

Impact of mental health challenges on the enjoyment of human rights by young people
Submission by The Concerned for Working Children, India to
The Office of the High Commissioner for Human Rights (OHCHR), February 2026

The Concerned for Working Children (CWC) is a civil society, secular, and democratic development organisation that has worked for 45 years to advance children's rights and strengthen civil society participation. We partner with Bhima Sangha (a union of working children), collectives of school-going and out-of-school children, and vulnerable communities to co-create strategies that empower the most marginalised.

Through our work with local and state governments, we strive to make governance child-rights responsive and inclusive. Our efforts have helped deepen democratic decentralisation and enable meaningful engagement of citizens, especially those most excluded. We focus on building leadership of adolescents at the national level, ensuring their informed, equitable, and active participation in shaping their futures. Our community-driven models have influenced policies and practices, rooted in rights, justice, inclusion, and solidarity. We have supported child- and youth-led networks to engage with governments and global decision-makers, holding them accountable to children's rights. We have lead global youth initiatives, the first alternate reports to the UNCRC¹, International Movements of Working Children², the successful campaign for the UN declared International Day of Play³, and we consult with UNICEF on children's participation and agency.

In recognition of our work's global and generational impact, we were honoured with Nobel Peace Prize nominations in 2012, 2013, 2014.

Following is our submission:

According to the *Child and Adolescent Mental Health Service Mapping 2024* by UNICEF⁴, India has one of the largest child and adolescent populations globally, with over 436 million young people. With a total population of approximately 1.45 billion, nearly 30% are below 18 years of age, making the prioritisation of their developmental and mental health needs a national imperative. Available evidence indicates that a significant proportion of young people are already experiencing mental health challenges. The Global Burden of Disease (2021) estimates that around 14% of adolescents aged 10–19 in India live with a mental disorder. Earlier, the National Mental Health Survey (2015–16) reported that nearly 7% of adolescents aged 13–17 were affected, translating at that time to approximately 8–11 million children and adolescents requiring mental healthcare. More than a decade later, and following major disruptions such as the COVID-19 pandemic, prolonged school closures, economic distress and social isolation, it is reasonable to conclude that the scale of mental health needs among young people has increased significantly.

Based on our grassroots experiences, these statistics do not fully capture the real situation. India's diverse socio-cultural contexts mean that mental health concerns are understood and expressed differently across communities, making reporting inconsistent. Due to stigma, low awareness and fear of discrimination, low and uneven access to diagnosis and care, especially in marginalised and rural areas, many children and adolescents do not openly share their distress or seek support. Actual mental health needs are likely much higher than reported, particularly in the post-pandemic period.

¹ Working Children's Report, 1998 <https://share.google/YqY14HB2BE23YD06u>

² Joint Declaration of the International Movements of Working Children and Adolescents in response to the the Sixth Global Conference on Elimination of Child Labour <https://www.concernedforworkingchildren.org/news/2026/02/joint-declaration-of-the-international-movements-of-working-children-and-adolescents-in-response-to-the-the-sixth-global-conference-on-elimination-of-child-labour-morocco-11-13-february-202/>

³ Making Play a Right: CWC's Local-to-Global Impact on the International Day of Play (2023–2025) <https://www.concernedforworkingchildren.org/news/2025/07/making-play-a-right-cwcs-local-to-global-impact-on-the-international-day-of-play-2023-2025/>

⁴ <https://www.unicef.org/india/reports/child-and-adolescent-mental-health-service-mapping-india-2024>

1) Main mental health challenges faced by young people and the impact on their human rights

Six years after COVID-19, young people in India continue to face serious mental health challenges. The pandemic not only created new problems but also worsened existing inequalities. In Karnataka, as in the rest of India, many families experienced job loss, financial insecurity and poverty, which increased stress at home. Children and adolescents faced grief due to the loss of parents and relatives, long periods of isolation, disruption of schooling and uncertainty about their future. These experiences have led to increased anxiety, depression, stress, low self-esteem and feelings of hopelessness among adolescents and youth, that shaped the trajectory of their growth and development and continues to impact many even now, six years later.

In addition, there has been a noticeable rise in addictions and harmful coping behaviours. Increased screen time during lockdowns has continued even after schools reopened, leading to digital addiction, social media, and gaming dependencies. The Economic Survey 2025-26 of India⁵, presented to the Parliament of India, flags digital addiction among children and youth as a growing public health concern, warning that excessive use of smartphones, social media, gaming and online platforms is linked with reduced concentration, sleep loss, anxiety, depression, low self-esteem and social withdrawal among young people, especially those aged 15–24. It also notes associations with stress, cyberbullying and gaming-related behavioural issues.

Substance abuse, including alcohol and drugs, has also become a serious concern, especially among vulnerable adolescents. The 51st Report (government parliamentary report): Drug Abuse Amongst Young Person – Problems and Solutions by the Ministry of Social Justice and Empowerment, Government of India⁶ shows survey findings that children and adolescents, form a measurable population as users of alcohol, tobacco, inhalants, and other psychoactive substances in school-going populations. In communities where alcohol misuse among adults is high, children are exposed to violence, neglect and emotional distress. Some adolescents themselves turn to alcohol or substances as a way to cope with stress, unemployment and academic pressure. These addictions further worsen mental health, increase risk-taking behaviour and affect relationships and education.

