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GROWING AWARENESS OF MENTAL HEALTH PROBLEMS AND THEIR TREATMENT A Narrative Review of Awareness, Stigma, Help-Seeking, and Youth Mental-Health Burden

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ABSTRACT :

Mental health problems are common during adolescence and young adulthood, but stigma, limited mental-health literacy, and barriers to care can delay help-seeking. The World Health Organization estimates that 14.3% of people aged 10–19 experience a mental health condition (WHO, 2025). This narrative review examines awareness, stigma, help-seeking, and treatment using WHO and UNICEF publications, India's National Mental Health Survey, and peer-reviewed reviews. Global Burden of Disease analyses estimate that disability-adjusted life years attributable to mental disorders among people aged 10–24 rose from 26.1 million in 1990 to 36.3 million in 2021, while the age-standardised DALY rate increased by 14% (Tian et al., 2025). Evidence suggests that school-based literacy programmes can improve knowledge, although effects on stigma and help-seeking are less consistent (Amado-Rodríguez et al., 2022; Ma et al., 2023). This review uses secondary sources only and collects no original participant data. It concludes that awareness is most useful when linked to safe disclosure, trained support, clear referral pathways, and affordable, youth-friendly services.

Keywords: mental health awareness; adolescents; young people; stigma; help-seeking; psychological treatment; mental health literacy; prevention.

1. INTRODUCTION

1.1 Empirical Context and Key Indicators

Published estimates show why adolescent mental health warrants attention, while also illustrating why measures must be kept distinct. WHO's global prevalence estimate, India's older adolescent subsample, GBD burden estimates for ages 10–24, and UNICEF's survey indicators measure different populations and outcomes. They are presented together for context, not as directly comparable estimates or as evidence that awareness itself has increased.

Table 1. Empirical snapshot of global and Indian youth mental-health indicators

Indicator	Published estimate	Population / period	Interpretation and source
Adolescents experiencing a mental health condition	14.3% (about 1 in 7)	Global, ages 10–19; WHO 2025 fact sheet	Modelled global estimate; not a university-specific rate (WHO, 2025).
Mental-disorder burden	15% of disease burden in this age group	Global, ages 10–19	WHO burden indicator; not a prevalence percentage (WHO, 2025).
Prevalent mental-disorder cases	278.98 million (95% UI 248.61–312.81)	Global, ages 10–24; 2021	GBD 2021-based estimate; wider age band than WHO's adolescent statistic (Wang et al., 2025).
Age-standardised DALY rate	1,687.7 in 1990; 1,923.7 in 2021 per 100,000	Global, ages 10–24	14% increase (95% UI 12%–16%) from 1990 to 2021 (Tian et al., 2025).
Indian adolescent mental morbidity	7.3% preliminary estimate	Ages 13–17; limited subsample from four states, NMHS 2015–16	Historical, limited-coverage estimate; not a current all-India adolescent rate (NIMHANS, 2016).
Mental morbidity in the main	10.6%	Adult population, NMHS 2015–	Adult estimate; do not apply

Indian survey		16	directly to adolescents (Gururaj et al., 2020).
Treatment gaps across conditions	About 70%–92%	Conditions included in NMHS 2015–16	Varies by disorder; not a single adolescent-specific rate (Gururaj et al., 2020).
Often feeling depressed / little interest	14%	Indian respondents aged 15–24; UNICEF-reported survey during COVID-19 period	Self-reported feeling, not a clinical diagnosis (UNICEF India, 2021).
Saying it is good to seek mental-health support	41%	Indian respondents aged 15–24; UNICEF-reported survey	Attitude indicator; not actual help-seeking or service use (UNICEF India, 2021).

1.2 Background of the Study

Mental health includes our emotional, psychological, and social well-being. It affects how we think and feel, relate to others, handle stress, learn, and make decisions. Having good mental health does not simply mean having no diagnosed disorder; well-being can change over time as our circumstances, relationships, physical health, and surroundings change (World Health Organization [WHO], 2025).

Adolescence is a major stage of change. Young people experience physical development, changing relationships, questions about identity, greater academic expectations, and increasing independence. These changes can help them grow, but they can also bring challenges such as bullying, discrimination, family conflict, violence, exclusion, academic pressure, and online harassment. The WHO estimates that around one in seven people aged 10–19 experiences a mental disorder worldwide, and many adolescent mental health conditions go unrecognised or untreated (WHO, 2025). This is a global estimate, not a figure that should be applied automatically to every school or community.

Mental health difficulties can affect attendance, schoolwork, sleep, physical health, friendships, family relationships, and everyday activities. If distress is not recognised and supported, its effects may continue into adulthood. At the same time, feeling upset or anxious does not automatically mean that a young person has a mental disorder. A qualified professional can assess whether symptoms are persistent or severe, or are affecting daily life enough to need further care (WHO, 2024; NIMH, 2024).

1.3 Understanding Mental Health Awareness

Mental health awareness means having clear and reliable information about emotional well-being, common mental health conditions, possible warning signs, available treatments, and where to find support. Mental health literacy goes a step further: it includes recognising when something may be wrong, understanding what can contribute to difficulties, challenging stigma, and knowing how to seek appropriate help. So awareness is more than learning diagnostic terms or sharing mental health posts on social media (Jorm, 2012; WHO, 2025).

When young people have accurate information, they may find it easier to recognise when they or a friend need support, talk about distress, and reach out to a trusted adult or professional. It can also help parents, teachers, and peers respond with understanding instead of blame. However, information campaigns have limited value when services are too expensive, unavailable, or do not feel safe to use. Awareness needs to grow alongside access to care (Jorm, 2012; UNICEF India, 2025).

1.4 Statement of the Problem

Although mental health is discussed more openly today, many young people still find it difficult to recognise symptoms, tell everyday stress apart from ongoing distress, or seek professional help. Beliefs that mental health conditions show weakness, poor character, or personal failure can make people afraid to speak up. Some families and communities may dismiss emotional difficulties as a normal part of growing up; others may simply not know where to find trustworthy help. UNICEF India's service-mapping report identifies stigma, limited awareness, poor help-seeking, and the dismissal of adolescents' concerns as reasons needs may go unmet (UNICEF India, 2025).

This report focuses on the gap between recognising that mental health matters and making sure young people can actually get timely, appropriate, evidence-based support. It therefore looks at ways to build awareness as well as treatment options, particularly for adolescents and young people (WHO, 2025; UNICEF India, 2025).

1.5 Aim of the Study

The aim of this report is to examine how awareness of mental health problems among adolescents and young people can be strengthened, and to review evidence-based treatment and support options described in established health research and guidance.

1.6 Objectives of the Study

- To explain the meaning and importance of mental health awareness among young people.
- To identify common mental health concerns and relevant social, developmental, and environmental influences.
- To examine stigma, misconceptions, and barriers that may prevent young people from seeking help.
- To review evidence-based treatment and support approaches for children, adolescents, and young adults.

- To identify practical roles for families, schools, communities, health services, and digital platforms in improving awareness and access to care.
- To summarise the strengths and limitations of the available secondary evidence.

1.7 Research Questions

1. What makes mental health awareness important during adolescence and young adulthood?
2. What factors may prevent young people from recognising mental health concerns or seeking help?
3. Which treatment and support approaches are recommended by credible health organisations?
4. What can schools, families, communities, and public institutions do to promote awareness and improve access to care?

1.8 Significance of the Study

This topic matters because many mental health conditions first appear during adolescence, and recognising concerns early can help reduce their effects on development and everyday life. The report aims to help students see mental health as a health and social issue, not a personal failing. It may also be useful to educators, parents, and community members who want to encourage respectful conversations and informed decisions about seeking help (WHO, 2025; UNICEF, 2021).

1.9 Scope of the Study

The report mainly focuses on adolescents aged 10–19 and also discusses young people more broadly when the sources use wider age ranges. It covers awareness, stigma, help-seeking, prevention, and treatment, drawing on global evidence and selected information from India. As a literature-based report, it does not measure the mental health or awareness levels of a particular group of students.

