

Review

Barriers and facilitators for adolescents seeking mental health care in India: a systematic review

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ABSTRACT

Background: Common mental disorders (CMDs) and psychological distress contribute substantially to morbidity among adolescents in India yet help-seeking remains limited. Understanding determinants of help-seeking behaviour is essential to designing context-specific, adolescent-friendly mental health interventions.

Methods: This systematic review was conducted following MOOSE guidelines and reported in line with PRISMA 2020 framework. Searches across PubMed, EMBASE, PsycINFO, and CINAHL identified studies published between January 2010 and April 2025. Eligible studies included qualitative, quantitative, and mixed-methods research conducted among adolescents aged 10–19 years in India that examined barriers or facilitators to help-seeking for CMDs, psychological distress, self-harm, or substance misuse. Data were synthesised narratively using an integrative thematic approach.

Results: Twenty-six studies (reported in 27 articles) met inclusion criteria. Most were school-based; only a small number of studies were conducted exclusively in urban slum settings. Across study types, stigma (self, public and structural) emerged as the most pervasive barrier to seeking care. Low mental health literacy among adolescents, parents, and teachers further delayed help-seeking. Additional barriers included negative or distrustful experiences with healthcare providers, concerns regarding confidentiality, academic pressures, and socioeconomic constraints. Facilitators included supportive peers and families, positive relationships with counsellors, psychoeducation delivered through school- or community-based programmes, and involvement of trained lay counsellors. Technology-enabled approaches showed promise but faced acceptability challenges within families. **Conclusion:** Help-seeking among adolescents in India is shaped by multilayered individual, social, and structural barriers, with stigma and low mental health literacy at the core. Youth-centred interventions that promote literacy, reduce stigma, strengthen social support networks, and increase acceptability of services are crucial. Evidence gaps are substantial for adolescents in vulnerable contexts, particularly those living in urban slums.

1. Introduction

Common mental disorders (CMDs) and psychological distress remain major contributors to adolescent morbidity globally, with recent Global Burden of Disease (GBD) estimates indicating that mental disorders account for approximately one-fifth of years lived with disability among children and adolescents worldwide (Global burden of disease, 2022). Most CMDs typically start between 11 and 18 years of age (Patton et al.,

2016; Kessler et al., 2005), a developmental period characterised by rapid biological, psychological, and social transitions. Adolescents are particularly vulnerable to depression, anxiety, and self-harm during this stage, all of which are major causes of disability and mortality in India (Dhiman et al., 2023; Joshi et al., 2017). Evidence indicates that the burden of depression, anxiety, and related mental health problems among adolescents has increased globally over time, with recent global burden estimates showing substantial increases in incidence and

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disability for these disorders, particularly during the 2019–2021 period (McGorry et al., 2025). Findings from the National Mental Health Survey of India (2015–2016) indicate that nearly 7% of adolescents aged 13–17 years' experience a clinically significant mental health condition, with similar prevalence among boys and girls (Gururaj et al., 2017).

Adolescence is a critical developmental phase during which changes associated with puberty, shifting social environments, increasing academic and interpersonal demands, and evolving cognitive processes shape mental well-being (Crone and Dahl, 2012; McGorry et al., 2025; Mastorci F et al., 2024). These challenges may be intensified for young people living in socioeconomically disadvantaged contexts, such as urban slums, where additional stressors including poverty, overcrowding, inadequate housing, and frequent exposure to communicable diseases further heighten vulnerability (Chandra et al., 2018; Goswami and Manna, 2013; Subbaraman et al., 2014).

Despite this growing burden, most individuals with mental illness do not receive adequate care (MacDonald et al., 2018), and the treatment gap for CMDs in India is estimated at approximately 95% (Hossain and Purohit, 2019). Very little evidence exists regarding the magnitude of the treatment gap specifically among adolescents or the contextual barriers driving low service use in this age group. Research from other settings points to constraints such as shortages of trained mental health professionals, limited-service availability, pervasive stigma, and concerns related to treatment affordability and adherence (Lakshmana et al., 2022; Böge et al., 2018). Even less is known about adolescents' own help-seeking behaviours, whether they seek mental health care, and what influences their decisions.

Failure to seek timely mental health support during adolescence can lead to long-term consequences, including poor academic performance, impaired psychosocial functioning, increased risk-taking behaviours, self-harm, and suicide (Goldston et al., 2008; Roy et al., 2019). These consequences extend beyond the individual, affecting families and communities. Evidence indicates that the onset of most common mental disorders occurs during early to mid-adolescence, with population-level analyses showing that a substantial proportion of mental disorders begin by around 14 years of age (Patton et al., 2016; Kieling et al., 2024). In India, untreated mental health conditions during adolescence often persist into adulthood, contributing to more severe mental disorders and long-term psychological, social, and functional impairment (Solmi et al., 2022; GBD, 2019 Mental Disorders Collaborators, 2022; Malhotra and Patra, 2014). The aim of this review was to systematically synthesise evidence on barriers and facilitators of help-seeking for mental disorders among adolescents in India.

Specifically, the review sought to address the following research question: What individual, social, and structural factors influence adolescents' decisions to seek or not seek formal mental health care in the Indian context?

2. Methods

This systematic review was conducted in accordance with the Meta-analysis of Observational Studies in Epidemiology (MOOSE) guidelines (Brooke et al., 2021) and with the Joanna Briggs Institute (JBI) methodology for mixed-methods systematic reviews and reported following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) framework (Page et al., 2021). The MOOSE checklist is provided in the supplementary materials. The review protocol was prospectively registered with PROSPERO (CRD42020214349). Although the registered protocol covered adolescents in low- and middle-income countries, this paper reports findings from studies conducted in India only.

