mental health initiatives targeting young people within health sector programs and across programs from different sectors covered in this review. For instance, the available literature on assessment of programs like RKSK, SABLA, AEP, and NYKS do not assess the direct and indirect impact of these programs on mental health of young people and their access to psychosocial care (Bharat and Sethi, 2019; Hoopes et al., 2016). Similarly, evaluations of the Adolescent Friendly Health Clinics do not describe the impact on mental health (Santhya et al., 2014;

Srivastava, 2016) and young people consulting CHWs for mental health issues is also understudied (Santhya et al., 2014). This needs to be addressed by including mental health indicators within the routine reporting systems as well as undertaking holistic evaluations of programs that have mental health components.

Community-based, non-specialist care models using digital technologies are being developed and tested by academicians and researchers with promising results (Bergin et al., 2020; Deb et al., 2018; Sreejith and Menon, 2019). Establishment of a Virtual Knowledge Network in collaboration with project Extension for Community Healthcare Outcomes (ECHO) to build the capacities of medical officers in remote areas is one such initiative (Kumar et al., 2020). Leveraging digital technologies in integrated programs to help CHWs including Accredited Social Health Activists (ASHA), *Anganwadi* workers, and Auxiliary Nurse Midwifes (ANM) of National Health Mission; Health and Wellness Ambassadors of the School Health Program; Peer Educators of RKSK; and Youth Councils of NYKS can yield wider community outreach. The apex national body on mental health—NIMHANS—is working on multiple digital initiatives to realize the commendations made in MHCA and NMHP such as the e-Manas (Bairy et al., 2021; Gajera et al., 2021; Ibrahim et al., 2020, 2021).

Key recommendations to build stronger mental health services for youth in India have been summarized in Box 1.

A range of systemic barriers, and factors related to political, contextual, organizational, and community participation limit the scope and implementation of the various youth focused policies and programs, including for mental health, in the country (Singh, 2015). The geographical and cultural vastness of the country places additional challenges in translating policies into action. Therefore, meaningful local actions at district and below-district levels are the most amenable ways to overcome these challenges. Further, 'health' being a state subject, implementation may vary depending on the state-specific priorities and availability of human and material resources (Bali and Ramesh, 2021). Frequent and bi-directional communication between policymakers, program implementers, and service users at the community level, and strong monitoring, learning, and evaluation framework is needed to translate the policy information into locally relevant interventions (Duran et al., 2014). Barriers related to community participation can be further addressed by assessing the preferences and priorities of young people, coupled with awareness and information campaigns to enhance their trust, responsibility, enrolment, and active engagement in existing programs (Samudre et al., 2016).

Intersectoral convergence between health, education, social justice, youth affairs, and Panchayati Raj (local governance) also holds huge potential to implement synchronized campaigns on mental health awareness and reducing self-harm and suicides by involving influential youth icons like sportspersons, cinema celebrities, politicians, and religious-spiritual leaders. The highly intersectoral determinants of mental health need to be recognized, not only for prevention of mental health problems but also for suicide prevention. Presently, large-scale interventions for preventing suicides and providing emergency crisis management support are largely confined to helplines and emergency care in select tertiary healthcare facilities. There is a need for a coordinated national strategy for suicide prevention that engages with the existing policies and programs for improving non-discriminatory access to health, education, and employment along with reduction in the risk factors for suicide (Cherian et al., 2020; Gupta and Basera, 2021). Simultaneously, upgradation of education standards, promoting anti-bullying policies and access to mental health services at schools and educational institutions, and periodically sensitizing children and parents on red flags for self-harm are necessary (Gupta and Basera, 2021; Vijayakumar et al., 2022). Similarly, context-specific stressors, particularly the burden caused by failure in examinations, can be relieved by allowing students to reappear for examinations in the same month when results are declared (Vijayakumar et al., 2022). Forming a peer network of young people living with mental health problems or organized around shared vulnerabilities will help them to listen, support, and learn from each other (Banandur et al., 2021).

Substance abuse and sexual health are important determinants that impact the mental health of school going children. However, the AEP was suspended in eight states in 2008 due to the socio-culturally objectional content related to sexuality, sexual health, and substance abuse in the modules (Ismail et al., 2015). This clearly indicates a need to realize the recommendations made in policies like NEP, NYP, and National Mental Health Policy for promotion of mental health and life skills to factor in gender sensitivity, sexuality, and promote resilience through on-campus and online programs. According to the 2018–2019 All India Survey on Higher Education, India has a vibrant network of 993 universities, 39, 931 colleges, and 10,725 standalone institutions where 37.4 million youth aged 18–23 years are enrolled in higher education in India (Ministry of Human Resource Development, 2019). This scenario presents opportunities to include preventive promotive programs at educational institutes with targeted interventions for those at high risk of substance abuse and related mental health problems. This can also be included in student induction sessions as well as in the training module for teachers. Large-scale engagement of school and college-going young people in community service initiatives like NYKS and NSS could be a cost-effective way to address burning issues like destigmatization and raise awareness about availability of mental health services. Engaging young people in such initiatives has been found to be effective in improving self-esteem, coping, emotional health promotion, and awareness of social and civic issues (Hameed and Mehrotra, 2017; Nehru Yuva Kendra Sanghatan, 2003; Srikala and Kishore, 2010).