1.10 Important Terminology

Mental health condition: a condition that affects emotional, psychological, cognitive, or behavioural functioning and may require professional assessment or care. Mental health problem: a broad, non-diagnostic term for emotional or psychological difficulty. Awareness: knowledge and understanding of mental health and routes to support. Stigma: negative beliefs, stereotypes, or discriminatory behaviour associated with a condition. Help-seeking: taking steps to obtain support from trusted people or appropriate services. Evidence-based treatment: an intervention supported by research and delivered with appropriate professional judgement.

2. LITERATURE REVIEW

2.1 Mental Health During Adolescence

Adolescence involves rapid changes as brain development, hormonal shifts, relationships, and new responsibilities come together. The WHO highlights how much a young person's well-being can depend on supportive environments at home, at school, and in the wider community. Possible risk factors include adversity, peer pressure, bullying, violence, harsh parenting, discrimination, and financial or social hardship (WHO, 2025). These experiences affect people differently; having a risk factor does not mean that a mental health condition will definitely develop.

Supportive relationships, emotional regulation, problem-solving skills, healthy sleep, physical activity, safe learning environments, and access to appropriate care can all help protect well-being. Prevention is not just about telling young people to be resilient. It also means addressing harmful conditions and making sure they can ask for help without fear (WHO, 2025; UNICEF, 2021).

2.2 Common Mental Health Concerns

2.2.1 Anxiety Disorders

Everyone feels anxious sometimes, but an anxiety disorder involves more than occasional nervousness. Ongoing or excessive worry, panic symptoms, avoidance, and physical discomfort can begin to interfere with school, relationships, sleep, or everyday tasks. The WHO identifies anxiety disorders as among the most common mental health conditions in adolescence. An assessment matters because anxiety-like symptoms can also overlap with physical health conditions or other difficulties (WHO, 2025; National Institute of Mental Health [NIMH], n.d.).

2.2.2 Depression

Depression may involve a lasting low mood or irritability, losing interest in usual activities, changes in sleep or appetite, low energy, trouble concentrating, feelings of worthlessness, or thoughts about death. In young people, it may show up as irritability, withdrawal, a drop in school performance, or changes in behaviour rather than obvious sadness. A qualified professional can assess whether these symptoms meet diagnostic criteria and recommend suitable care (WHO, 2025; NIMH, 2024).

2.2.3 Stress and Emotional Distress

Young people may feel stressed by exams, family expectations, friendships, money worries, uncertainty about the future, or major changes in life. Stress is a normal response to pressure, but when it lasts a long time it can affect sleep, mood, concentration, and physical health. Awareness programmes should offer practical coping skills and explain when ongoing or worsening distress is a reason to seek professional support (WHO, 2025).

2.2.4 Behavioural and Neurodevelopmental Conditions

Some young people have difficulties with attention, impulse control, learning, or behaviour that affect everyday life. Attention-deficit/hyperactivity disorder (ADHD) and disruptive behaviour disorders are examples of conditions that may need proper assessment and support. These difficulties should not automatically be dismissed as laziness, disobedience, or bad character. Depending on the young person's needs, support may involve the individual, caregivers, teachers, and clinicians (Centers for Disease Control and Prevention [CDC], 2026; NIMH, 2024).

2.2.5 Eating Disorders and Body-Image Concerns

Eating disorders involve serious changes in eating behaviour and distress related to food, body weight, or body shape. They can harm both physical and psychological health and may occur alongside anxiety or depression. For some young people, social comparison, bullying, and idealised images online can add to body dissatisfaction, although experiences differ from person to person. Professional assessment is important when eating habits, weight-related behaviours, or body concerns begin to cause harm (WHO, 2025).

2.2.6 Self-Harm and Suicide Risk

Self-harm and suicidal thoughts should always be met with care and timely attention. They should not be brushed off as attention-seeking or treated as a moral failing. Awareness efforts can teach people to listen without judgement, take concerns seriously, involve trusted adults and professionals, and seek urgent help when there is immediate danger. Public messages should avoid sensational details and guide people toward safe, reliable support (WHO, 2025; UNICEF, 2021).

2.3 Global Evidence on Adolescent Mental Health

The WHO's adolescent mental health fact sheet estimates that one in seven people aged 10–19 experiences a mental disorder worldwide. It also highlights depression, anxiety, and behavioural disorders as important contributors to illness and disability in this age group (WHO, 2025). These conditions can affect education, relationships, and physical health, while stigma may make young people less willing to ask for help.

UNICEF's State of the World's Children 2021 report also highlights the mental health and well-being of children and young people, including the effects of unmet needs and inadequate support (UNICEF, 2021). Global estimates help show why this issue matters, but reports may use different methods, definitions, age groups, and country contexts. Their figures should not be compared as though they all came from the same survey.

2.4 Mental Health in the Indian Context

India's National Mental Health Survey 2015–16, coordinated by NIMHANS and supported by the Ministry of Health and Family Welfare, included a limited group of adolescents aged 13–17 from four states. It reported a preliminary estimated mental morbidity prevalence of 7.3% for this adolescent subsample, with anxiety and depressive disorders among the conditions assessed (National Institute of Mental Health and Neuro Sciences [NIMHANS], 2016). These findings provide useful historical evidence, but they are not a current national estimate for every adolescent in India.

The National Mental Health Survey also found substantial treatment gaps across several mental health conditions in the population it studied. In other words, having a mental health concern does not guarantee that someone will receive care promptly. Cost, travel distance, shortages of trained professionals, limited awareness, stigma, and service availability can all affect access. UNICEF India's service-mapping report likewise points to the need for youth-centred services and notes that adolescents' concerns may go unnoticed when adults dismiss them as ordinary growing-up difficulties (UNICEF India, 2025).

2.5 Stigma and Misconceptions

Stigma can show up in different ways. Public stigma refers to negative beliefs held by a community; self-stigma happens when people begin to believe those messages about themselves; and institutional stigma occurs when systems or policies make fair treatment harder to access. Young people may worry about being called weak, unstable, dramatic, or incapable. They may also fear a breach of privacy, negative family reactions, gossip, or consequences at school (WHO, 2025; UNICEF India, 2025).

Common myths include the idea that mental health conditions always reflect weakness, that people should simply think positively, that therapy is only for severe problems, or that asking for help will ruin someone's future. Awareness programmes should address these beliefs with clear, calm, and accurate information. They should also avoid the opposite mistake of diagnosing someone based on a short social-media post or treating every normal emotional response as a disorder (Jorm, 2012; WHO, 2025).

2.6 Mental Health Literacy and Help-Seeking

Mental health literacy means being able to notice signs of distress, understand that effective help may be available, know where to find services, and feel able to approach them. A young person might first speak to a friend, parent, teacher, school counsellor, doctor, psychologist, or psychiatrist. The right route depends on the circumstances, the person's age, how serious the symptoms are, and what services are available (Jorm, 2012; WHO, 2025).
Even when a young person knows mental health is important, they may still hesitate to seek support. Fear of judgement, concerns about privacy, costs, waiting lists, or family opposition can get in the way. Awareness programmes are therefore more useful when they connect people with accessible services and explain how to get a referral. Young people need to know not just what a condition is, but also what steps they can take if they are worried about themselves or a friend (Jorm, 2012; UNICEF India, 2025).

2.7 The Role of Families and Caregivers

Parents and caregivers can support a young person's well-being by listening, avoiding blame or ridicule, noticing changes in behaviour, keeping routines as steady as possible, and helping them access professional assessment when needed. A conversation should not feel like an interrogation, and adults should avoid assuming they already know how the young person feels. Open questions, acknowledgement, and working together on next steps can make it easier to talk (CDC, 2026; WHO, 2025).
Caregivers may need trustworthy information and support themselves. Family involvement can be helpful in treatment for children and adolescents, but it should take account of the young person's development, safety, privacy, and the law. If home is unsafe or a caregiver is contributing to the problem, another trusted adult or safeguarding professional may need to help (NIMH, 2024; CDC, 2026).