2.1. Eligibility criteria

2.1.1. Study designs

We included qualitative, quantitative, and mixed-methods studies

published in English. Eligible quantitative designs comprised cross-sectional studies, feasibility and acceptability trials, pre–post (before–after) designs, and cohort studies. Case reports and case series were also considered. No restrictions were placed on sample size or duration of follow-up. Only studies conducted in India, or those reporting disaggregated data for Indian adolescents, were included. The review focused on common mental health conditions in adolescence that are frequently examined in relation to help-seeking behaviour, including depression, anxiety and psychological distress, suicidal behaviour, and alcohol and substance misuse. Studies that examined overall mental health or emotional wellbeing were also included where they reported help-seeking experiences. Mental health conditions were defined according to the definitions used by the original study authors, and studies using self-reported symptoms, screening tools, clinical diagnoses, or qualitative descriptions were eligible. Formal diagnostic criteria such as DSM or ICD were not required, in line with the review's focus on help-seeking behaviour rather than clinical diagnosis.

2.1.2. Participants

Adolescents were defined as individuals aged 10–19 years, consistent with the World Health Organization definition. Studies that included broader age ranges were eligible only if adolescent-specific data or findings were reported. In such cases, only results pertaining to adolescents aged 10–19 years were extracted and synthesised for this review.

2.1.3. Outcomes

The primary outcomes of this review were barriers to and facilitators of mental health help-seeking among adolescents. Barriers were defined as any individual, social, or structural factors that stopped, delayed, or prevented adolescents from seeking mental health care (e.g. stigma, limited resources, poor quality of care, socioeconomic constraints, or structural inaccessibility).

Facilitators were defined as any strategy, process, or contextual factor that supported or improved adolescents' seeking mental health care (e.g., trained providers, digital support tools, psychoeducation, social support).

Secondary outcomes included adolescents' knowledge, attitudes, experiences, and behaviours related to seeking mental health care.

Studies that did not address barriers or facilitators, did not contribute relevant evidence, or focused solely on personality disorders, PTSD, or acute psychiatric conditions, were excluded.

2.2. Information sources and search strategy

Searches were conducted in PubMed, EMBASE, PsycINFO, and CINAHL for articles published between 1 January 2010 and 1 April 2025. Search strategies used combinations of Medical Subject Headings (MeSH) and keywords; the full protocol contains detailed strategies, with one example provided in [Appendix 1](#).

The search strategy combined concepts for:

1. CMDs (e.g., depression, anxiety, psychological distress, alcohol use, self-harm),
2. adolescents (10–19 years), and
3. barriers/facilitators to help-seeking.

2.3. Selection process

Search results were imported into EndNote for de-duplication (Hupe, 2019) and uploaded to Rayyan for screening (Johnson and Phillips, 2018).

Two reviewers (SK and PK) independently screened titles/abstracts using predefined criteria. Full texts were retrieved for potentially eligible studies. Disagreements were resolved through discussion. Reasons for exclusion were documented and are shown in the PRISMA flow

diagram (Fig. 2.1) (Haddaway et al., 2021).

2.4. Data collection

A structured extraction form was used to collect information on:

- Publication details (authors, year, journal)
- Study characteristics (location, setting, sample size)
- Participant characteristics
- Study design
- Intervention characteristics (if applicable)
- Outcomes (barriers, facilitators)
- Strengths and limitations

Data extraction was completed by SK and checked independently by PK. For multiple papers from a single study, data were extracted from the earliest article providing barrier/facilitator information.

2.5. Data synthesis and analysis

Data from mixed-methods studies were synthesised alongside quantitative findings.

Qualitative findings were first synthesised using thematic analysis (Liamputtong and Ezzy, 2005; Kiger and Varpio, 2020).

A convergent integrated approach was used in accordance with JBI methodology for mixed-methods systematic reviews. This approach was selected because the review question could be addressed by qualitative, quantitative and mixed-methods evidence, and because substantial heterogeneity in study designs, populations, measures and outcomes precluded meaningful statistical aggregation. Quantitative findings were transformed into textual descriptions and synthesised alongside qualitative and mixed-methods findings. The synthesis focused on identifying convergent and complementary evidence on barriers and

facilitators to help-seeking, rather than estimating pooled effect sizes.

2.6. Critical appraisal

Critical appraisal was conducted to assess rigour and transparency across studies. For qualitative research, appraisal focused on credibility, coherence, and methodological congruity rather than bias in estimating causal effects. Quality was assessed using Joanna Briggs Institute (JBI) critical appraisal tools appropriate to each study design.

1. JBI Checklist for Qualitative Research (Munn et al., 2020)
2. JBI Checklist for Quasi-Experimental Studies (Lockwood et al., 2015)
3. JBI Checklist for Analytical Cross-Sectional Studies (Moola, 2020)
4. JBI Checklist for Randomised Controlled Trials (Barker et al., 2023).

Two reviewers independently assessed all studies; disagreements were resolved through discussion. No studies were excluded based on quality. When reporting was insufficient, the domain was rated “unclear.”

3. Results

3.1. Study selection

Database searches conducted up to April 2025 identified a total of 93,063 records. Following removal of duplicates, 86,147 records were screened by title and abstract. Automated filtering in Rayyan to identify studies conducted in India reduced the number of records to 2400. 2231 records were excluded and 169 full text articles were assessed for eligibility. Of these, 26 studies, reported across 27 articles, met the inclusion criteria and were included in the review. The flow of studies and reasons for exclusion are summarised in Fig. 2.1 (PRISMA).