Marginalised groups in Karnataka — including children from rural areas, urban slums, migrant families, working children, scheduled castes and tribal communities, children with disabilities, girls, gender minorities, religious minorities— have been acutely affected by mental health issues. For them, mental health challenges are closely linked to poverty, social exclusion, violence, discrimination and lack of access to resources.

These mental health issues directly impact young people’s human rights. When adolescents are depressed, addicted, traumatised or anxious, their right to health, education, protection and development is affected. Many drop out of school, enter labour, experience early marriage or become exposed to exploitation. Their ability to participate in decisions affecting their lives is reduced. Mental health is therefore not just a health issue but a matter of dignity, equality and justice.

3) Main barriers to the right to mental health

Young people in India face serious barriers in accessing mental health care, including stigma and social misinformation. In terms of availability, there is a major shortage of trained child and adolescent mental health professionals. In the state of Karnataka, in which our scope of work is located, services are concentrated in urban centres, leaving rural Karnataka and marginalised communities underserved. De-addiction and rehabilitation services for adolescents are limited and often not adolescent or youth-friendly.

Accessibility is another concern. Many families cannot afford travel or private counselling. Awareness about services is low. Tele counselling has not proven to be an effective strategy yet in rural reaches of the state where access to the internet and devices themselves are inconsistent. Further, marginalised communities face language

⁵ <https://www.indiabudget.gov.in/economicsurvey/>

⁶ <https://narcoindia.gov.in/narcoindia/Resources/1693377979-1145-DOC-Fifty->

<https://narcoindia.gov.in/narcoindia/Resources/1693377979-1145-DOC-Fifty-First%20Report%20on%20the%20%80%98Drug%20Abuse%20among%20young%20persons%20%E2%80%93%20problems%20and%20solutions%E2%80%99%20of%20MoSJE.pdf>

barriers and discrimination within health systems. Further adolescent girls and young women face even more mobility restrictions and social control, limiting their ability to seek support.

Acceptability remains a major issue due to stigma. Mental health problems are often dismissed as weakness or bad behaviour, or age-related occurrences that will iron out in time. Addictions are seen as moral failure rather than health concerns. Quality is also uneven. Public services are non-existent, inadequate or overburdened and very often are not culturally sensitive. Further, the scope for long-term follow-up is very limited due to large distances and lack of decentralisation of services. There are few safe and confidential spaces for adolescents to speak openly.

These barriers weaken young people's human rights. Without accessible and appropriate care, mental distress continues untreated. This affects education, protection from violence, participation, bodily autonomy and overall wellbeing. Marginalised youth face compounded barriers and therefore greater rights violations.

2) Steps taken by the Government

The Government of India has taken policy-level steps to address mental health concerns. The Mental Healthcare Act recognises mental healthcare as a legal right and promotes dignity, non-discrimination and access to services. However, while the Act is progressive on paper, implementation remains weak. Many young people and families are not aware of this right. There is limited budget allocation, poor monitoring, and very few child-friendly mental health facilities. The Act does not clearly define specialised pathways for children and adolescents, which leads to gaps in age-appropriate care.

The National Mental Health Programme aims to provide services through district-level systems under the District Mental Health Programme (DMHP). While this has expanded mental health into public healthcare, it faces serious shortages of trained professionals, especially child and adolescent specialists. Services are largely hospital-based and urban-centred, and in many districts, while the DMHP exists on paper, in reality, regular psychiatrists or counsellors are *either few or contract-based* rather than permanent posts; thus they are not equipped to deal with cases and long term follow ups. Further, while a few efforts have been made to incorporate preventive, school-based and community-level interventions in urban setups, they are largely relegated to the states capital and ancillary urban area, and there too rollout remains inconsistent. Follow-up care and long-term psychosocial support are limited.

The Rashtriya Kishore Swasthya Karyakram includes adolescent mental health as a priority area and promotes peer educators and adolescent-friendly health clinics. However, in practice, mental health often receives less attention compared to physical health issues. Counsellors are not consistently available, and many adolescents are unaware of these services. The programme further does not adequately address growing concerns such as digital addiction, alcohol and substance abuse, trauma and violence.

The rollout of Ayushman Bharat in Karnataka, including its School Health Programme, has promoted awareness through wellness ambassadors and school health initiatives. However, implementation gaps remain significant. Teachers assigned as Health and Wellness Ambassadors are often overburdened and lack adequate training to address mental health concerns. Many rural and marginalised schools do not have access to counsellors at either the school or cluster level. In several schools our projects engage with, counselling services are entirely absent, and children must seek support at the district level under the District Mental Health Programme, which is often inaccessible for poor and vulnerable families due to distance, cost and stigma. Referral pathways are unclear, and there is weak coordination between schools, child protection systems and mental healthcare providers. As a result, while awareness efforts have expanded, meaningful, accessible mental health support for children and adolescents remains limited, particularly in underserved areas.