2.8 The Role of Schools and Colleges

Schools and colleges are important places for promoting mental health because young people spend much of their time there. Changes in attendance, participation, relationships, or academic performance may be noticed in these settings. Institutions can help through age-appropriate education, anti-bullying policies, staff training, counselling access, and clear procedures for responding to distress. Teachers should have referral options rather than being expected to diagnose or treat conditions themselves (WHO, 2025; UNICEF India, 2025).
Awareness sessions work best when they invite participation and take cultural differences into account. Students can learn how to support friends while understanding that peers cannot replace trained professionals. Schools should explain the limits of confidentiality, protect students' privacy, and avoid identifying publicly anyone who seeks help (WHO, 2025; UNICEF India, 2025).

2.9 Social Media and Digital Environments

Digital platforms can make reliable information easier to find, connect young people with peer support, and point them toward professional resources. But they can also spread misinformation, fuel harmful comparisons, expose users to harassment, and turn complex conditions into simplistic trends. Online content may encourage someone to start a conversation, but it cannot reliably diagnose a condition or replace a professional assessment (UNICEF, 2021).
Digital awareness content should use plain language, name credible sources, include links to support, and avoid sensational or stigmatising images. Young people can be encouraged to check who created a post, whether its claims are backed by evidence, and whether it is promoting an unverified cure. Protecting privacy is especially important when digital tools are used by minors (UNICEF, 2021).

2.10 Evidence-Based Treatments and Support

Many mental health conditions can be treated, but the right approach depends on the condition, the person's age and circumstances, the severity of the problem, and a clinical assessment. The WHO highlights the importance of early recognition, appropriate care, supportive environments, and respect for young people's rights. Treatment should fit the individual rather than assume one approach will work for everyone (WHO, 2025; CDC, 2026).

2.10.1 Psychological Therapies

Psychotherapy, often called talking therapy, gives a person the chance to work with a trained professional to understand their difficulties and build ways to manage them. Cognitive behavioural therapy (CBT) is one evidence-based approach. It helps people explore how thoughts, feelings, and behaviour affect one another and practise different coping strategies. The CDC notes that CBT can help with several common concerns in children and adolescents, including anxiety and depression (CDC, 2026). Other approaches, such as interpersonal psychotherapy or family-based interventions, may suit particular needs.

2.10.2 Family-Based and Caregiver Interventions

For children and adolescents, treatment may involve caregivers when that is appropriate and helpful. Family-based support can improve communication, routines, problem-solving, and support at home. Parent training in behaviour management may help with some disruptive behaviour concerns. Family involvement should always be guided by the young person's needs and safety; it is not the right or necessary choice in every situation (CDC, 2026).

2.10.3 Medication

After an assessment, a qualified medical professional may recommend medication for certain mental health conditions. The decision depends on the diagnosis, symptoms, possible risks and benefits, age, other health factors, and the availability of follow-up care. Medication should be prescribed and monitored by an authorised clinician. Young people should not start, stop, share, or change psychiatric medication based on online advice. For children and adolescents, decisions should include appropriate discussion with the young person and caregivers, along with monitoring for benefits and side effects (NIMH, 2024).

2.10.4 Lifestyle and Psychosocial Support

Regular sleep, physical activity, balanced nutrition, social connection, time to relax, and manageable routines can all support general well-being. Skills such as problem-solving, relaxation, emotional regulation, and expressing needs may also help young people handle stress. These habits can be useful alongside care, but they are not guaranteed cures and do not replace professional treatment when it is needed (WHO, 2025; CDC, 2026).

2.10.5 School and Community Support

School counselling, peer-support programmes, mentoring, community health services, and youth-friendly clinics can make it easier to get help. Peer support may reduce isolation and encourage someone to seek assistance, but peer supporters need clear boundaries, training, and a way to escalate serious concerns. Community programmes should connect awareness to real services and involve young people in shaping the support they need (UNICEF India, 2025; WHO, 2025).

2.11 Prevention and Early Intervention

Prevention aims to reduce risks, strengthen protective factors, and create supportive environments before difficulties become more serious. Universal approaches can include social and emotional learning, anti-bullying efforts, mental health literacy, and access to trusted adults. Additional support may be useful for groups facing greater adversity, while young people already showing signs of distress may need more targeted help. These categories should never be used to label students publicly (WHO, 2025).

Early intervention means responding when concerns first appear rather than waiting for a crisis. Depending on the situation, this might start with a conversation with a trusted adult, an appointment with a primary-care provider, a school counsellor, or a specialist service. Awareness campaigns should explain that asking for help early is a positive step and that improvement may take time, follow-up, and changes to the support plan (NIMH, 2024; WHO, 2025).

2.12 Summary of the Literature

The sources reviewed point to several consistent themes: adolescent mental health is an important part of overall health; stigma and limited awareness can delay help-seeking; supportive relationships and school environments matter; and evidence-based treatments are available for many conditions. Still, awareness does not automatically mean that care is accessible. Young people also need reliable information, trained professionals, affordable services, privacy protections, involvement from families and schools, and clear ways to get help (Jorm, 2012; WHO, 2025; UNICEF India, 2025).

2.13 Evidence from Reviews of School-Based Mental Health Literacy

Peer-reviewed intervention reviews provide a more cautious picture than the assumption that awareness sessions automatically improve help-seeking. Amado-Rodríguez et al. (2022) reviewed school-based mental health literacy programmes and included 15 studies from 795 references identified. The meta-analysis reported a positive effect on mental health knowledge immediately after an intervention (SMD = 0.61; 95% CI [0.05, 0.74]), at approximately two months (SMD = 0.60; 95% CI [0.40, 1.07]), and at six months (SMD = 0.39; 95% CI [0.27, 0.51]). The review did not find statistically significant pooled effects for stigma reduction or help-seeking behaviour. These estimates suggest that educational programmes can increase knowledge, but the translation of knowledge into changed attitudes or actual service use is less certain.

Ma et al. (2023a) reviewed 21 studies describing 20 school-based interventions and found moderate evidence that programmes could improve mental health literacy and reduce stigma in the short term. However, many studies lacked longer follow-up, and the interventions and outcome measures varied. A second systematic review by Ma et al. (2023b), focused specifically on help-seeking outcomes, included 11 studies with 7,066 participants from 66 secondary schools. It found no strong evidence of consistent improvements in general attitudes, intentions, confidence, knowledge of how to seek help, or actual help-seeking. The two reviews are not contradictory: programmes may improve knowledge or some stigma-related outcomes without reliably changing behaviour or service utilisation.

For practical programme design, these findings support including more than information delivery. Students need to practise how to start a conversation, understand confidentiality and its limits, identify a trusted adult or service, and learn what to do if the first contact is not helpful. Interventions should also address self-stigma, trust, perceived need, service availability, and practical barriers. Outcomes should be measured separately—for example, knowledge, attitudes, intentions, referrals, and actual help-seeking—rather than treating them as a single result (Amado-Rodríguez et al., 2022; Ma et al., 2023a, 2023b).

2.14 Barriers and Facilitators of Adolescent Help-Seeking

A systematic review by Aguirre Velasco et al. (2020) identified 90 studies: 54 examined barriers and facilitators, while 36 examined interventions. Stigma and negative beliefs about mental health services and professionals were among the most frequently reported barriers. Facilitators included mental health literacy and previous positive experiences with services. The authors also noted that study quality was generally low to moderate and that definitions and measures of help-seeking varied. The evidence therefore supports the importance of stigma and literacy, while cautioning against assuming that one intervention will work equally well across settings.

Help-seeking is shaped by more than an individual's knowledge. A young person may recognise distress but avoid disclosure because they fear being judged, worry that information will be shared without explanation, cannot afford care, do not know which service to contact, or believe that adults will dismiss the problem. Conversely, a trusted relationship with a counsellor, a positive prior experience, clear information about confidentiality, and a straightforward referral pathway can make help-seeking more feasible (Aguirre Velasco et al., 2020; UNICEF India, 2025). This is why programme evaluation should assess both individual outcomes and the service environment to which students are referred.