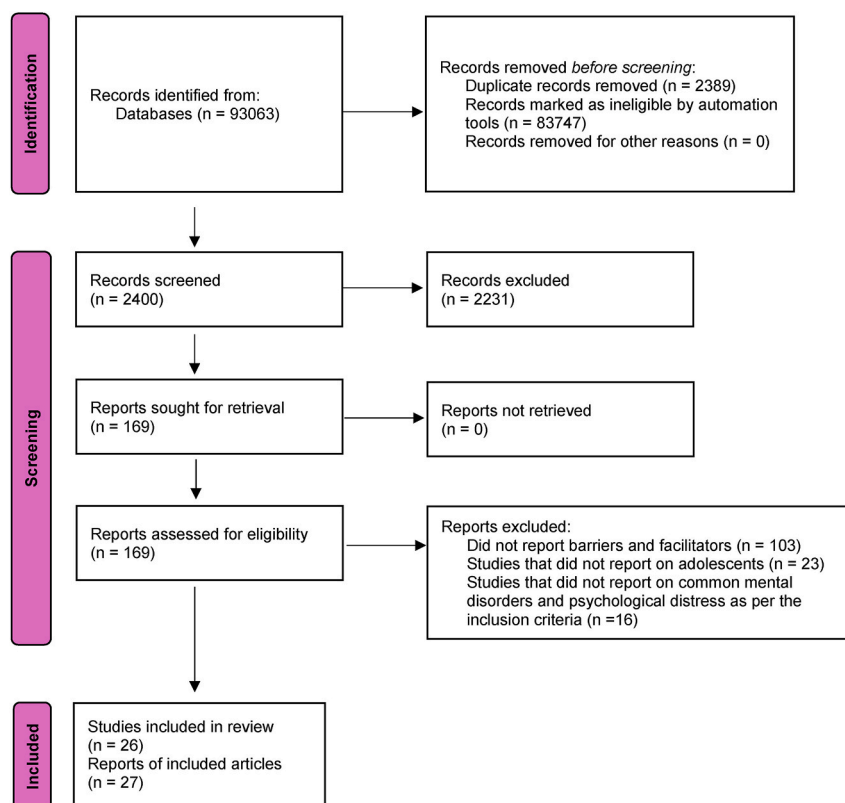


Fig. 2.1. PRISMA flow diagram for the systematic review of barriers and facilitators for adolescents seeking mental health care in India.

3.2. Study characteristics

The 27 included articles were methodologically diverse and conducted across multiple regions and settings in India, with over one-third originating from southern states (37.0%) and nearly one-third from northern states (29.6%). Mental health outcomes examined spanned depression, anxiety and psychological distress, self-harm and suicide, substance use, and overall wellbeing. While most studies focused on adolescents aged 11–19 years, several included older youth up to 24 years. Most studies focused on adolescents aged 10–19 years; however, some included broader age ranges extending up to 24 years (included only where disaggregated data for adolescents was available). If studies with participants outside the adolescent age range were included, only adolescent-specific findings were extracted and synthesised. Counts across study characteristics do not sum to 27 because some studies contributed to more than one category (e.g., region, setting, age or mental health focus). Detailed study characteristics are presented in Table 3.1.

3.3. Participant characteristics

Across the included studies, adolescent populations were the primary focus, with over one-third of studies concentrating exclusively on early to mid-adolescence (11–19 years; 38.5%), while just under one-quarter (23.1%) extended inclusion to older adolescents and young people. Age reporting was incomplete in a small proportion of studies (7.7%). Study samples ranged from small, in-depth qualitative studies to large-scale surveys. Nearly all studies (96.2%) included male and female participants.

Table 3.1
Characteristics of studies included in the review (N = 27).

Characteristic	Description
Total number of studies	27
Study design	Qualitative: 8 Mixed methods: 3 Quantitative: 16
Geographical distribution*	South India: 10 North India: 8 East India: 3 West India: 2 Northwest India: 1 Multiple regions: 3
Study settings	Schools/colleges: 12 Community-based: 7 Hospital/clinical: 5 Mixed or other settings: 3
Primary mental health focus*	Depression: 6 Self-harm/suicide: 5 Anxiety/psychological distress: 4 Alcohol/substance misuse: 3 Overall mental health/wellbeing: 3 Stress, stigma, or other mental health outcomes: 6
Age reporting	Age reported: 25 studies Age not specified: 2 studies
Overall participant age range	11–24 years
Age group coverage*	Adolescents only (11–19 years): 10 studies Adolescents and young adults (11–24 years): 6 studies Primarily older adolescents/young adults (18–24 years): 7 studies
Gender representation	Mixed-gender samples: 26 Female-only samples: 1
Sample size range	Qualitative studies: 15–191 participants Quantitative studies: 25–1571 participants Mixed-methods screening studies: >2700 participants

3.4. Combined narrative synthesis of qualitative and quantitative findings

Findings from the qualitative (Table 3.2) and quantitative (Table 3.3) studies were highly convergent, with key barriers and facilitators showing consistency across methods and settings. Where quantitative studies assessed barriers and facilitators, instruments used in those studies included validated stigma scales, mental health literacy questionnaires, screening tools, and intervention-specific pre–post assessments. It is also noted that many studies reported findings descriptively rather than providing numerical estimates of effect. Several mixed-methods studies contributed qualitative evidence on barriers and facilitators; however, quantitative findings were frequently reported narratively, particularly in feasibility and formative evaluations.

3.4.1. Stigma as a significant barrier

Across qualitative (Table 3.2) and quantitative (Table 3.3) studies, stigma was identified as a key barrier to adolescents' formal help-seeking. Self-stigma and anticipated public stigma - manifesting as feelings of shame, embarrassment, and fear of judgement - discouraged adolescents from disclosing emotional distress and seeking care (Aggarwal et al., 2020; Dhandapani et al., 2021). High levels of perceived stigma, particularly among adolescents experiencing depressive symptoms or suicidal ideation, which was associated with reduced willingness to seek professional support, were also reported in quantitative studies (Sharma et al., 2017; Singhal et al., 2014). Public stigma originating from peers, teachers, and family members was also frequently reported across study designs as a barrier to accessing services (Nebhinani et al., 2020; Parikh et al., 2019a,b), highlighting the multilevel nature of stigma within adolescent help-seeking pathways.

3.4.2. Low mental health literacy

Low awareness and poor understanding of mental health emerged as a universal barrier across the studies. Qualitative research highlighted that adolescents, parents, and teachers often struggled to recognise symptoms of mental health problems or distinguish them from typical adolescent behaviour, contributing to delays in seeking support (Dhandapani et al., 2021; Shinde et al., 2021). Quantitative studies similarly documented limited knowledge about conditions such as depression, suicide risk, alcohol misuse, and available coping strategies, indicating a widespread lack of mental health literacy among young people (Anju, 2019; Kaur, 2020). Notably, interventions specifically designed to improve mental health literacy demonstrated positive effects, with participants showing more favourable attitudes and increased intentions to seek help after receiving structured psycho-education or skill-building programmes (Michelson, 2020; Manjari et al., 2024).

