Research Journal of Humanities and Social Sciences
(An Open Access International Peer Reviewed Journal)
ISSN: 2945-3968

Poverty, Unemployment, and the Mental Health of Young Indians: Causal Pathways, Long-Term Consequences, and Mitigation Strategies — A Review

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Abstract: India is home to more than 253 million adolescents, close to a fifth of the world's adolescent population, and to a labour market that absorbs comparatively few of them. Young people account for roughly 83% of the country's unemployed, and the educated share of that group has risen substantially since 2000. This narrative review examines what that economic position does to mental health among Indians aged 10 to 24, and argues that the Indian pattern differs from the global one in a specific respect. International evidence explains the poverty–mental health association mainly through absolute deprivation and chronic stress. Indian evidence supports those mechanisms but points toward a further pathway that appears more consequential here: the gap between educational attainment and labour market absorption. Reported prevalence of depressive symptoms among economically disadvantaged Indian youth spans roughly 20% to 55% across the studies examined, against a national adolescent morbidity estimate of 7.3%. Four pathways are examined — household financial stress transmitted through family process, material insecurity, blocked educational mobility, and stigma linked to caste, tribal status, and gender. On mitigation, school-based interventions delivered by lay counsellors show the most consistent Indian evidence, whereas cash transfer effects on youth mental health are small and inconsistent internationally and have never been evaluated on Indian youth. India's mitigation evidence is concentrated where young people are easiest to reach, and is largely absent where economic risk is greatest.
Keywords: poverty, unemployment, youth mental health, India, social determinants, educated unemployment, adolescents, health inequity

How to cite this article: Khanam RM, Begum A. Poverty, Unemployment, and the Mental Health of Young Indians: Causal Pathways, Long-Term Consequences, and Mitigation Strategies — A Review. **Research Journal of Humanities and Social Sciences.2026 Oct 10, 5(4): 256-275**
Source of support: Nil.
Conflict of interest: None
DOI: doi.org/10.58924/rjhss.v5.iss4.p25

Received: 10-08-2026
Revised: 12-08-2026
Accepted 25-09-2026
Published: 10-10-2026

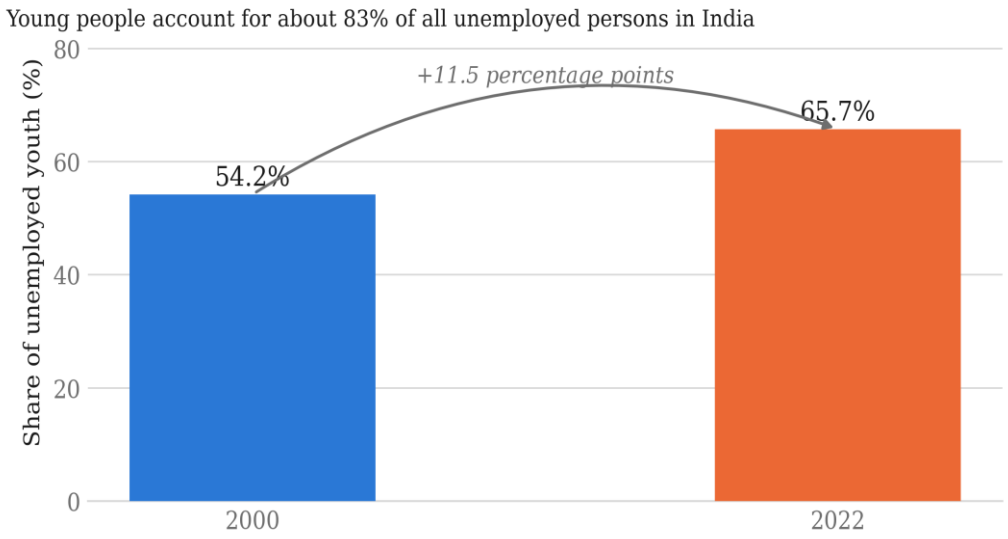
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1. INTRODUCTION

Two figures from Indian policy documents rarely appear on the same page, though they describe the same generation. The first concerns work. Young people account for roughly 83% of the country's unemployed, and educated young people now make up 65.7% of that group, up from 54.2% at the turn of the century (International Labour Organization & Institute for Human Development [ILO & IHD], 2024). Unemployment in India rises with education rather than falling with it; graduates face rates several times those of young people with primary schooling or less; Figure 1 shows how that educated share has shifted. The second figure concerns care. The National Mental Health Survey placed the treatment gap for common mental disorders above 80%, with adolescents among the least served (Gururaj et al., 2016). This review argues that the two figures belong together, and that the connection between them is more specific than the general proposition that poverty damages mental health.

Figure 1

Educated Young People as a Share of Unemployed Youth in India, 2000 and 2022



Note. Figures are drawn from the India Employment Report 2024 (ILO & IHD, 2024). Educated youth are those with secondary or higher education. The comparison shows the composition of youth unemployment, not the unemployment rate itself.

India's demographic position makes the question pressing rather than academic. The country is home to more than 253 million adolescents, close to 21% of its own population (Chauhan et al., 2019), and roughly one in five adolescents worldwide lives in India (Rath et al., 2020). The window in which that cohort might deliver a demographic dividend is finite. Mental ill health among 10- to 24-year-olds is one of the mechanisms capable of closing it early. Patton et al. (2016) made the general case for adolescent health as a development priority, and the Lancet Commission on global mental health placed social determinants at the centre of the global agenda (Patel et al., 2018). The Indian specifics have not received comparable attention.