2.15 Interpreting Global and Indian Prevalence Data

The WHO's 2025 fact sheet estimates that 14.3%—approximately one in seven—of people aged 10–19 experience a mental health condition, and that these conditions account for 15% of the global burden of disease in this age group. The WHO also identifies suicide as the third leading cause of death among people aged 15–29. These are global estimates and indicators of public-health importance; they do not estimate the prevalence of a particular diagnosis among students at an individual institution (WHO, 2025).

The Indian evidence needs equally careful interpretation. The National Mental Health Survey 2015–16 was conducted across 12 states and included 34,802 adult interviews in its main survey; an additional, limited adolescent subsample aged 13–17 was included in four states. The reported 7.3% adolescent estimate was preliminary and based on that limited subsample, so it should not be described as a current national prevalence rate for all adolescents. The adult survey reported a 10.6% prevalence estimate for mental morbidity among adults, but this adult figure must not be applied to adolescents (Gururaj et al., 2020; NIMHANS, 2016).

The adult survey also reported substantial treatment gaps, commonly summarised across disorders as approximately 70%–92%. This range refers to the adult/population conditions and definitions examined in the survey; it is not an adolescent-specific treatment-gap estimate. It is useful as a system-level indicator of unmet need, but the report should avoid implying that every adolescent condition has the same treatment gap. UNICEF India's 2024 service mapping, published in 2025, further identifies under-recognition, stigma, poor help-seeking, and inadequate child and adolescent mental-health service capacity as concerns, reinforcing the need for age-appropriate services and clearer routes to care (UNICEF India, 2025).

2.16 Synthesis and Evidence Gaps

Across the sources, three conclusions are relatively well supported. First, adolescent mental health is a substantial public-health concern, although prevalence estimates vary by age range, diagnostic definition, and method. Second, stigma, limited mental health literacy, negative expectations of care, and service-access barriers can impede help-seeking. Third, school-based programmes can improve knowledge and may reduce some stigma-related outcomes, but evidence that they reliably change actual help-seeking remains limited. These conclusions support an integrated approach combining education with trusted adults, confidentiality safeguards, trained personnel, and accessible services (Aguirre Velasco et al., 2020; Amado-Rodríguez et al., 2022; Ma et al., 2023a, 2023b; WHO, 2025).

2.17 Long-Term Trends in the Global Burden of Youth Mental Disorders, 1990–2021

A 20–25-year review is feasible, but the strongest directly comparable global time series available for this paper extends from 1990 to 2021. The Global Burden of Disease (GBD) framework estimates prevalence and disability across years using harmonised modelling rather than repeated identical surveys of the same people. A GBD 2021-based analysis estimated an age-standardised prevalence rate of 14,764.9 per 100,000 among people aged 10–24 in 2021; the 1990 prevalence-rate baseline previously considered could not be verified against the cited source and is therefore not used. For the age-standardised disability-adjusted life-year (DALY) rate, the comparable estimates were 1,687.7 per 100,000 in 1990 and 1,923.7 in 2021, an increase of 14% (95% uncertainty interval 12%–16%) (Wang et al., 2025; Tian et al., 2025).

The number of DALYs—years of healthy life lost because of illness, disability, or premature mortality—also increased, from an estimated 26.1 million in 1990 to 36.3 million in 2021 in the same GBD-based analysis. This represents a rise of approximately 39.1% in the total burden count. Counts are affected by population growth as well as changes in rates, so the count increase should not be interpreted as an equivalent increase in an individual young person's risk. Age-standardised rates are more suitable for comparing burden over time because they adjust for changes in age structure (Tian et al., 2025).

A separate GBD 2021 analysis estimated 278.98 million prevalent cases of mental disorders among people aged 10–24 in 2021, with a 95% uncertainty interval of 248.61–312.81 million. It estimated 36.31 million years lived with disability (YLDs) in this age group. Anxiety disorders were the largest prevalent diagnostic group, followed by depressive disorders and ADHD in the reported 2021 estimates (Wang et al., 2025). These figures use a broad 10–24 age range, which includes adolescents and young adults; they should not be presented as estimates for adolescents aged 10–19 alone.

The long-run pattern is not a simple, uninterrupted increase in every condition. The GBD trend analysis reported significant increases in disability rates for depressive and anxiety disorders over 1990–2021, while several other diagnostic categories showed different patterns, including decreases for ADHD and schizophrenia in the modelled rates. It also identified a marked increase in age-standardised disability rates for depression and anxiety during 2019–2021, a period overlapping the COVID-19 pandemic. These changes are consistent with concern about pandemic-related mental-health

burden, but the time-series association alone cannot prove that the pandemic caused every observed change (Wang et al., 2025; Tian et al., 2025; WHO, 2022).

The data are estimates rather than a complete annual census of diagnoses. GBD estimates combine available epidemiological information, case definitions, population structures, and statistical modelling. Results can change when data sources, modelling methods, and diagnostic definitions are updated. Consequently, the present paper uses the published time-series estimates as the best available basis for a historical comparison, while clearly distinguishing them from Indian survey findings and from studies of mental-health awareness or help-seeking.

3. METHODOLOGY

3.1 Research Design

This report follows a qualitative, descriptive secondary-research design. It brings together existing reports, fact sheets, and guidance from recognised public health and clinical organisations to explore mental health awareness and treatment among adolescents and young people. No original data were collected, and no questionnaire or interview was carried out for this report.

3.2 Sources of Information

Sources include WHO guidance and fact sheets; UNICEF publications on children's and adolescents' mental health; India's National Mental Health Survey materials from NIMHANS and the Ministry of Health and Family Welfare; and peer-reviewed research located through PubMed and publisher records. Particular attention was given to systematic reviews of school-based mental health literacy, stigma, and adolescent help-seeking (Aguirre Velasco et al., 2020; Amado-Rodríguez et al., 2022; Ma et al., 2023a, 2023b). These sources were selected for direct relevance to the report's questions and the credibility of their methods or publishing organisations.

3.3 Source Selection and Review

Sources were selected purposively for relevance to adolescents and young people, credibility, and coverage of prevalence, risk and protective factors, stigma, help-seeking, prevention, and treatment. The review prioritised official reports and fact sheets for population estimates, and systematic reviews for evidence about intervention effectiveness and help-seeking. This was a focused narrative search, not an exhaustive systematic search: no formal protocol, comprehensive screening log, or risk-of-bias assessment was completed. Published estimates were retained with their original population, date, and methodological caveats.

3.4 Method of Analysis

The material was reviewed by theme. The main themes were: (1) mental health needs during adolescence; (2) awareness, stigma, and help-seeking; (3) family, school, community, and digital influences; (4) evidence-based treatment and prevention; and (5) access to services and limitations in the Indian context. Because the report contains no original participant data, the findings are presented as a descriptive synthesis rather than a statistical analysis.

3.4.1 Longitudinal Comparison and Scenario Analysis

For the historical comparison, the paper extracted published global estimates for the 10–24 age group from GBD-based analyses covering 1990–2021. The main indicators were age-standardised prevalence rate, age-standardised DALY rate, and total DALYs. Percentage changes were calculated from the reported endpoints using (final value − initial value) / initial value × 100. Because the retrieved publications did not provide a consistent set of annual values in the accessible source text for every year from 2000 to 2025, the tables and graphs use only reported anchor-year estimates and do not interpolate missing annual observations. A simple 2030 continuation scenario is included for illustration only; it is not a validated epidemiological forecast and does not account for policy, service expansion, demographic changes, or future shocks.

3.5 Ethical Considerations

Because the report uses publicly available secondary sources and does not collect personal information, it does not involve direct participation by human subjects. Even so, it uses respectful, non-stigmatising language and avoids diagnosing individuals. Mental health conditions are discussed as health concerns that may need assessment and care, not as character flaws. Sources are acknowledged in the text and reference list.