Technological advancement aimed at improving service delivery,

Box 1
Key recommendations for programmatic priorities towards stronger youth mental health services

1. Strengthened health and education departments for implementing psychosocial education at schools and colleges.
2. Establishing referral linkages between schools, colleges, AFHCs, DMHP, and HWCs.
3. Leveraging tele-medicine facilities for psychosocial therapy to school children in need.
4. Deploying technology-based hybrid solutions to strengthen existing service delivery platforms and community outreach.
5. Improving availability of psychotropic medicines in primary healthcare facilities.
6. Enhancing skills of the health and non-health workforce at AFHCs and primary healthcare settings for quality psychosocial first aid and counseling services for young people.
7. Building capacities of teachers as Health and Wellness Ambassadors for promoting emotional wellbeing along with practical skills of identifying red flags, providing psychological first aid and initiating appropriate referrals for schoolchildren.
8. Capacitating the community health workers and outreach workers to mobilize young people to observe Adolescent Health and Wellness Days at schools and colleges.
9. Improved funding and budget allocation to the existing mental health program.
10. Including mental health indicators in existing Health Management Information System.

public engagement, and transparent governance is gradually gaining prominence especially in low-resource settings like India (Nadhamuni et al., 2021). The School Health Program envisages digitization of Student Health Cards which comprise data related to screening and service access for each student. It also aims to develop mobile apps, e-health, and social media platforms for health promotion and counseling support. The 'Saathiya Salah' app was developed to be used as an aid while engaging with adolescents through the RKSK initiatives; its use is further recommended during sessions like Adolescent Health Day which is a convergent activity of frontline workers of the Health, Education, and Women and Child Development departments. However, there is a lack of evidence on the usefulness of Apps in such convergent platforms. Nonetheless, research-backed, technology-driven interventions are emerging promisingly in response to the ever-increasing burden of mental health problems in India (Orlowski et al., 2016; Patel et al., 2016).

While being comprehensive in its approach, this review has some limitations. Firstly, this review focused on the major policies and programs related to young people and their mental health at the national level. In India, states may develop specific initiatives to address their specific priorities over and above these national level initiatives. Such state-specific initiatives were not identified. Secondly, despite the coexistence of biomedical care, psychological care, Indian Systems of Medicine, and religious and faith-based healing practices in the country, the national policies largely follow the biomedical care approach in the management of mental health, although the relevance of these systems in addressing mental health and especially in coordinating care pathways has been recommended. This review, therefore, inadvertently offers a limited perspective on the scope of the non-biomedical care models in addressing the mental health needs of the youth in the country. Finally, the policies and programs and their implementation plans lacked a comprehensive discussion on adoption of transdisciplinary approaches, thereby limiting the inferences for enabling an intersectoral coordinated approach and specific implementation strategies. Future research and review of the policies and programs should explore the application of transdisciplinary approaches and discuss the scope of the policies and programs to include the salient features of transdisciplinary approaches.

5. Conclusion

The existing programmatic frameworks and administrative capacities have numerous strengths and opportunities for the creation of a truly transformed system of youth mental health care embedded within the current larger system. For example, within the health sector, the national mental health policy and programs, the national adolescent health program, the school health and wellness initiative, as well as the Ayushman Bharat–Health and Wellness Centres, all endorse the need to focus on the mental health and well-being of adolescents and young people. Similarly, within the education sector, the promotion of life skills and psychosocial well-being of young people is emphasized. The Ministry of Youth Affairs and Sports promotes holistic youth development as it engages with young people both in and out of educational institutions.

Reimagining the approach to advance young people's mental health is therefore needed and collective efforts are called upon at the level of health systems, community, and educational institutions to create a mental health friendly environment for youth. Such a transformed service needs to be designed specifically for—and with—youth to address the social and other health needs of youth experiencing mental health issues, while being sensitive to their sociocultural realities and commensurate with their preferences for digital and non-digital tools to seek cross-connected care both vertically for specialized services and horizontally for other health and social services. The guiding principles of action could include sustainable intersectoral partnerships for quality services, enhancing young people's agency so that they are empowered, respecting their dignity and rights, and fostering meaningful digitalization.

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Bhushan Girase: Conceptualization, Methodology, Formal analysis, Resources, Data curation, Writing – original draft, Visualization, Project administration. **Rachana Parikh:** Conceptualization, Methodology, Formal analysis, Resources, Visualization, Writing – review & editing, Supervision. **Samica Vashisht:** Resources, Data curation, Formal analysis. **Anushka Mullick:** Resources, Data curation, Formal analysis. **Vaibhao Ambhore:** Methodology, Formal analysis, Writing – review & editing, Supervision. **Sudhir Maknikar:** Methodology, Writing – review & editing, Supervision, Visualization.

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