Scope and Approach

This is a narrative review rather than a systematic one. It does not claim exhaustive coverage of the literature, no formal screening protocol was applied, and no risk-of-bias appraisal was conducted. What it offers instead is an argument assembled from the available evidence, with sources selected for their bearing on the Indian case. The limitations this design imposes are set out in full before the conclusion.

Literature was identified through PubMed, Scopus, and Google Scholar, combining terms for poverty, unemployment, and economic deprivation with mental health outcomes and Indian population terms, covering publications from 2010 onward. Grey literature from the International Labour Organization, the World Health Organization, the National Crime Records Bureau, and the National Mental Health Survey was included where it supplied population-level context unavailable in the peer-reviewed literature. Reference lists of four prior reviews were scanned for Indian primary studies (Lund et al., 2010; Mudunna et al., 2025; Rajkumar et al., 2022; Zimmerman et al., 2021).

Studies were prioritised when they reported Indian data on people aged 10 to 24 linking an economic exposure to a mental health outcome. The 2010 starting point reflects the post-2008 shift in India's youth labour market. The 10-to-24 range, rather than the more common 10 to 19, is deliberate: unemployment bites hardest, migration for work begins,

and suicide risk peaks in the upper half of that band, which most Indian adolescent research excludes. A small number of studies whose samples extend beyond 24 are included where they address the school-to-work transition directly; where this occurs, the sample's age range is stated and the finding is treated as indicative for the transition period rather than as a prevalence estimate for the 10-to-24 band.

The Global Evidence Base

The association between economic deprivation and common mental disorder is among the better-replicated findings in social epidemiology. Lund et al. (2010) reviewed 115 studies from low- and middle-income countries and found positive associations in roughly three quarters of them, though with real variation by poverty dimension. Education, food insecurity, and financial stress tracked mental disorder consistently. Income and consumption proved more equivocal, a distinction that matters for the Indian case.

Ridley et al. (2020) assembled the causal evidence and described a two-way relationship: economic shocks cause mental illness, and mental illness reduces employment and earnings. Kirkbride et al. (2024) set out the prevention implications across the life course, drawing chiefly on evidence from the Global North while acknowledging that other contexts face determinants of their own. That caution matters. Maselko (2017) argued directly that findings from high-income countries cannot be assumed to transfer to low- and middle-income settings, since both the meaning and the distribution of a given social variable may differ. The Lancet–World Psychiatric Association Commission on depression reached a similar conclusion about the geographic narrowness of the evidence base (Herrman et al., 2022).

Three mechanisms dominate this literature. Chronic stress physiology is one: sustained deprivation keeps the hypothalamic–pituitary–adrenal axis activated, degrading emotional regulation over months and years. Family process is a second, and Yoshikawa et al. (2012) traced poverty's effects on children's behavioural health largely through parental stress and disrupted parenting. Social exclusion and inequality form a third; Burns (2015) argued that income inequality mediates much of the relationship through social comparison and eroded social capital.

Unemployment carries a signature of its own. Vancea and Utzet (2017) mapped 46 European studies and found support for social causation in 44, with mental disorder the most common outcome. That framing, however, assumes conditions India does not provide: a welfare floor, standard employment as the reference category, and a short interval between finishing education and starting work.

Why the Indian Case Requires Separate Treatment

Indian labour markets differ from the settings that generate most of this evidence in ways that alter the mechanism, not merely its magnitude. Informal employment accounts for the overwhelming majority of Indian jobs. Employed and unemployed are therefore not the clean categories they represent in data from member countries of the Organisation for Economic Co-operation and Development. A young person in precarious informal work may be worse off than one who is formally jobless but supported by family. Unemployment benefits are largely unavailable to first-time jobseekers. Family structures absorb economic shock in ways that both buffer and burden. Caste, tribal status, and gender determine who is able to convert education into employment at all.

Existing regional syntheses show the limits of pooling across this variation. Mudunna et al. (2025) reviewed 117 South Asian studies and reported prevalence ranges wide enough

to be nearly uninformative, with anxiety between 1.5% and 81.6% in Indian school-based studies. Part of that spread reflects measurement heterogeneity. Part of it is real: economic conditions within India vary enough that a single pooled figure conceals more than it reveals. Rajkumar et al. (2022) narrowed the focus to rural Indian adolescents and produced tighter estimates, though without treating economic exposure as the organising variable.

There is also an age problem. Most Indian adolescent mental health research stops at 19 and is conducted in schools, which excludes by design the young people carrying the greatest economic risk: those who have left school, those in informal work, rural-to-urban migrants, and unemployed graduates. Jena et al. (2024), analysing 26 years of National Crime Records Bureau data, found late adolescents at markedly higher suicide risk than early adolescents, with poverty and unemployment appearing as rising contributory causes. The group at greatest risk is the group least studied.