3.6 Scope and Limitations

- The report is a narrative review rather than a systematic review with a registered protocol or exhaustive database search.
- Published sources differ in date, population, definitions, screening tools, and methods; estimates should not be treated as directly interchangeable.
- Some Indian data cited are from the National Mental Health Survey 2015–16 and are historical rather than current estimates.
- The report does not measure the awareness, attitudes, or help-seeking behaviour of a specific school, college, or local community.
- The review cannot establish causal relationships between awareness campaigns and treatment outcomes.
- Clinical guidance may vary by country and is updated over time; individual care decisions require qualified professional assessment.

3.7 Why No Primary Survey Was Conducted

This project was planned as a secondary-research report, so it does not include a participant count, questionnaire results, percentages, or graphs based on original responses. Instead, the findings summarise published evidence and recurring themes; no survey data have been invented. A future project could include a primary survey, provided it has appropriate consent, privacy protections, and institutional approval where required.

4. FINDINGS FROM SECONDARY RESEARCH

This section summarises the main findings from the sources reviewed. Since the report did not include a primary survey, these findings reflect published evidence rather than responses collected from a new group of participants.

4.1 Mental Health Needs Are Important During Adolescence

The WHO estimates that around one in seven people aged 10–19 experiences a mental disorder worldwide (WHO, 2025). This highlights adolescent mental health as an important public health concern and underlines the need for age-appropriate prevention, early recognition, and access to care. It does not mean that every young person who experiences stress has a diagnosable disorder.

4.2 Many Conditions Remain Unrecognised or Untreated

WHO guidance notes that mental health conditions among adolescents often go unrecognised and untreated. UNICEF India's service-mapping report also points to stigma, limited awareness, low help-seeking, and the tendency to dismiss adolescent distress as a normal part of growing up (UNICEF India, 2025). Taken together, these sources show that the challenge is not only that mental health conditions occur, but also that young people and the adults around them may not recognise concerns or know how to respond helpfully.

4.3 Stigma Can Discourage Disclosure

The sources reviewed identify stigma and discrimination as reasons adolescents may not feel safe asking for help. Fear of being judged can lead young people to hide symptoms, downplay what they are going through, or depend only on informal support. Awareness initiatives should therefore promote respectful language, explain confidentiality, and make help-seeking feel normal without suggesting that every emotional difficulty is a disorder.

4.4 The Indian Context Includes Significant Access Challenges

India's National Mental Health Survey 2015–16 reported a preliminary estimated mental morbidity prevalence of 7.3% in its limited subsample of 13–17-year-olds from four states (NIMHANS, 2016). The survey also documented substantial treatment gaps across mental health conditions in the wider population studied. These findings show why services and referral pathways matter, but because of the survey's age and design, the figure should not be treated as a current estimate for every state or group of adolescents.

4.5 Evidence-Based Treatments Are Available

Clinical and public health guidance describes several possible parts of care, including psychological therapies, caregiver involvement when appropriate, behavioural interventions, and medication for selected conditions. The CDC notes that CBT can be effective for a number of concerns affecting children and adolescents, while NIMH explains that treatment choices should follow a professional assessment of the young person's needs (CDC, 2026; NIMH, 2024). The key point is that care should be tailored to the individual and guided by appropriately trained professionals.

4.6 Awareness Must Be Connected to Services

Awareness campaigns can explain symptoms and challenge myths, but they cannot do much on their own if a young person cannot access care or does not know where to go. Schools and community organisations can help by providing trusted contacts, clear referral steps, and information about local services. The sources reviewed support combining public education with accessible, youth-friendly care (Jorm, 2012; UNICEF India, 2025).

4.7 Supportive Environments Can Protect Well-Being

The WHO highlights the importance of supportive family, school, and community environments, along with healthy sleep, physical activity, coping skills, and interpersonal skills (WHO, 2025). These factors can support well-being and prevention, but they are not guaranteed cures and should never be used to blame a young person whose symptoms continue.

Quantitative evidence should be interpreted by population and outcome. The global WHO estimate (14.3% of 10–19-year-olds) is a broad burden indicator; the 7.3% Indian adolescent estimate is a preliminary result from a limited four-state subsample; and the 10.6% estimate from the same national survey refers to adults. These numbers are not directly comparable. Intervention reviews add a different type of evidence: the pooled improvement in knowledge reported by Amado-Rodríguez et al. (2022) did not coincide with significant pooled changes in stigma or help-seeking, while Ma et al. (2023b) found no strong evidence of consistent improvement in help-seeking outcomes across 11 studies and 7,066 participants.

4.8 Summary Table of the Reviewed Evidence

Table 2. Summary of themes identified in the reviewed literature

Theme	Evidence reviewed	Implication
Adolescent mental health burden	WHO estimates around one in seven 10–19-year-olds experiences a mental disorder globally.	Mental health deserves routine attention in adolescent health and education.
Unmet need	WHO and UNICEF identify under-recognition, stigma, and poor help-seeking as concerns.	Awareness should include clear pathways to support.
Indian context	NMHS 2015–16 reported 7.3% adolescent mental morbidity in the surveyed group; historical estimate.	Use local evidence carefully and strengthen service access.
Treatment	Clinical sources describe psychotherapy, caregiver interventions, and medication where appropriate.	Treatment should be individualised and professionally guided.
Prevention	Supportive relationships, safe schools, coping skills, sleep, and physical activity are relevant protective factors.	Interventions should involve families, schools, communities, and services.

Evidence source	Population / evidence base	Quantitative finding	Interpretation / caveat
WHO (2025)	Global ages 10–19	14.3% (about 1 in 7) experience a mental health condition; 15% of disease burden in this age group.	Global estimate; not a local university prevalence figure.
WHO (2025)	Global ages 15–29	Suicide is the third leading cause of death.	A public-health indicator; do not use as a proxy for prevalence of mental disorders.
NIMHANS (2016)	Adolescents aged 13–17 in a limited subsample from four Indian states	Preliminary mental morbidity estimate: 7.3%.	Historical and limited subsample; not a current all-India adolescent estimate.
Gururaj et al. (2020)	Main NMHS adult survey across 12 states; 34,802 adult interviews	Adult mental morbidity prevalence estimate: 10.6%; treatment gaps across conditions commonly reported in the 70%–92% range.	Adult findings must not be applied to adolescents; treatment gaps vary by condition.
Amado-Rodríguez et al. (2022)	Meta-analysis of 15 school-based intervention studies	Knowledge: SMD 0.61 immediately, 0.60 at about 2 months, and 0.39 at 6 months; no significant pooled effect on stigma/help-seeking.	Outcome definitions and intervention content varied; knowledge gains do not guarantee service use.
Ma et al. (2023b)	11 studies, 7,066 participants, 66 secondary schools	No strong evidence of consistent improvement in help-seeking outcomes.	Highlights need for practical skills, trusted services, and better outcome measurement.
Aguirre Velasco et al. (2020)	Systematic review: 90 studies (54 barriers/facilitators; 36 interventions)	Stigma and negative beliefs about services were frequently reported barriers.	Review noted generally low-to-moderate study quality and inconsistent measures.

Table 3. Selected quantitative evidence on adolescent mental health, service gaps, and intervention outcomes.

4.9 Long-Run Comparison of Published Data

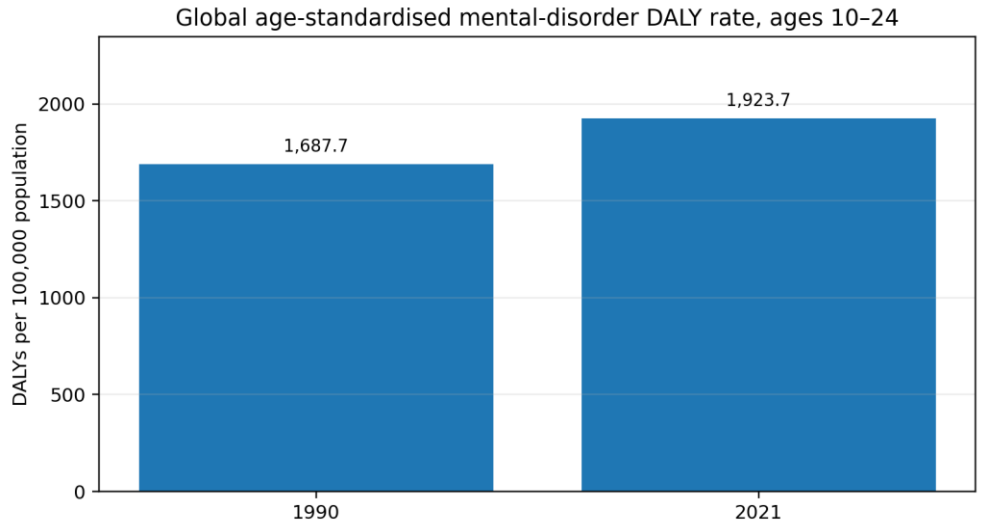
The cited GBD-based analysis provides comparable global estimates for 1990 and 2021, with additional reported changes for 2019–2020 and 2020–2021. The paper does not reconstruct missing annual values or present the two endpoints as a complete annual time series. The comparisons below preserve the original population age range and measurement type (Tian et al., 2025; Wang et al., 2025).