3.4.3. Structural and system-level barriers

Evidence from qualitative (Table 3.2) and quantitative (Table 3.3) studies indicates the presence of substantial structural barriers that limit adolescents' access to mental health care. These barriers included limited availability of trained mental health providers, long travel distances and transportation challenges, and financial constraints that affected affordability and continuity of care (Dhandapani et al., 2021; Nebhinani et al., 2020; Shinde et al., 2021). Academic pressures and competing school commitments were also commonly identified as constraints, restricting adolescents' ability to attend appointments or engage consistently with services (Parikh et al., 2019a,b; Shinde et al., 2022). A consistent concern across studies was the lack of adolescent-friendly services, alongside fears about confidentiality breaches and negative interactions with healthcare professionals, including dismissive or disrespectful behaviour (Behera et al., 2023; Duara et al., 2022). Quantitative studies reinforced these findings, noting that many adolescents were unsure where to seek help and that competing school and household responsibilities further constrained their ability to access services (Sharma et al., 2017; Mukherjee et al., 2024).

Table 3.2
Barriers and Facilitators for help seeking for mental illnesses among adolescents reported in Qualitative Studies.

Lead author, year	Study Characteristics	Barriers and Facilitators	Strengths and Limitations
Aggarwal et al. (2020)	Region: Mumbai; Setting: hospital; Mental health: suicide/self-harm; Participants: 15.	Barriers: stigma; unhelpful treatment experiences; structural issues; discomfort with counsellors. Facilitators: family & friends; tailored counselling.	Strengths: Clearly explores the contextual factors related to self-harm. Data used to inform the design of an evidence-based intervention for self-harm in youth in that setting. Limitations: Conducted in one tertiary hospital in one location so the findings may not be generalisable. Differences in contextual factors and the challenges or experiences of help seeking may not be the same in other locations.
Behera et al. (2023)	Region: Odisha; Setting: slum; Mental disorder: CMDs; Participants: 25.	Barriers: low mental health information; stigma by providers/caregivers; lack of facilities; rude providers; financial barriers.	Strengths: The study contributes qualitatively to public health and policy research on access to mental healthcare services among adolescents residing in urban slums in Odisha. Source triangulation- multiple stakeholders were involved in the study. Limitations: The study might not have adequately covered other related vital stakeholders because of their consent and availability to obtain rich data about the experiences and perceptions of mental healthcare among adolescents in the state. The study was conducted in one district of Odisha state; the findings may not be generalisable to other Indian states.
Dhandapani et al. (2021)	Region: Chennai & New Delhi; Setting: community; Mental disorder: common mental health problems; Participants: 52.	Barriers: delay in recognising problems; lack of awareness; self/public stigma; financial constraints. Facilitators: community awareness; policy advocacy; curriculum integration; financial support; NGO/government involvement; teacher training.	Strengths: multi-site qualitative study with broad stakeholders. Limitations: Sample may not have been representative as participants were from small sections of a large country. Findings cannot be generalised as the contextual factors in this setting may not be the same in all
Duara et al. (2022)	Region: Assam; Setting: schools, community, rehab; Mental disorder: substance misuse; Participants: 30.	Barriers: stigma; low awareness; academic pressure; disbelief in posters alone. Facilitators: visual storytelling; hope-based messages; social media; co-creation.	Strengths: Strong reach across diverse audiences (students, general public, policymakers). Demonstrated potential for stigma reduction and increased awareness. Limitations: Case study design limits generalisability. Heavy reliance on visual literacy and digital access may exclude some groups which do not have access to these.
Gonsalves et al. (2024)	Region New Delhi Setting secondary schools, medical university, community centres Mental disorder Depression and Anxiety Design Participatory co-design study Number & distribution of participants Young People's Advisory Group (N = 11), Stakeholder Group (N = 20), Co-design participants (N = 42) Age range 16-24 years % Female 50% Duration 1 year	Barrier Limited positive mental health stories; trust, privacy and digital access concerns Facilitator Peer storytelling; high usability; youth involvement throughout	Strengths Extensive youth involvement and iterative refinement Limitations Urban low-resource settings only; digital dependence
Parikh et al., 2019a; 2019b	Region: urban Goa & New Delhi; Setting: schools; Mental health: stress, overall wellbeing; Participants: 191.	Barriers: distraction as coping; substance use (minority of boys); stigma; low awareness; school schedule conflicts. Facilitators: support from friends; prayer; empathic counsellors; awareness materials.	Study 1- Strengths: Explored a variety of stressors, social environments and the coping mechanisms that were employed by adolescents to address these day-to-day stressors. The differences in the coping mechanisms to overcome the stressors were clearly described by age, gender, and geographic location. Study 2- Used a holistic approach to get insights from all of stakeholders to adapt and implement mental health service provision in an effective way. Limitations: Study 1- No participants from rural areas. Audio-recording was not permitted for two FGDs; so some loss of data cannot be ruled out. Study 2- Representatives from the various stakeholder groups were purposively sampled to achieve maximum variation across sites, age groups, and gender distribution which may have led to bias due to targeting diversity rather than the majority.
Shinde et al. (2021)	Region: Bihar; Setting: schools; Mental disorder: depression; Participants: 100.	Barriers: stigma; low awareness; negative teacher attitudes; lack of professionals; preference for traditional healers; long distances; academic pressure. Facilitators: trust from mothers, siblings, friends; desire for school/community support.	Strengths: Provides new insights into adolescent understanding of depression and help-seeking in rural India. Includes perspectives of both boys and girls, enabling exploration of gender differences. Limitations: Does not include younger adolescents (10-14

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Table 3.2 (continued)