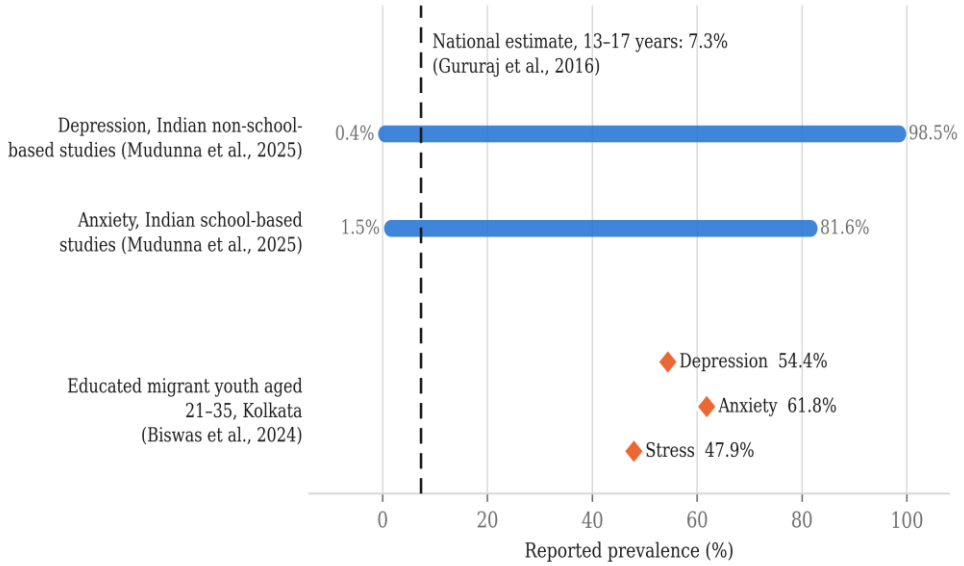
Evidence From India

Prevalence Among Economically Disadvantaged Youth

Across the studies examined here, reported prevalence of depressive symptoms among economically disadvantaged Indian youth spans roughly 20% to 55%. This range is descriptive rather than a pooled estimate. Instruments, cut-offs, sampling frames, and age bands differ enough across these studies that direct comparison is not warranted, and no quantitative synthesis was attempted. Figure 2 displays the reported ranges against the national estimate, Table 1 lists the principal studies with their designs and instruments so that the basis of the range is visible, and Figure 3 maps where those studies sit by age band and setting.

Figure 2

Reported Prevalence of Mental Health Problems Among Indian Youth Compared With the National Adolescent Estimate



Note. Bars show the full span of prevalence figures reported across Indian studies as summarised by Mudunna et al. (2025); they are ranges of reported values, not confidence intervals, and the width reflects heterogeneity in instruments, cut-offs and sampling frames rather than sampling error. Diamonds show point prevalence from Biswas et al. (2024), whose sample aged 21–35 extends beyond this review's age range and is included as indicative of the school-to-work transition. The dashed line marks the National Mental

Health Survey estimate for 13- to 17-year-olds (Gururaj et al., 2016). Figures are not directly comparable across sources.

Table 1
Principal Indian Studies Discussed

Study	Design and setting	Sample	Measure	Key finding
Biswas et al. (2024)	Cross-sectional survey; Kolkata, West Bengal	400 higher-educated migrant youth, aged 21–35	DASS-21	54.4% depression, 61.8% anxiety, 47.9% stress; unemployment a significant predictor
Chauhan et al. (2019)	Cross-sectional; slums of Lucknow, Uttar Pradesh	Adolescents resident in slum settlements	Screening for mental health disorder	Elevated prevalence alongside overcrowding and poor sanitation
Daniel et al. (2022)	Cross-sectional survey; urban slums, multiple sites	3,490 older adolescents, aged 15–19	PHQ-9; slum adversity questionnaire	Depression associated with slum adversity beyond standard socioeconomic measures
Gnanaselvam & Joseph (2018)	Comparative cross-sectional; Tamil Nadu	107 each of current, past and never-employed adolescent girls and young women	PHQ	Depression elevated among current textile workers; tracked working conditions
Shrivastav et al. (2023)	Cross-sectional; tribal region, Central Rural India	Adolescent girls	Psychological distress; gender disadvantage and resilience scales	Gender disadvantage associated with distress; resilience partially buffering
Nair et al. (2017)	Cross-sectional school survey; Anand District, Gujarat	693 students, aged 13–17	Screening instrument for mental health problems	Urban–rural differences partly explained by household socioeconomic position
Michelson et al. (2020)	Randomised controlled trial; six government schools, New Delhi	Adolescents in low-income urban schools	Youth Top Problems; SDQ	Brief lay-counsellor problem-solving intervention improved common mental health problems
Bhatia et al. (2023)	Cluster-randomised controlled trial; West Singhbhum, Jharkhand	38 clusters; rural adolescent girls	Mental health, attendance, dietary diversity	Participatory groups with livelihood promotion; mixed effects across outcomes
Raghuvir et al. (2023)	Retrospective cross-sectional programme data; Karnataka	10,340 care recipients, Yuva Spandana centres	Psychological distress	Establishes feasibility of community youth mental health promotion at scale
Jena et al. (2024)	Pooled analysis of national registry data, 1995–2021; India	National Crime Records Bureau child and adolescent suicide records	Recorded suicide deaths	Rising trend; poverty and unemployment increasingly common contributory causes

Note. DASS-21 = Depression Anxiety Stress Scales, 21-item version; PHQ = Patient Health Questionnaire; PHQ-9 = Patient Health Questionnaire, 9-item version; SDQ = Strengths and Difficulties Questionnaire. Studies are listed in the order discussed in the text. Sample descriptions follow the source publications.