Table 4. Long-run global estimates for mental disorders among people aged 10–24 years. Sources: Tian et al. (2025) and the GBD 2021-based analysis published in 2025.

Indicator	1990	2019–2021 / 2021	Change	Interpretation
Age-standardised prevalence rate, ages 10–24 (per 100,000)	Not reported in the cited source used here	14,764.9 (2021)	No endpoint change calculated	A 1990 baseline is not used because the previously cited value could not be verified against the cited source.
Age-standardised DALY rate, ages 10–24 (per 100,000)	1,687.7	1,923.7 (2021)	+14.0% (1990–2021)	Age-standardised disability burden increased by 14% from

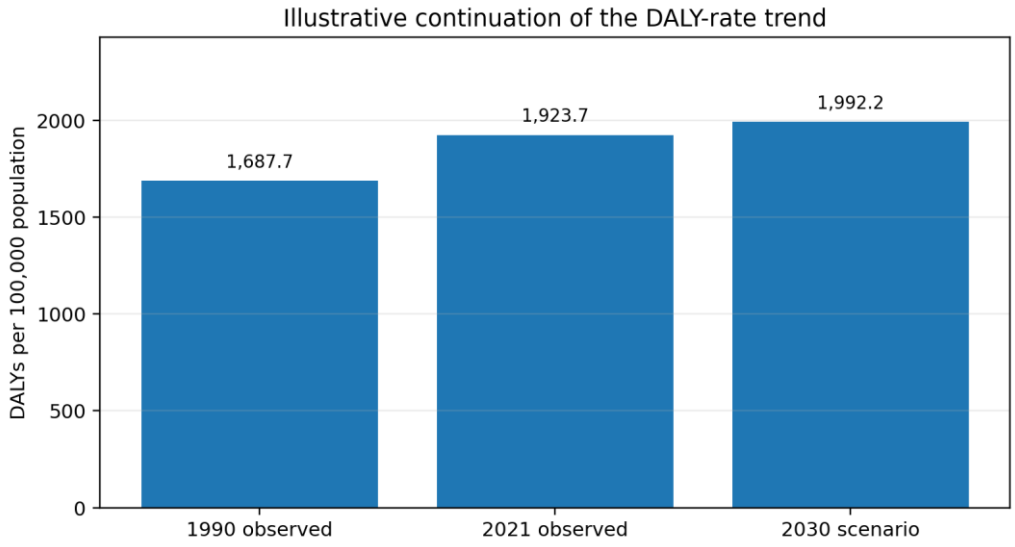
				1990 to 2021.
Total DALYs, ages 10–24 (million)	26.1	36.3 (2021)	+39.1% (1990–2021)	Total count also reflects population growth.
Prevalent mental-disorder cases, ages 10–24 (million)	Not reported here	278.98 (2021; 95% UI 248.61–312.81)	No direct endpoint change calculated	Separate GBD analysis; use as a 2021 burden estimate.
Prevalence / disability trend around COVID-19	—	Increase reported during 2019–2021; some rates accelerated in 2020–2021	Condition-specific; depression and anxiety increased notably	Temporal overlap does not establish causation.

Figure 1. Age-standardised DALY rate for mental disorders among people aged 10–24 in 1990 and 2021. Source: Tian et al. (2025).



4.10 Future-Oriented Scenario Analysis (2030)

Figure 2. Projected age-standardised DALY rate for mental disorders among people aged 10–24 in 2030, assuming the average annual change observed between 1990 and 2021 continues unchanged. The value is an arithmetic extrapolation of published estimates, not a validated epidemiological forecast.



For a forward-looking comparison, the average annual change in the age-standardised DALY rate between 1990 and 2021 was extended mathematically to 2030. Under this assumption, the rate would be approximately 1,992 DALYs per 100,000 people aged 10–24. This value is an extrapolation based on historical endpoints; it does not account for future demographic changes, changes in diagnosis or reporting, intervention effects, uncertainty, or unexpected events and should not be interpreted as a validated epidemiological forecast.

This scenario is useful only as a transparent arithmetic illustration. It shows what the 2030 rate would be if the same absolute annual change continued; it does not account for demographic shifts, changing diagnosis and reporting, intervention effects, uncertainty, or future shocks. It therefore should not be described as a prediction of actual future burden.

4.11 Period-Wise Comparison of Published Trends

The following table compares time windows explicitly reported in the GBD-based literature. It does not claim to represent every decade with a single comparable statistic: the source reports long-run 1990–2021 changes and specific pandemic-period changes, while diagnostic categories and outcome measures differ.

Table 5. Period-wise comparison of published global burden estimates for people aged 10–24 years. Sources: Wang et al. (2025) and Tian et al. (2025).

Period	Indicator / disorder	Published change	Interpretation
1990–2021	Overall mental-disorder DALY rate, ages 10–24	+14% (95% UI: 12%–16%)	Long-run age-standardised disability burden increased.
1990–2021	Total DALYs, ages 10–24	26.1 million to 36.3 million	Absolute burden increased; population growth also influences counts.
1990–2021	Depressive-disorder DALYs	+25% (95% UI: 20%–29%)	Substantial long-run increase in burden.
1990–2021	Anxiety-disorder DALYs	+21% (95% UI: 18%–24%)	Substantial long-run increase in burden.
2019–2020	Anxiety-disorder DALY rate	+18.9%	Sharp increase during the first pandemic year in the GBD analysis.
2019–2020	Depressive-disorder DALY rate	+23.7%	Sharp increase during the first pandemic year in the GBD analysis.
2020–2021	Overall mental-disorder age-standardised DALY rate	Approximately +11.8%	Further increase reported; the time association does not by itself prove causation.

4.12 Additional Disorder-Specific and India-Focused Comparisons

These comparisons separate prevalent cases by disorder, long-run changes in disability burden, and self-reported indicators from an Indian youth survey. The measures use different denominators and should not be interpreted as a single common scale.

Table 6. Selected mental-disorder prevalence counts among people aged 10–24, 2021

Condition	**Estimated prevalent cases**	**Age group**	**Source / note**
Anxiety disorders	93.95 million	10–24 years	GBD 2021-based estimate (Wang et al., 2025).
Depressive disorders	57.49 million	10–24 years	GBD 2021-based estimate (Wang et al., 2025).
Attention-deficit/hyperactivity disorder (ADHD)	41.03 million	10–24 years	GBD 2021-based estimate (Wang et al., 2025).

Figure 3. Estimated prevalent cases by selected disorder among people aged 10–24 in 2021. Source: Wang et al. (2025).