Lead author, year	Study Characteristics	Barriers and Facilitators	Strengths and Limitations
Shinde et al. (2022)	Region: Chennai, Prayagraj, Hyderabad, Pune; Setting: schools; Mental disorder: wellbeing; Participants: 256.	Barriers: dislike of group activities; prescriptive programme; teacher time constraints. Facilitators: high acceptability; improved peer bonding; prosocial responses.	years), limiting age representativeness. Only includes adolescents from government schools, findings not generalisable to private school settings. Strengths: A creative and participatory design of the program facilitated the involvement of a variety of stakeholders, including students and teachers. This qualitative study indicates this could be a promising model for definitive evaluation and subsequent scaling up of improving life skills and promoting psychological wellbeing in adolescents. Limitations: The research was conducted in public schools and government aided schools in four distinct cities in India. School infrastructure, teaching and curriculum may not be the same across states and school types in India. This study was a qualitative investigation, and no control group was included, and no quantitative measures of acceptability and feasibility were included

3.4.4. Trust, confidentiality, and relational dynamics

Trust emerged as a critical determinant of adolescents' willingness to seek mental health support. Trust was primarily described in relational terms, including adolescents' confidence in confidentiality, non-judgemental attitudes, and perceived empathy of service providers, teachers, counsellors, and other adults involved in care. Qualitative studies described how discomfort in discussing sensitive issues with unfamiliar counsellors, combined with concerns about confidentiality, often discouraged adolescents from engaging with services (Aggarwal et al., 2020; Parikh et al., 2019). Quantitative evidence further demonstrated that disruptions in counselling continuity such as being assigned different counsellors across sessions reduced adolescents' engagement and hindered progress (Mallik, 2022). Conversely, adolescents were more willing to seek help when providers were perceived as warm, empathetic, and non-judgmental, indicating that the quality of therapeutic relationships plays a pivotal role in shaping help-seeking behaviours (Michelson, 2020; Singhal et al., 2014).

3.4.5. Role of peers and families as facilitators

Peers and family members consistently emerged as important sources of informal support that shaped adolescents' help-seeking decisions. Qualitative findings showed that adolescents often preferred to discuss emotional difficulties with friends, viewing them as accessible and trustworthy confidants (Parikh et al., 2019; Shinde et al., 2021). Quantitative studies similarly indicated that peers and school counsellors were considered appropriate and acceptable sources of help when mental health concerns arose (Sharma et al., 2017). Family members particularly mothers and siblings also played a significant role in influencing whether adolescents sought formal care, either by encouraging help-seeking or, in some cases, contributing to delays (Menon, 2013; Aggarwal et al., 2025).

3.4.6. Effectiveness and acceptability of school- and community-based interventions

Across six studies that described and examined mental health interventions, school- and community-based approaches were identified as acceptable and accessible avenues for supporting adolescent mental health. Evidence from quantitative studies demonstrated that life skills education, problem-solving interventions, and teacher-supported programmes enhanced adolescents' knowledge, coping abilities, and

social-emotional skills (Srikala and Kishore, 2010; Michelson, 2020). Qualitative findings further indicated that adolescents wanted mental health content to be integrated into the school curriculum and expressed a need for more trained and approachable teachers who could identify and respond to emotional difficulties (Parikh et al., 2019; Shinde et al., 2022). In addition, innovative delivery models including mHealth, digital decision-support tools, and co-design approaches were highly acceptable within low-income and underserved communities, particularly when materials were culturally relevant and developed collaboratively with adolescents (Mukherjee et al., 2024; Duara et al., 2022).

3.5. Quality appraisal

Quality assessment of included studies broadly reflected the methodological strengths and limitations inherent to each study design, with detailed scoring presented in Tables 3.4–3.7. Qualitative studies generally demonstrated strong methodological congruity, which means all key components of a study are well aligned with each other. There is clear alignment between research aims, data collection, and analysis, and with good representation of participant perspectives; however, a consistent weakness across all studies was the limited reporting of researcher reflexivity.

The quasi-experimental studies were of moderate quality overall, with the most common limitations being the absence of control groups, incomplete follow-up, and unclear strategies for identifying or managing potential confounding factors. The single randomised controlled trial (Michelson, 2020) showed high methodological quality, supported by appropriate randomisation procedures and outcome assessment. The analytical cross-sectional studies demonstrated moderate to good quality, but many showed unclear reporting on confounding and limited information on the validity and reliability of measures used to assess key exposures, such as mental health symptoms and help-seeking-related factors.

4. Discussion

This review identifies mental health-related stigma and discrimination as the most prominent barriers to help-seeking among adolescents in India. Stigma was a barrier for initial care-seeking and continued engagement with mental health services, while low mental health literacy among adolescents, parents, and teachers further delayed or

Table 3.3
Barriers and Facilitators for help seeking for mental illnesses among adolescents reported in Quantitative Studies.