Figure 3

Coverage of the Indian Studies Reviewed, by Participant Age Band and Study Setting



Note. Cells show the number of studies listed in Table 1 that supply data for each combination of age band and setting; a study spanning two age bands is counted in both. Darker shading indicates denser coverage. The mapping is the authors' own and reflects only the studies discussed in this review, not the Indian literature as a whole. The empty and near-empty cells in the 20-to-24 row and the unemployed column identify where evidence is thinnest.

Two studies at the upper end warrant particular attention. Biswas et al. (2024) surveyed 400 higher-educated migrant youth aged 21 to 35 in Kolkata using the Depression Anxiety Stress Scales (DASS-21), and found 54.4% with depression, 61.8% with anxiety, and 47.9% with stress. Unemployed respondents scored substantially higher than employed ones, and the association held after adjustment for sex, marital status, and migration history. This sample extends beyond the upper bound of the present review, and the figures are accordingly treated as indicative of conditions at the school-to-work transition rather than as prevalence estimates for the 10-to-24 band. With that qualification stated, the study remains the clearest available Indian evidence on the population this review is concerned with.

Gnanaselvam and Joseph (2018) compared adolescent girls and young women currently working in a Tamil Nadu textile factory against past employees and never-employed women. Depression was elevated among current workers, and the elevation tracked working conditions rather than employment status. The finding complicates any simple reading of the exposure. In the Indian informal sector, holding a job is not automatically protective; the job itself can be the source of the distress.

At the population level, the National Mental Health Survey estimated 7.3% mental morbidity among 13- to 17-year-olds nationally (Gururaj et al., 2016). Every focused study of a deprived subgroup reports multiples of that figure. Some of the gap reflects instrument and cut-off differences. The pattern of which groups sit above the national estimate, however, is consistent across studies: residents of urban slums (Chauhan et al., 2019; Daniel et al., 2022), tribal adolescent girls (Shrivastav et al., 2023), factory workers (Gnanaselvam & Joseph, 2018), and unemployed graduates (Biswas et al., 2024).

Geographic coverage is uneven in a revealing way. Studies cluster in Karnataka, Maharashtra, Tamil Nadu, Delhi, and West Bengal. States with the highest youth unemployment and the weakest mental health infrastructure have produced the fewest studies. Kokane et al. (2019) observed the same imbalance when reporting National Mental Health Survey findings from Madhya Pradesh, a state performing below the national average on most indicators and correspondingly under-researched. State-level analyses exist for Kerala (Jyrwa et al., 2023) and Tamil Nadu (Dinakaran et al., 2023) in large part because those states chose to produce them.

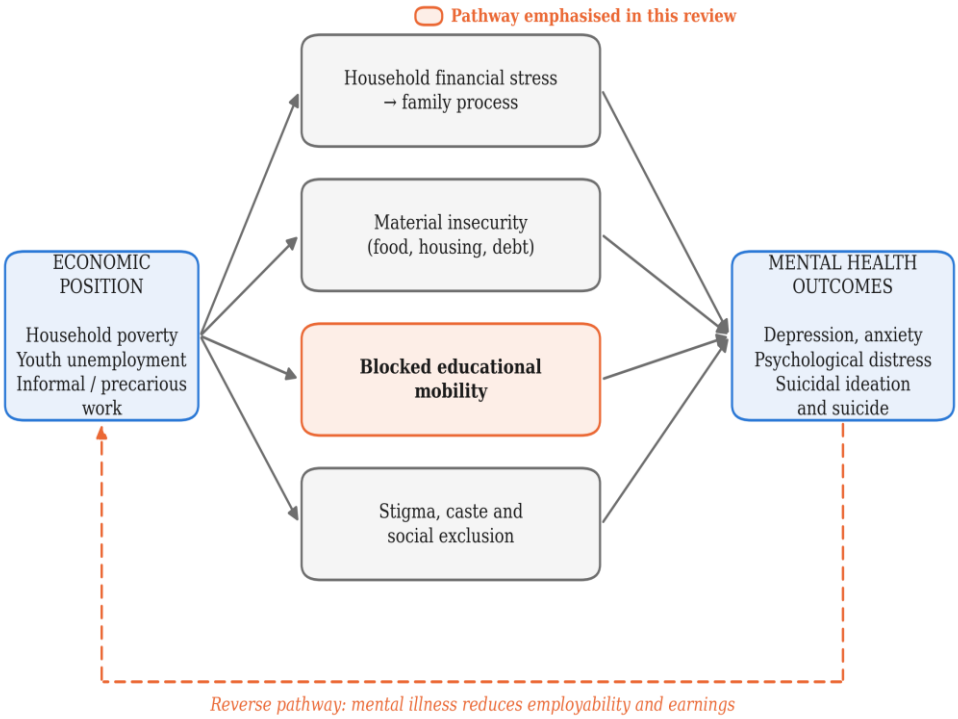
Gender interacts with deprivation rather than simply adding to it. Shrivastav et al. (2023) measured gender disadvantage directly among tribal adolescent girls in central rural India and found it associated with psychological distress, with resilience buffering only part of the effect. Nair et al. (2017), surveying 693 students across urban and rural Gujarat, found setting differences partly explained by household socioeconomic position.