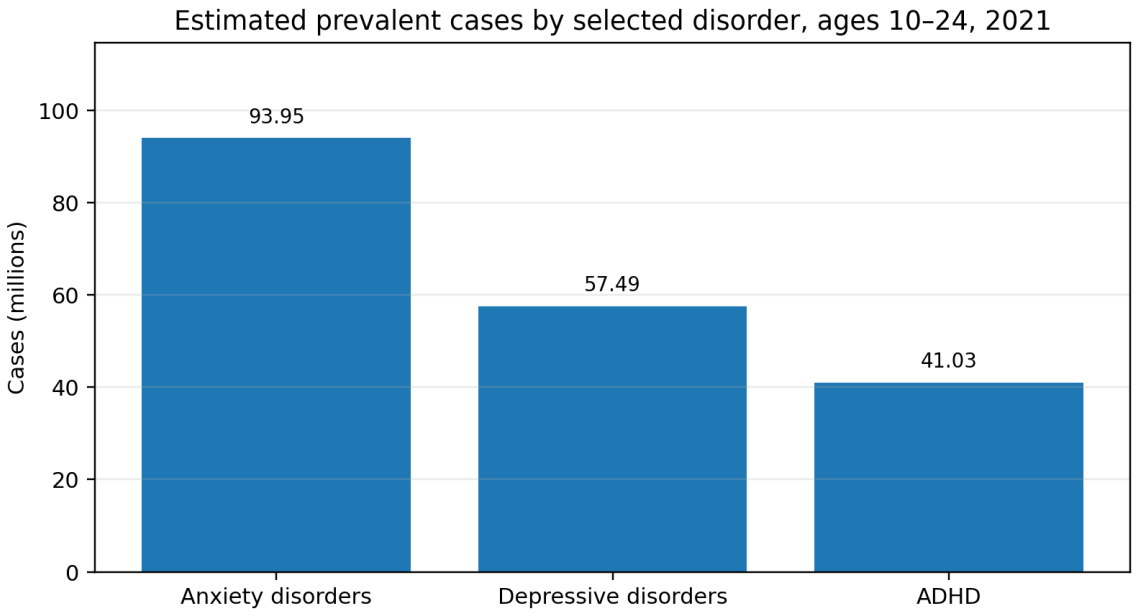


Table 7. Long-run change in DALYs for selected mental disorders, 1990–2021

Disorder	Change in DALYs	95% uncertainty interval	Interpretation
Depressive disorders	+25%	20%–29%	Largest increase among the three selected categories shown.
Anxiety disorders	+21%	18%–24%	Substantial long-run increase.
Eating disorders	+17%	14%–20%	Increase smaller than the depressive- and anxiety-disorder changes shown.

Figure 4. Percentage change in DALYs for selected disorders, 1990–2021. Source: Tian et al. (2025).

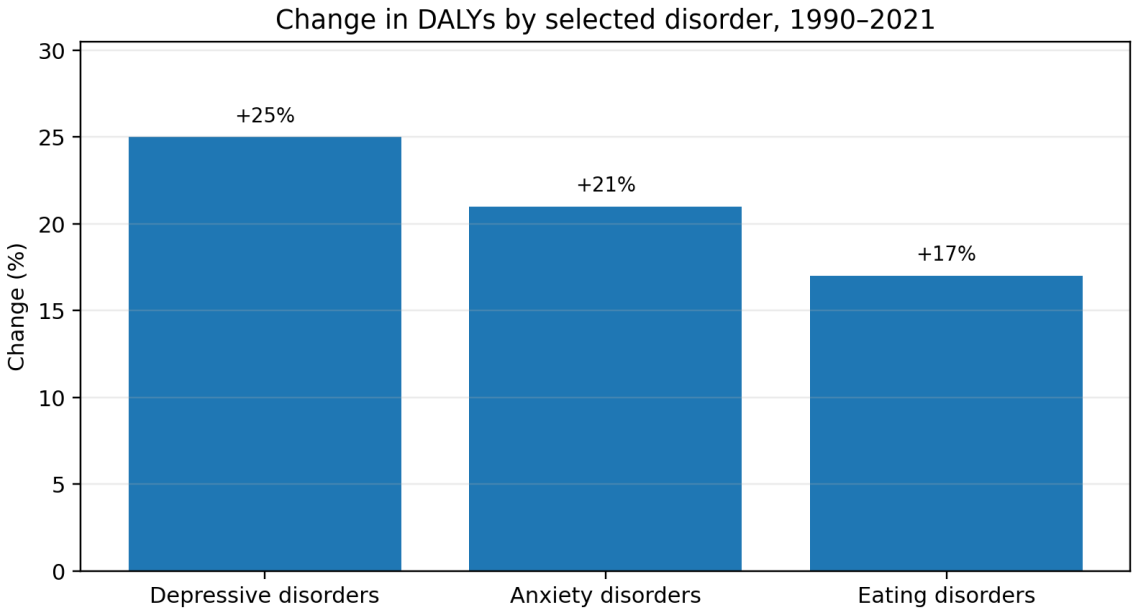
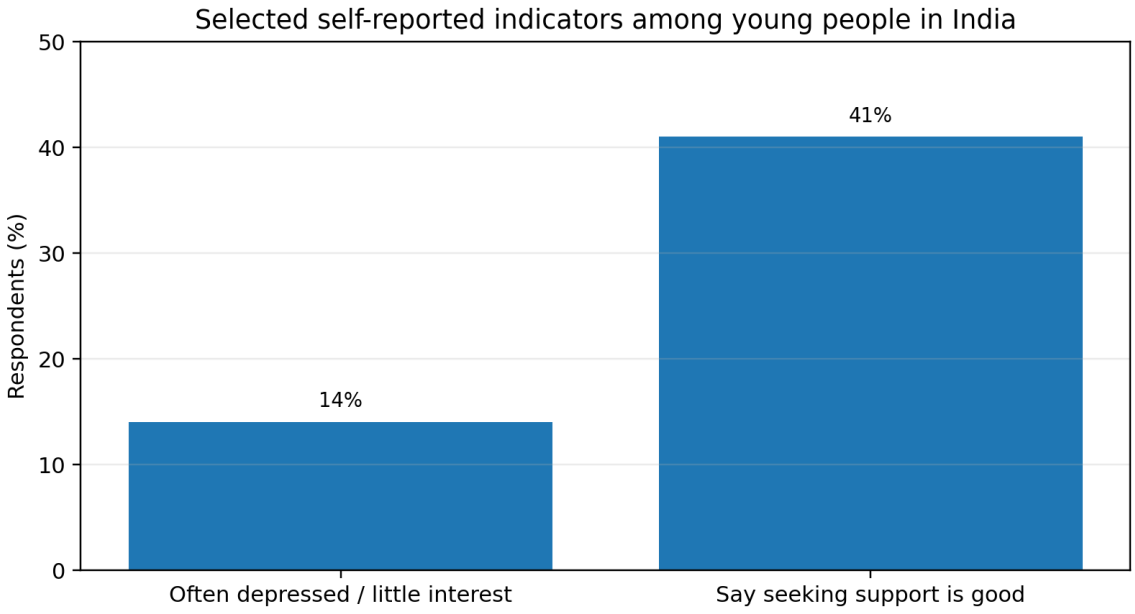


Table 8. Selected self-reported mental-health indicators among young people in India

Indicator	Estimate	Population / context	Interpretation
Often feeling depressed or having little interest in doing things	14%	Indian respondents aged 15–24; UNICEF-reported survey during COVID-19 period	Self-reported feeling, not a clinical diagnosis.
Agreeing that it is good to get support for mental-health problems	41%	Indian respondents aged 15–24; UNICEF-reported survey	Attitude indicator; not actual help-seeking or service use.

Figure 5. Two distinct survey indicators among young people in India; they are not complementary categories. Source: UNICEF India (2021).



5. DISCUSSION

Overall, the sources suggest that awareness of mental health problems among young people is essential, but it cannot solve the problem by itself. The WHO's global estimate shows the scale of adolescent mental health needs, while WHO and UNICEF materials describe how stigma, missed signs, and barriers to services can prevent young people from receiving suitable support. Awareness should therefore be part of a broader response that includes prevention, early recognition, treatment, and ongoing support (WHO, 2025; UNICEF India, 2025).

5.1 Awareness Versus Practical Help-Seeking

Knowing the names of mental health conditions does not necessarily help a young person recognise a concern in themselves or a friend, tell a warning sign from an everyday change, or find professional support. Mental health literacy needs to be practical: young people should learn how to start a conversation, whom to approach, where to find reliable information, and when a concern needs urgent attention. Awareness activities should not be used to diagnose students or pressure them into sharing private experiences (Jorm, 2012; WHO, 2025).