Lead author, year	Study characteristics	Barriers and facilitators	Strengths and limitations
Aggarwal et al. (2020)	Region Mumbai, west India Setting hospital Mental disorder self-harm Design intervention Number & distribution of participants 6 participants Mean age not reported. Age range 15 to 24 years (SD-not reported) % Female not reported Duration Length of program 1.5 years	Barrier Lack of empathy from treatment providers(counsellors) Involving a family member (who is responsible for the stressful condition) in the therapy process Stigma related to treatment (public stigma) Facilitator Involving friends in treatment process Mobilising social support Family education	Strengths Identified problem solving, emotion regulation and improving of social network as elements that may help to reduce the different types of problems experienced by adolescents The developed program allows for input from family members when acceptable to adolescents Limitations Sample was very small The method of sampling was not clearly described Conducted in a tertiary hospital setting in a single geographic location. Results might not be generalisable
Aggarwal et al. (2025)	Region Mumbai, West India Setting outpatient psychiatry department of a public sector tertiary hospital Mental disorder- Self harm leading to suicide Design Mixed methods single arm feasibility study Number & distribution of participants 27 Age range 14 to 24 years Mean age not reported % Female 67 % Duration 10 months	Barrier <ul style="list-style-type: none"> • Scarcity of publicly funded mental health services, shortage of psychiatrists. • Lack of youth-friendly services for self-harm. • Limited availability of psychological interventions, reliance on medication. • Previous negative experiences with mental health services reduce engagement with these services. • Strong stigma around self-harm and help-seeking in LMIC contexts. • Resource-intensive therapies (like DBT-A) not feasible in India. • Recovery often shaped by socio-cultural factors, complicating help-seeking. Facilitator <ul style="list-style-type: none"> • Brief and flexible intervention (5–8 sessions) suited to low-resource contexts. • Optional modules co-selected with youth improve engagement. • Culturally adapted vignettes and materials improved participation. • Can be delivered by non-specialists which supports scalability. • Additional follow-up sessions (6–8 months) promote continuity of care. • Improved understanding or awareness of self-harm among youth and families supports adaptive coping. 	Strengths <ul style="list-style-type: none"> • Mixed-methods design strengthened findings through quantitative and qualitative data. • Delivered by both specialist and non-specialist counsellors and tested for scalability. • Intervention developed through systematic, culturally grounded process. • Feasible for LMIC implementation due to its flexibility. Limitations <ul style="list-style-type: none"> • Small sample: 27 enrolled; 18 completed; 13 followed up. • Single tertiary hospital recruitment limits generalisability. • No control group—cannot establish causality. • Not suitable for high-risk youth with imminent suicidal intent requiring inpatient care. • Cost-effectiveness unknown, long-term treatment pathways may offer better outcomes.
Anju et al., 2019	Region Panipat, Haryana, north India Setting school Mental disorder alcohol misuse Design intervention Number & distribution of participants 60 participants Mean age not reported. Age range not reported (SD-not reported) % Female not reported Duration Length of program 7 days	Barrier Lack of knowledge on ill effects of alcoholism Facilitator A structured teaching programme in schools is effective in increasing knowledge on the ill effects of alcoholism among adolescents. This helped them to seek help rather than choosing alcohol to reduce their problems	Strengths The 7-day intervention increased knowledge of the ill effects of alcohol consumption, and processes to control alcohol misuse among adolescents Limitations Conducted in one school making it difficult to generalise Data were collected using a self-report questionnaire which may have reporting bias The objective of the study was to assess the knowledge of ill effects of alcohol consumption before and after intervention and did not have the barriers and facilitators for accessing care as an objective. Study duration was very short (one week)
Bhola et al. (2017)	Region Bangalore, Karnataka, south India Setting school and college (urban) Mental disorder self-harm Design cross sectional Number & distribution of participants 1571 participants Mean age 17.5 (SD - 14.2) years % Female 57.8% Duration Length of program- not reported	Barrier Adaptation to pain from self-injury Internalized feelings and externalized presentation of distress seen more in adolescents engaging in self-injurious behaviours Facilitator Distinguishing from non-suicidal and suicidal self-injurious behaviours among different sociodemographic profiles helps to reduce the severity of self-harm	Strengths Large and diverse sample. A variety of school and college settings which gives diverse perspectives Limitations Primary aim was not help-seeking; consent challenges may have resulted in biased sample
Chandra et al. (2014)	Region Bangalore, Karnataka, south India Setting urban slums	Barrier Not owning a phone and sharing a phone with another family member	Strengths Culturally acceptable mobile text message intervention for young women

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Table 3.3 (continued)

Lead author, year	Study characteristics	Barriers and facilitators	Strengths and limitations
	Mental disorder overall mental health Design mixed methods intervention Number & distribution of participants 40 participants Mean age 16.8 (SD 1.7) years % Female 100% Duration Length of program 3 months	Family objections to receiving messages Lack of trust regarding the service provider Facilitator Liked receiving messages; felt cared for; alternative delivery via friend/family phone or printed material	Limitations Female-only, small sample, limited power, English literacy requirement
Malik et al., 2022	Region New Delhi Setting school Mental disorder common mental disorders Design mixed methods pilot study Number & distribution of participants 80 Mean age 15.3 years % Female 55% Duration 7 months	Barrier Perceived problem resolution; long gaps between steps; dislike of changing counsellors Facilitator Strong counsellor connection; clear escalation pathway	Strengths Triangulated quantitative and qualitative data; lay counsellor model Limitations No control group; small Step-2 sample
Manjari et al. (2024)	Region Odisha (East India) Setting preuniversity college Mental disorder common mental disorders Design quasi experimental pre post Number & distribution of participants 49 Age range 14-18 years % Female 42.9% Duration 6 weeks	Barrier Low knowledge; high stigma Facilitator MHAD program improved knowledge and reduced stigma	Strengths Validated tools; real-world classroom delivery Limitations Small sample; single setting; no control group
Mukherjee et al. (2024)	Region New Delhi and Vijayawada Setting Urban slums Mental disorder depression, self-harm/suicide risk Design mixed methods formative evaluation Number & distribution of participants 2752 Age range 10-19 % Female 50.3% Duration 12 months	Barrier Parental stigma; financial and access constraints; self-stigma Facilitator Co-designed IEC; community camps; mHealth EDSS	Strengths Large-scale screening; strong stakeholder engagement Limitations Short intervention duration; persistent access barriers
Nebhinani et al. (2020)	Region northwest India Setting college Mental disorder suicide prevention Design Intervention Number & distribution of participants 243 Mean age 19.74 (SD 1.82) years % Female 30% Duration 3 days	Barrier Structural stigma; reluctance to disclose suicide intent Facilitator Perceived reward of suicide prevention work	Strengths Assessed attitudes of medical students Limitations Single college; short follow-up
Rao et al. (2021)	Region Delhi Setting urban community Mental disorder drug misuse Design Intervention Number & distribution of participants 838 Mean age 24.5 (SD 5.4) years % Female 1% Duration 2 years	Barrier Resource constraints; community objections Facilitator Mobile dispensing; community participation	Strengths Long duration; multiple dispensing sites Limitations Not adolescent-specific
Sharma et al. (2017)	Region New Delhi Setting school Mental disorder Depression Design cross sectional Number & distribution of participants 354 Age range 13 to 17 years % Female 47.5%	Barrier Self-stigma; lack of knowledge of services Facilitator Positive peer attitudes; preference for counsellors	Strengths Explores reasons for not accessing care Limitations Single school; limited generalisability
Singhal et al. (2014)	Region Bangalore, Karnataka Setting school (urban) Mental disorder Depression	Barrier Embarrassment and self-stigma	Strengths Assessed needs and efficacy of coping skills program