Four Pathways

Figure 4 presents the conceptual framework, and Table 2 summarises the four pathways identified across the literature examined, with the strength of Indian support for each. They are discussed below in descending order of that support.

Figure 4

Conceptual Framework: Pathways From Economic Position to Youth Mental Health Outcomes in India



Note. The four mediating pathways are those identified across the literature reviewed. The pathway shown in the contrasting colour is the one this review argues is most consequential in the Indian context. The dashed return path represents the reverse causal direction documented by Ridley et al. (2020); the relative strength of the two directions among Indian youth has not been established.

Table 2
Pathways Linking Economic Deprivation to Youth Mental Health in India, With Strength of Indian Evidence

Pathway	Proposed mechanism	Key supporting sources	Strength of Indian evidence
Household financial stress and family process	Economic strain alters parenting, supervision and family conflict; effects reach the young person indirectly	Yoshikawa et al. (2012); Chauhan et al. (2019)	Moderate — consistent direction, but few Indian studies measure family process variables directly
Material insecurity (food, housing, debt)	Sustained cortisol elevation degrades emotional regulation; overcrowding and poor sanitation add chronic stressors	Lund et al. (2010); Chauhan et al. (2019); Daniel et al. (2022)	Moderate — well documented in slum samples; food insecurity rarely measured as a distinct exposure
Blocked educational mobility	Educational investment that fails to convert into employment produces loss of expected status and of family expectation	ILO & IHD (2024); Bhat & Rather (2012); Biswas et al. (2024); Díaz et al. (2022)	Emerging — strong signal from a small number of studies; no Indian longitudinal test
Stigma, caste and social exclusion	Poverty-related stigma acts as a distinct stressor; low mental health literacy restricts help-seeking	Maina et al. (2025); Saraf et al. (2018)	Weak — very few Indian studies treat caste or tribal status as an exposure

Note. Strength ratings are the author's qualitative appraisal of the Indian evidence discussed in this review. They are not derived from a formal certainty framework such as GRADE, and no systematic risk-of-bias assessment was conducted.

Household Financial Stress and Family Process

The best-supported mechanism operates indirectly. Economic strain alters parenting and family functioning, and those changes reach the young person. Yoshikawa et al. (2012) set out the general model, and Indian data are consistent with it. Households under financial pressure show more conflict, less supervision, and more punitive discipline, each of which predicts internalising symptoms.

Indian family structure introduces a consideration the Western literature does not address. Multigenerational households distribute both resources and stress. A young person's distress may originate in a parent's job loss even when the young person's own material circumstances remain unchanged, and the causality runs in the other direction as well, with parental mental health responding to adult children's unemployment.

Material Insecurity

Food insecurity recurs as a stronger predictor than income. This matches Lund et al. (2010), where food insecurity ranked among the most consistent poverty dimensions while income proved equivocal. The physiological account is straightforward: chronic food insecurity sustains cortisol elevation, which degrades the baseline for emotional regulation over the long term.

Housing operates similarly. Chauhan et al. (2019) documented mental disorder prevalence among adolescents in Lucknow slums alongside overcrowding and poor sanitation. Daniel et al. (2022) surveyed 3,490 older adolescents in Indian urban slums and constructed a purpose-designed slum adversity questionnaire, because standard socioeconomic measures were not capturing what drove distress in that population. That

methodological choice constitutes evidence in itself: the conventional instruments are missing something.

Blocked Educational Mobility

Indian evidence departs most sharply from the global picture here, and this review treats the pathway as central. In most high-income settings, more education predicts better mental health. Among Indian young adults the relationship is less straightforward. Unemployment rises with education level (ILO & IHD, 2024). Bhat and Rather (2012), comparing India and China, argued that globalisation had produced educated unemployment alongside intensified educational competition, and connected both to youth suicide patterns.

The psychological logic concerns the distance between expectation and outcome. A young person from a poor household who completes a degree has usually absorbed substantial family investment, and family expectation along with it. When the degree fails to convert into work, the loss is not only material; it is also the loss of the account the family had constructed about what the investment was for. Biswas et al. (2024) surveyed precisely this population, and their DASS-21 scores rank among the highest reported in any Indian youth sample.

Supporting evidence comes from outside India. Díaz et al. (2022), using Colombian national data, found that deprivations tied to human capital — falling behind in school, working while studying, lacking health insurance — predicted adolescent mental health problems more strongly than material deprivations did. No Indian replication exists, which is itself a finding worth stating.

Stigma and Social Exclusion

Poverty in India is rarely experienced as economic position alone. Maina et al. (2025), synthesising focus groups with adolescents across 13 countries, found young people describing stigma for being poor as a distinct source of distress, separate from material lack. Saraf et al. (2018) surveyed mental health literacy among 337 young women in an urban Indian slum and found low recognition of mental disorders alongside low help-seeking. Deprivation restricts access to the concepts required to seek help, not only to the services themselves.

Caste and tribal status stratify all of this. Indian studies that treat caste as an exposure rather than a covariate are uncommon, and that constitutes a substantive gap rather than a minor one.