5.2 Reducing Stigma Without Over-Pathologising

A balanced approach challenges the idea that mental health difficulties are a sign of weakness without suggesting that every low mood, worry, or stressful day is a disorder. Emotional ups and downs are part of life, but symptoms that are persistent, severe, or interfere with daily functioning deserve attention. Explaining this difference clearly can reduce shame while encouraging people to seek an appropriate assessment when needed (WHO, 2025; UNICEF India, 2025).

5.3 The Importance of Youth-Centred Services

Young people may hesitate to seek help if they are unsure who will see their information or worry that adults will dismiss their concerns. Youth-centred services should feel welcoming and accessible, respect cultural differences, and explain confidentiality and its safety-related limits clearly. Where possible, young people should have a say in decisions about their care in ways that fit their age and circumstances (UNICEF India, 2025).

5.4 Families and Schools as Gateways to Support

Families and schools may notice changes before a young person reaches a clinical service. Their role is not to diagnose; it is to listen, offer practical support, notice when concerns continue, and help the young person connect with appropriate care. Teachers can benefit from training on responding safely to distress, bullying, and disclosures. Families may also need guidance on supportive communication and what treatment can involve (CDC, 2026; WHO, 2025).

5.5 Treatment Must Be Evidence-Based and Individualised

The phrase 'cures for mental health problems' can give the impression that one solution works for everyone. In practice, care depends on the condition, its severity, the young person's developmental stage, personal circumstances, and preferences. Many conditions can improve with suitable treatment and support, while some need ongoing management. Awareness campaigns should offer realistic hope without promising guaranteed cures or recommending unverified remedies (WHO, 2025; CDC, 2026).

5.6 Implications for India

Evidence from India shows both why adolescent mental health deserves attention and how difficult it can be to turn need into accessible care. The National Mental Health Survey 2015–16 offers useful baseline information, but it is not a current count of all adolescents. UNICEF India's service mapping reinforces the need to recognise young people's concerns, develop youth-centred care, and reduce stigma. Programmes should reflect local languages, cultures, family structures, school resources, and service availability instead of assuming one campaign will work everywhere (NIMHANS, 2016; UNICEF India, 2025).

5.7 Limitations of the Evidence Base

This report draws on a selected group of credible sources; it is not a systematic review of all published research. The sources may use different age ranges, diagnostic criteria, sampling methods, and publication dates, so their estimates are not always directly comparable. The report does not test a particular awareness campaign or collect first-hand accounts from adolescents. Its conclusions are a synthesis of existing guidance and selected reports, not new empirical findings.

5.8 Overall Interpretation

The clearest message across the sources is that awareness, prevention, and treatment need to work together. Young people need accurate information and supportive relationships, but they also need to feel safe asking for help and be able to reach services that respond. Mental health should be a normal

part of health education and community well-being, with clear professional pathways when informal support is not enough (WHO, 2025; UNICEF India, 2025).

6. RECOMMENDATIONS

6.1 For Schools and Colleges

- Include age-appropriate mental health literacy in student well-being and life-skills education.
- Train teachers and student-support staff to recognise possible signs of distress and respond without judgement, while avoiding diagnosis.
- Establish clear referral pathways to counsellors, healthcare professionals, and local support services.
- Maintain anti-bullying and anti-discrimination policies and provide safe ways to report concerns.
- Explain confidentiality and its limits in student support services.
- Offer information sessions for caregivers and ensure awareness activities are inclusive of different backgrounds and abilities.

6.2 For Parents and Caregivers

- Listen calmly and take a young person's concerns seriously instead of dismissing them as drama or weakness.
- Ask open questions and allow time for the young person to explain what they are experiencing.
- Notice persistent changes in mood, sleep, behaviour, relationships, or everyday functioning.
- Help the young person access qualified professional support when concerns persist, worsen, or interfere with daily life.
- Avoid unverified online cures, blame, threats, and comparisons with other young people.

6.3 For Young People

- Learn from credible health organisations rather than relying only on social-media posts.
- Speak with a trusted adult, counsellor, doctor, psychologist, or other qualified professional if distress persists or affects everyday life.
- Offer friends empathy and encouragement to seek support, but do not take sole responsibility for managing a serious mental health crisis.
- Support general well-being through sleep, movement, social connection, balanced routines, and activities that feel meaningful.
- Remember that asking for help is a constructive step, not a sign of personal failure.

6.4 For Communities and Public Institutions

- Support public campaigns that use respectful, evidence-based language and practical information about where to seek help (Jorm, 2012; WHO, 2025).
- Improve the availability and affordability of mental health services for children, adolescents, and families.
- Strengthen links between schools, primary care, specialist services, and community organisations.
- Ensure public information is accessible in local languages and for young people with disabilities.
- Monitor awareness initiatives for reach, accessibility, and whether they lead to improved knowledge of support pathways.

6.5 For Digital Platforms and Content Creators

- Use reliable sources and clearly distinguish general education from diagnosis or treatment advice.
- Avoid sensational portrayals, stigma, unverified cure claims, and content that glamorises self-harm.
- Provide clear links to credible support resources where appropriate.
- Protect young users' privacy and avoid encouraging public disclosure of sensitive personal information.

6.6 Suggested Framework for an Awareness Programme

A practical awareness programme for adolescents could be organised in five connected stages:

5. Learn: introduce mental health, common concerns, protective factors, and myths using age-appropriate material.
6. Recognise: explain signs that may indicate a need for support while emphasising that only qualified professionals diagnose conditions.
7. Talk: practise respectful conversations, listening, and how to approach a trusted adult.
8. Connect: provide verified contact details for school counsellors, primary care, mental health professionals, and crisis services relevant to the location.
9. Review: evaluate whether participants understand key messages and know where to seek support, without collecting unnecessary sensitive personal information.

6.7 Suggestions for Future Research

Future research could examine mental health literacy and help-seeking among adolescents across different regions, age groups, and school settings.

Studies could assess whether awareness programmes improve knowledge of services, reduce stigma, and increase appropriate referrals over time. Research should use ethically approved methods, informed consent and assent where required, privacy protections, and clear safeguarding procedures. Researchers should avoid asking participants to disclose sensitive experiences unless the study has appropriate support and referral arrangements.

7. CONCLUSION

Building awareness of mental health problems and their treatment is important for the health, education, and social development of adolescents and young people. Adolescence brings major physical, emotional, and social changes, and mental health difficulties can affect learning, relationships, participation, and later well-being. The WHO reports that mental health conditions are common among adolescents worldwide, while WHO and UNICEF sources highlight continuing concerns around missed signs, stigma, and low help-seeking (WHO, 2025; UNICEF India, 2025).

Evidence from India also shows why awareness needs to be linked with services that people can actually reach. The National Mental Health Survey 2015–16 provides historical information about adolescent mental health concerns and treatment gaps across the conditions studied. UNICEF India's service-mapping work highlights the need to recognise young people's concerns and strengthen support designed around their needs. Although these sources differ in date and method, both underline that awareness cannot replace the availability of care.

The reviewed sources also show that effective care is available and may include psychological therapies, support for families or caregivers, school and community services, lifestyle measures, and medication when a qualified professional considers it appropriate. There is no single cure for every mental health problem. Treatment should fit the individual and be guided by qualified professionals. Healthy daily habits can support well-being, but they should not replace clinical care when it is needed.

The most useful response brings several elements together: accurate education, open and non-judgemental conversations, safe environments at home and school, early recognition, clear referral pathways, and accessible evidence-based treatment. Young people should be able to ask for help without shame, and adults and institutions share responsibility for making support easy to understand and reach. Because this report uses secondary research only, it does not present new survey findings or measure awareness in a specific student group. Further local research could help identify which approaches work best in different communities.

Ultimately, mental health awareness should mean more than knowing the names of different conditions. It should help young people recognise when they may need support, feel safe enough to ask for it, and reach services that can provide appropriate care. Treating mental health as an essential part of overall health can help society support young people throughout adolescence and into adulthood.

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