(continued on next page)

Table 3.3 (continued)

Lead author, year	Study characteristics	Barriers and facilitators	Strengths and limitations
Srikala et al., 2010	Design Intervention Number & distribution of participants 300 Age range 13 to 18 years % Female 82% Duration 6 months	Facilitator Same-gender counselling groups; willingness to participate	Limitations Short follow-up; self-report bias
	Region Chennapatna and Udipi, Karnataka Setting rural schools Mental disorder overall mental health Design program evaluation Number & distribution of participants 500 Age range 14 to 16 years % Female 40%	Barrier School dropout; adjustment issues Facilitator Life skills education integration	Strengths Large sample; school-based feasibility Limitations Rural-only; unclear pre/post evaluation
Sudarshan et al. (2018)	Region Bangalore and Gauribidanur Setting college Mental disorder Depression, Anxiety, Alcohol misuse Design cross sectional Number & distribution of participants 1555 Age range 18 to 24 years % Female 52.4%	Barrier Low family/community support Facilitator Kinship and social rituals	Strengths Urban and rural college representation Limitations Younger adolescents excluded

• Descriptive quantitative findings are presented where effect sizes were not reported.

discouraged help-seeking. Negative interactions with healthcare providers such as limited empathy, inadequate consultation time, and poor communication along with socio cultural vulnerabilities including younger age, female gender, and socioeconomic disadvantage, contributed to treatment avoidance and discontinuation. In contrast, supportive peers and family members facilitated help-seeking, particularly when adolescents were able to openly discuss their concerns. Interventions focused on mental health education, stigma reduction, and community engagement, including the involvement of teachers, parents, and lay health workers, were associated with improved help-seeking. Early access to counsellors and psychologists within school and healthcare settings also appeared to support adolescents in articulating distress and engaging with care.

Different types of stigma including self-stigma, public stigma and structural stigma were identified as key factors that interfered with help seeking barrier across similar settings, which is consistent with global reports documenting how institutional and professional stigma fosters shame, concealment, and withdrawal among young people with mental health concerns (Heflinger and Hinshaw, 2010). Consistent with this review, systematic reviews conducted largely in high-income countries similarly identify service-level barriers including limited availability of specialist services, fragmented or unclear pathways to care, and negative or dismissive provider attitudes as major constraints on adolescent mental health help-seeking and continued engagement with services (Gulliver et al., 2010; Aguirre Velasco et al., 2020; Cox et al., 2024). These reviews also highlight the stigma, low mental health literacy, and negative prior experiences with services in deterring adolescents from accessing care, closely mirroring the barriers identified in this review.

Low mental health literacy among adolescents, parents, and teachers was another consistent barrier. This mirrors findings from a mixed-

methods systematic review of adolescents in low- and middle-income countries, which described how poor symptom recognition, limited understanding of mental disorders, and mistrust of available services constrain help-seeking behaviour (Renwick et al., 2022). Similar to the findings of this review, existing systematic reviews have highlighted the influence of socio-cultural norms on adolescent mental health help-seeking, including preferences for informal support networks and, in some contexts, traditional or non-biomedical sources of care (Aguirre Velasco et al., 2020; Radez et al., 2021). These patterns mirror the reliance on family, peers, and community-based sources of support identified in the included Indian studies, reinforcing the importance of culturally sensitive and community-oriented approaches to adolescent mental health care.

Social support particularly from peers and family members emerged as a key facilitator of help-seeking in the Indian studies included in this review. This finding is consistent with evidence from international systematic reviews, largely drawing on studies from high-income countries. For example, (Aguirre Velasco et al., 2020) synthesised evidence from over 50 studies examining barriers and facilitators of help-seeking for common mental health problems among adolescents and found that supportive family and peer relationships were consistently associated with greater willingness to seek help. Similarly, (Radez et al., 2021), in a systematic review of 53 qualitative and quantitative studies involving children and adolescents primarily from Europe, North America, and Australia, identified anticipated responses from peers and family members as a central influence on disclosure and help-seeking. Across these reviews, supportive reactions were found to facilitate help-seeking, whereas fears of negative, dismissive, or overprotective responses could discourage disclosure through concerns about stigma, burdening others, or loss of autonomy. These insights suggest that

interventions must strengthen relational environments around adolescents while fostering supportive but autonomy-enhancing communication.

This review has several strengths. It included studies from diverse geographical and socio-economic settings in India and integrated findings across qualitative, quantitative, and mixed-methods research. This allowed a more nuanced understanding of the mechanisms shaping help-seeking behaviour. Some limitations are - many quantitative studies did not explicitly aim to assess help-seeking, methodological reporting gaps, including limited reflexivity in qualitative work and insufficient management of confounders in analyses in cross-sectional and quasi-experimental designs, which could potentially introduce bias.

Despite these limitations, the findings identify clear and modifiable targets for intervention. Reducing stigma, improving mental health literacy, enhancing trust and confidentiality within services, and strengthening peer and family support systems may improve help-seeking behaviour among adolescents. Equipping teachers, lay counsellors, and healthcare providers with adolescent-centred training; integrating mental health literacy into school curricula; and developing culturally resonant communication materials may further strengthen help-seeking pathways. Several quantitative and mixed-methods studies included small samples, which limits statistical power and generalisability. Consequently, quantitative findings were interpreted cautiously and synthesised alongside qualitative evidence to strengthen contextual understanding rather than to draw causal inferences.

Only a few studies included in the review were conducted exclusively in urban slum settings, including Behera et al., Chandra et al. and Mukherjee et al. Given this scarcity of evidence from vulnerable groups, especially adolescents living in urban slums, future research should prioritise these populations to inform equitable mental health policies and interventions.