Longer-Term Consequences

Longitudinal Indian data are thin, which constrains what can be claimed in this section. What exists is largely mortality data. Jena et al. (2024) pooled 26 years of National Crime Records Bureau records, identified a rising youth suicide trend forecast to continue for a further decade, and found poverty and unemployment among increasingly common contributory causes, with late adolescents at substantially higher risk than early adolescents. The Global Burden of Disease analyses provide comparable regional context for both suicide (GBD 2021 Suicide Collaborators, 2025) and the wider burden of mental disorders (GBD 2021 Diseases and Injuries Collaborators, 2024). The pandemic period compounded these pressures across low- and middle-income countries, with young people and the economically insecure disproportionately affected (Kola et al., 2021).

Beyond mortality, Indian evidence for scarring effects is largely inferential, imported from high-income cohort studies and assumed to transfer. Whether it does is unknown.

The mechanisms that produce scarring in European labour markets, such as employer signalling and skill depreciation, may operate differently where most employment is informal and hiring proceeds through networks rather than written applications. This is the clearest research gap identified here.

Mathiyazhagan et al. (2024) offer partial evidence from the opposite direction, documenting how a youth helpline addressing social and economic needs affected suicidal ideation. At minimum, this establishes that the economic pathway is modifiable within Indian service settings.

Mitigation Strategies

Cash Transfers and Social Protection

Figure 5 summarises the pooled effect sizes discussed below. The global evidence is real but modest. McGuire et al. (2022) meta-analysed 45 studies covering 116,999 people in low- and middle-income countries and found small significant effects on mental health ($d = 0.07$, 95% CI [0.05, 0.09]) and subjective well-being ($d = 0.13$, 95% CI [0.09, 0.18]), with transfer size the strongest predictor of effect magnitude. Wollburg et al. (2023) restricted attention to randomised trials and found a pooled effect of $d = -0.10$ on depression and anxiety, larger for unconditional than conditional transfers, with benefits fading two to nine years after programmes ended.

Restricted to young people, the picture weakens. Zimmerman et al. (2021) reviewed 12 studies of cash transfers and youth mental health in low- and middle-income countries. Eleven of 13 interventions improved at least one outcome, yet the meta-analysis on depressive symptoms found no effect (0.02, 95% CI [−0.19, 0.23]), with heterogeneity at $I^2 = 95.2\%$. Ángeles et al. (2019) did find a 15-percentage-point reduction in depression indicators among girls in Malawi's unconditional programme, with identifiable pathways accounting for roughly half the effect. Evans-Lacko et al. (2023) proposed a conceptual framework for the mechanisms by which such programmes might work, and Bauer et al. (2021) argued for building youth mental health objectives into cash transfer design directly rather than hoping for them as a by-product.

Conditionality carries risk that Indian programme designers should take seriously. Prencipe et al. (2021) found that Tanzania's conditional transfer reduced depressive symptoms among young men while increasing them among young women, apparently because the conditions relied on stereotypically female labour.

The Indian gap here is notable. The Mahatma Gandhi National Rural Employment Guarantee Act scheme, PM-KISAN, and state-level direct benefit transfers reach hundreds of millions of people. None has been evaluated for youth mental health outcomes.

School-Based Psychological Interventions

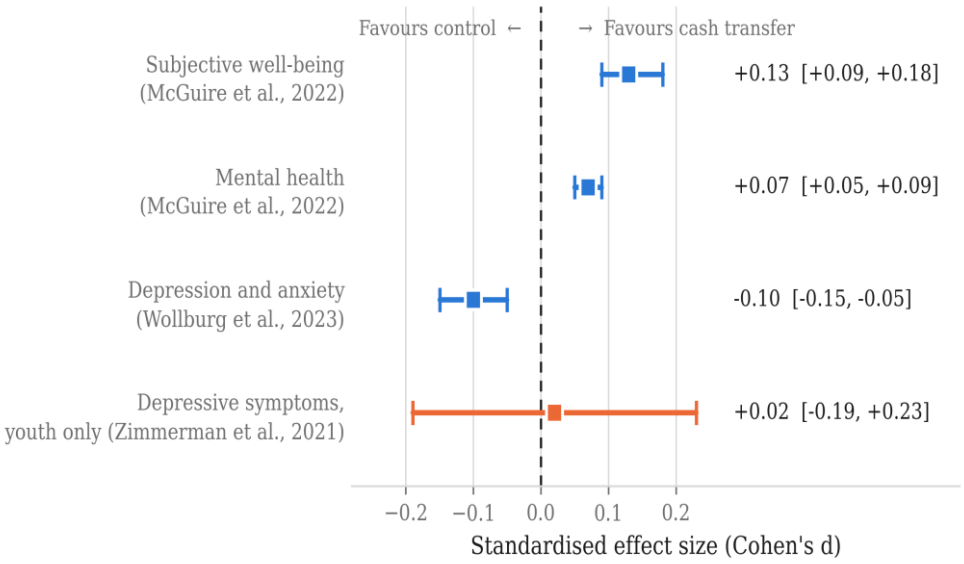
This constitutes the strongest Indian evidence, and it is genuinely strong. Michelson et al. (2020) randomised adolescents across six government-run, low-income schools in New Delhi to a brief problem-solving intervention delivered by non-specialist lay counsellors, and reported benefits on common mental health problems. The trial matters on two counts. It worked in precisely the population this review concerns, and it demonstrates a delivery model that does not depend on a psychiatrist workforce India does not possess.

Bhatia et al. (2023) took a different route in the JIAH cluster-randomised trial across 38 clusters in Jharkhand, combining participatory adolescent groups, youth leadership, and livelihood promotion for rural adolescent girls, with school attendance, dietary diversity, and mental health as outcomes (see Rath et al., 2020, for the protocol). Pairing an

economic component with a psychosocial one is in principle what the mechanistic evidence calls for.

Figure 5

Pooled Effect Sizes for Cash Transfer Interventions on Mental Health and Well-Being Outcomes



Note. Squares show pooled point estimates and bars show 95% confidence intervals, as reported in each source. Direction of benefit differs by outcome: for the Wollburg et al. (2023) estimate the outcome is symptom severity, so a negative value indicates improvement. The youth-only estimate from Zimmerman et al. (2021) is shown in the contrasting colour because it is the only estimate restricted to the population of interest here, and it is the only one whose interval includes zero. Estimates derive from different study sets and are not directly comparable.

Community Models and Policy Architecture

Karnataka's Yuva Spandana programme provides the largest Indian implementation dataset, with Raghuvir et al. (2023) analysing 10,340 care-recipient records across five years. Mathiyazhagan et al. (2024) described a youth development approach targeting socioeconomic determinants of suicidal ideation. Neither is a controlled evaluation, so what they establish is feasibility at scale rather than effect.

On policy, much of the architecture already exists. The Rashtriya Kishor Swasthya Karyakram names mental health among its priority areas and operates through community peer educators, the same structure the JIAH trial tested. The National Mental Health Programme and the Mental Healthcare Act 2017 supply the legal frame. What is missing is coordination. George et al. (2021) mapped adolescent health interventions against the sectors responsible for delivering them and found the multisectoral working that adolescent mental health requires largely absent. Knifton and Inglis (2020) made the parallel argument for policy more broadly, contending that poverty-focused mental health policy fails when it is confined to the health sector. Table 3 sets out the principal Indian instruments and what is known about each.

Table 3
Indian Policy and Programme Instruments Relevant to Youth Mental Health, With Evidence Status

Instrument	Sector and reach	Mental health provision	Evidence status
Rashtriya Kishor Swasthya Karyakram (RKSK)	Health; national adolescent health strategy delivered through community peer educators	Names mental health among its priority areas; peer educator groups provide a discussion space	Programme architecture tested in trial form by Bhatia et al. (2023); no national outcome evaluation
National Mental Health Programme	Health; district-level service delivery	General mental health service provision; no youth-specific component	Treatment gap above 80% recorded by Gururaj et al. (2016)
Mental Healthcare Act 2017	Legal; rights framework, national	Establishes a right to access mental healthcare	Implementation not evaluated for youth outcomes
MGNREGA and PM-KISAN	Social protection; hundreds of millions of beneficiaries	None; income support with no mental health component or measurement	No evaluation of youth mental health outcomes has been conducted
Skill India and allied skilling missions	Labour; youth training and placement	None; no mental health screening or referral built in	Not evaluated for mental health outcomes

Note. Instruments are those discussed in the text. Evidence status refers to published evaluation of youth mental health outcomes specifically, not to evaluation of the programme's primary objectives.

2. DISCUSSION

The Central Argument

The claim this review presses concerns which pathway carries the weight. Global models foreground absolute material deprivation and chronic stress physiology. Indian data support those mechanisms. The pathway that appears most distinctive here, however, is the mismatch between educational attainment and labour market absorption. Educated unemployment is not a footnote to Indian youth mental health. On the evidence reviewed, it sits close to the centre.

That reframing carries a direct policy consequence. If the operative mechanism were absolute deprivation, expanding cash transfers would be the obvious response, and the global evidence would predict small but real gains. If the operative mechanism is blocked mobility among young people who have already made the educational investment, cash transfers address the wrong thing. What follows instead is intervention at the transition point: active labour market programmes with mental health support built in, apprenticeship schemes, and services designed for young people who are neither in education nor in work.

A second observation concerns who is missing from the evidence. The Indian research base rests on school samples, which by construction exclude the young people carrying the greatest economic risk. The picture the literature presents is therefore systematically optimistic, and the degree of that optimism is unknown.

Relation to Existing Reviews

Mudunna et al. (2025) covered South Asian adolescent mental health broadly, with adolescence rather than economic exposure as the organising frame and the age range capped at 19. Rajkumar et al. (2022) produced pooled prevalence estimates for rural Indian adolescents without treating poverty as the exposure of interest. Lund et al. (2010) and Ridley et al. (2020) established the general relationship without Indian specificity.

The present review occupies the space those three leave open: Indian, economically framed, and extending to 24.

On cash transfers, the finding here aligns with the wider literature rather than contradicting it. Lund et al. (2011) concluded more than a decade ago that the mental health effects of poverty alleviation were inconclusive while mental health interventions reliably improved economic outcomes. That asymmetry has held. It suggests the intervention priority may run in the direction less often assumed: treating mental health in order to improve economic outcomes, rather than only the reverse.