5. Conclusion

This systematic review highlights the complex and interconnected factors influencing mental health help-seeking among adolescents in India. Across diverse settings and methodologies, the evidence consistently identifies stigma, low mental health literacy, structural barriers, and limited youth-friendly services as the most significant obstacles to timely care. Conversely, peer and family support, trusted counselling relationships, and school- or community-based interventions emerge as

important facilitators. These findings reinforce global evidence while underscoring context-specific challenges shaped by socio-cultural norms, resource limitations, and health system constraints in India.

Improving adolescent mental health outcomes will require multifaceted interventions that operate across individual, relational, and structural levels. Reducing stigma, integrating mental health literacy into schools and community programmes, strengthening the capacity of lay counsellors and teachers, improving confidentiality and trust in services, and developing culturally resonant educational materials may be vital components for effective strategies. Given the limited evidence from adolescents in highly vulnerable contexts particularly those living in urban slums future research should prioritise these populations to ensure equitable access to mental health care. Strengthening the evidence base for scalable, adolescent-centred interventions will be essential for addressing the substantial treatment gap and advancing national mental health goals.

CRedit authorship contribution statement

Sudha Kallakuri: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Project administration, Validation, Writing – original draft. **Prachi Kaistha:** Conceptualization, Data curation, Formal analysis, Methodology, Resources, Software, Validation, Writing – review & editing. **Pallab K. Maulik:** Conceptualization, Methodology, Resources, Supervision, Validation, Writing – review & editing. **Maree L. Hackett:** Conceptualization, Data curation, Supervision, Validation, Writing – review & editing.

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Declaration of competing interest

The authors declare that there are no conflicts of interest.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ssmmh.2026.100652>.

APPENDIX 1

Search Strategy.



Risk Of Bias tables

Table 3.4

Assessment of the risk of bias in qualitative studies that report barriers and facilitators to help seeking for common mental disorders and psychological distress among adolescents in India

Assessment criteria (JBI qualitative checklist)	Aggarwal et al. (2020)	Agarwal (2025)	Behera (2024)	Dhandapani et al. (2021)	Duara et al. (2022)	Gonsalves et al. (2024)	Mallik (2022)	Mukherjee et al. (2024)	Parikh et al. (2019), Study 1	Parikh et al. (2019), Study 2	Shinde et al. (2021)	Shinde S. (2022)
Congruity between philosophical perspective and methodology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Congruity between methodology and research question/objectives	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Congruity between methodology and data collection methods	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Congruity between methodology and data analysis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Congruity between methodology and interpretation of results	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Researcher located culturally or theoretically	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear
Researcher influence addressed (reflexivity)	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear
Participant voices adequately represented	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Ethical approval and ethical conduct reported	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Conclusions supported by data analysis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Overall methodological quality	Moderate	Moderate-High	Moderate-High	Moderate-High	Moderate-High	Moderate-High	Moderate-High	Moderate-High	Moderate-High	Moderate-High	Moderate-High	Moderate-High

Table 3.5

Assessment of the risk of bias in Quasi Experimental studies that report barriers and facilitators to help seeking for common mental disorders and psychological distress among adolescents in India

Assessment criteria (JBI quasi-experimental checklist)	Anju (2019)	Chandra et al. (2014)	Kaur (2020)	Manajari (2024)	Nebhinani et al. (2020)	Rao et al. (2021)	Singhal et al. (2014)	Srikala (2010)
Clear cause-effect relationship	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Participants similar across comparisons	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Participants received similar care apart from intervention	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Presence of a control group	No	No	No	No	No	No	No	No
Multiple outcome measurements pre- and post-intervention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Complete follow-up or differences explained	Unclear	Unclear	Yes	Yes	Yes	Yes	Unclear	Unclear
Outcomes measured consistently across participants	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Outcomes measured reliably	Unclear	Unclear	Unclear	Yes	Unclear	Unclear	Unclear	Unclear
Appropriate statistical analysis	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Overall risk of bias	Moderate	Moderate	Moderate	Low-Moderate	Moderate	Moderate	Moderate	Moderate

Table 3.6

Assessment of the risk of bias in randomised controlled trials that report barriers and facilitators to help seeking for mental disorders and psychological distress among adolescents in India

Assessment criteria (JBI RCT checklist)	Michelson (2020)
True randomisation used for assignment to treatment groups	Yes
Allocation to treatment groups concealed	Yes
Treatment groups similar at baseline	Yes
Participants blind to treatment assignment	Unclear
Those delivering treatment blind to assignment	Unclear
Outcome assessors blind to treatment assignment	Yes
Treatment groups treated identically other than intervention	Yes
Follow-up complete or differences adequately addressed	Unclear
Participants analysed in groups to which they were randomised	Yes
Outcomes measured in the same way for treatment groups	Yes
Outcomes measured in a reliable way	Yes
Appropriate statistical analysis used	Yes
Trial design appropriate and deviations accounted for	Yes
Overall risk of bias	Low-Moderate

Table 3.7

Assessment of the risk of bias of analytical cross-sectional studies that report barriers and facilitators to help seeking for common mental disorders and psychological distress among adolescents in India

Assessment criteria (JBI analytical cross-sectional checklist)	Bhola et al. (2017)	Menon (2013)	Nair MKC (2013)	Sharma et al. (2017)	Sudarshan et al. (2018)
Inclusion criteria clearly defined	No	Yes	Yes	Yes	Unclear
Study subjects and setting described	Yes	Yes	Yes	Yes	Yes
Exposure measured validly and reliably	Unclear	Yes	Yes	Unclear	Unclear
Objective standard criteria used	Yes	Yes	Yes	Yes	Yes
Confounders identified	Unclear	Unclear	Unclear	Unclear	Unclear
Strategies to address confounding	Unclear	Unclear	Unclear	Unclear	Unclear
Outcomes measured validly and reliably	Yes	Yes	Yes	Yes	Yes
Appropriate statistical analysis	Yes	Yes	Yes	Yes	Yes
Overall risk of bias	Moderate	Low-Moderate	Low	Moderate	Moderate

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