3. LIMITATIONS

The most serious limitation belongs to the evidence base rather than to the review design, and it bears directly on the central argument. Almost all the Indian association evidence is cross-sectional, and causal direction cannot be established from cross-sectional data. Ridley et al. (2020) demonstrate that the relationship runs in both directions globally. Which direction dominates among Indian youth, and at which ages, cannot be answered from what has been published. The argument advanced here about blocked mobility is therefore a reading of the available evidence, not a demonstrated causal claim, and it should be treated as a hypothesis for prospective testing.

The review design imposes its own constraints. As a narrative review, no formal screening protocol was applied, so the selection of sources reflects the author's judgement about relevance and relevant studies will have been missed. No risk-of-bias appraisal was conducted, and the reader should not assume uniform quality among the studies cited; several are cross-sectional with single-proxy poverty measures and limited adjustment for confounding. No quantitative pooling was attempted, and the prevalence figures reported here are descriptive rather than estimated.

One inclusion decision deserves particular note. Biswas et al. (2024), the study on which the central argument leans most heavily, sampled participants aged 21 to 35, which extends beyond this review's upper bound of 24. The study was retained because it addresses the school-to-work transition more directly than any within-range alternative, and because no Indian study confined to the 18-to-24 band examines educated unemployment and mental health together. Readers should nonetheless treat its prevalence figures as indicative of the transition period rather than as estimates for the population this review defines.

Further constraints apply to the evidence base itself. Restricting attention to work published from 2010 onward excludes earlier Indian research. A considerable volume of Indian public health research appears in journals indexed in no searchable database. Very few studies measure caste directly, so claims here about caste-related stratification rest on weaker ground than the remainder of the argument.

4. IMPLICATIONS

For policy, mental health support belongs inside employment and skilling programmes rather than running parallel to them. The Rashtriya Kishor Swasthya Karyakram peer educator network already exists and could carry a screening and referral function at low marginal cost. Any Indian cash transfer evaluation should include youth mental health outcomes as standard; the programmes are running regardless, and the measurement cost is trivial beside the evidentiary value.

For practice, the lay-counsellor model has now been demonstrated twice in Indian settings. Extending it beyond schools — to employment exchanges, skill development centres, and urban migrant settlements — is the obvious next step.

For research, several priorities follow, and Table 4 pairs each gap with the design that would close it. India needs prospective cohort studies following young people through the school-to-work transition with repeated mental health measurement. It needs studies that sample out-of-school and unemployed youth rather than convenient school populations. It needs caste, tribal status, and gender treated as exposures rather than covariates. And it needs at least one rigorous evaluation of an existing Indian social protection programme with youth mental health as a pre-specified outcome.

Table 4
Research Gaps Identified and Study Designs Required to Address Them

Gap	Why it matters	Design required
No longitudinal Indian data across the school-to-work transition	Causal direction cannot be established from cross-sectional data, and the central argument of this review rests on a temporal claim	Prospective cohort following participants from age 15 to 25, with repeated mental health measurement and employment history
Out-of-school and unemployed youth are rarely sampled	School samples exclude the young people carrying the greatest economic risk, so the published picture is systematically optimistic	Community and household sampling frames; recruitment through employment exchanges and migrant settlements
Caste and tribal status treated as covariates rather than exposures	Stratification determines who converts education into employment, yet its mental health consequences are largely unmeasured	Studies powered for stratified analysis with caste and tribal status specified as primary exposures
No Indian social protection programme evaluated for youth mental health	Programmes reaching hundreds of millions are running without any measurement of this outcome	Mental health outcomes added as pre-specified secondary endpoints to existing programme evaluations
Scarring effects assumed rather than demonstrated	Mechanisms established in formal European labour markets may not transfer to informal, network-based hiring	Long-term follow-up studies linking early unemployment spells to later mental health and earnings in Indian samples

Note. Gaps are those identified in the course of this review and correspond to the research priorities set out in the Implications section.

5. CONCLUSION

For young Indians, the link between economic hardship and mental distress appears to run most strongly through a particular mechanism: acquiring education that the labour market does not absorb. Household poverty, food insecurity, and family stress all contribute, and they are well documented. The 54.4% depression prevalence Biswas et al. (2024) recorded among educated, jobless migrant youth in Kolkata, set against a 7.3% national adolescent estimate, points toward something the standard deprivation model does not fully explain.

The mitigation evidence is thinner than the descriptive evidence, and thinnest where the need is greatest. Two Indian trials demonstrate that lay counsellors working in schools can help. Nothing yet demonstrates what helps a 22-year-old graduate in a district town who has been looking for work for eighteen months. Until that question is studied in

India rather than inferred from elsewhere, policy will continue to reach the young people who are easiest to find rather than those carrying the most risk.

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Appendix

Abbreviations

DASS-21 = Depression Anxiety Stress Scales, 21-item version
GBD = Global Burden of Disease Study
IHD = Institute for Human Development
ILO = International Labour Organization
JIAH = Jharkhand Initiative for Adolescent Health
MGNREGA = Mahatma Gandhi National Rural Employment Guarantee Act
NCRB = National Crime Records Bureau
NIMHANS = National Institute of Mental Health and Neuro Sciences
NMHS = National Mental Health Survey
PHQ = Patient Health Questionnaire
RKSK = Rashtriya Kishor Swasthya Karyakram
SDQ = Strengths and Difficulties Questionnaire
WHO = World Health Organization

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Research Journal of Humanities and Social Sciences
(An Open Access International Peer Reviewed Journal)
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