Further Karnataka is an example of how mental health through digital pathways may not serve children and adolescents mental health needs. The digital divide limits access for rural and low-income youth. Tele-services

cannot replace in-person, community-based care, especially for children facing violence, addiction or severe distress.

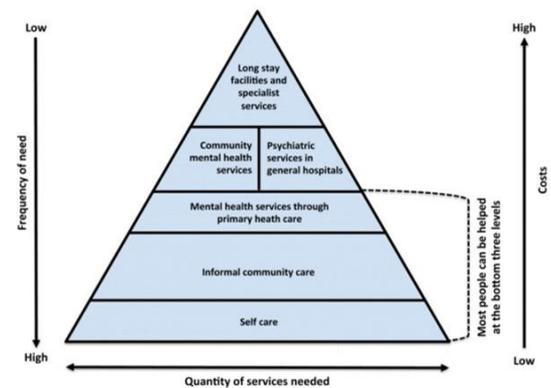
Overall, while there are systemic movements in mental health policy, children and adolescents and their unique developmental and psychosocial needs are not clearly articulated across programmes. There are no clearly defined, child-centred pathways of care that integrate prevention, early identification, counselling, de-addiction, family support and rehabilitation. Policies exist, but coordination, funding, trained human resources and accountability mechanisms remain insufficient. As a result, children and adolescents, especially those from marginalised and vulnerable communities, continue to face gaps in accessing their right to mental health.

Thus, while the above narrative may indicate that India does have a rights-based framework through the Mental Healthcare Act and other instruments, there remains a significant care gap, even more so six years after the pandemic (which expedited systemic and non-systemic response to mental health and well-being of children and adolescents). Children and adolescents require age-appropriate, trauma-informed and community-based services that recognise the link between mental health, addiction, digital harm, violence and socio-economic inequality. Stronger coordination between education, health and child protection systems is needed. Meaningful youth participation in policy design is also essential.

To truly respect, protect and fulfil the mental health rights of young people in Karnataka and across India, the approach must move beyond policy statements to practical, accessible and youth-centred systems of care. Mental health must be treated as both a public health priority and a human rights obligation.

The Concerned for Working Children (CWC): From Community Practice to Policy Influence⁷:

Within this context, **The Concerned for Working Children (CWC)** has partnered with domain experts, community systems and young people themselves to build a community mental wellbeing support network in the areas where it works, while also influencing state and national policy. Our field interventions engage with highly vulnerable children from rural communities, working adolescents, children with disabilities, and those at risk of early marriage, trafficking, substance use or digital addiction. These children face ongoing rights violations, insecurity, caste discrimination and weak support from duty-bearers. Violence, alcoholism and unsafe home environments often push them towards harmful coping mechanisms such as substance use, school dropout or early marriage. Many live in crowded areas without safe play spaces, while increased digital exposure adds new risks. At the policy level, CWC has consistently foregrounded children's mental health and wellbeing. As co-authors of the Karnataka State Child Protection Policy and contributors to District Child Rights Protection Protocols in Karnataka, we have ensured that mental health is recognised as a provision and a right of every child within these frameworks. CWC's child rights and mental health praxis lies within the pyramid of care model developed by the World Health Organisation, outlining a model for mental health care on a community scale to ensure well-being.



The WHO Optimal Mix of Mental Health Services

The bottom of the pyramid, with the highest number of individuals requiring care, focuses on preventive and accommodative initiatives for well-being. Self-care and informal community care initiatives play a crucial role at this level. Numerous studies emphasize that 80% of individuals with common mental health issues, such as anxiety, do not require professional mental health services. Besides, psychological well-being can be achieved

⁷ The Concerned for Working Children – Mental Health and Wellbeing Praxis <https://www.concernedforworkingchildren.org/news/2026/02/the-concerned-for-working-children-mental-health-and-wellbeing-praxis-from-community-practice-to-policy-influence/>

through self-care and informal community support. The pyramid is conceptualised with the three upper layers, including specialised institutions for mental health, followed by district-level hospitals, and panchayat⁸-level primary health centres. These upper levels of medical or drug-based care are reserved for individuals with severe mental health problems, constituting 10-20% of the total population.

A strong basis of the pyramid is informal community care (ICC) or self-care, where mental health and well-being initiatives are rooted in the community. The need for this care is significant, with lower capital/expenditure requirements compared to the top three layers. While the need is low in the top three tiers, the costs are high, and conversely, the need is high at the bottom, while costs are low.

The pyramid underscores the necessity for coordinated and effective initiatives to address mental health and well-being at the community level. In response to this need, the CWC is focussing on mental health pathways, focusing on a community-led approach at the pyramid's bottom. The model emphasises tools and resources for self-awareness and care and sustained informal community support.

Discussions with children's collectives, parents and community self help and support groups showed growing mental health concerns in the community and how these directly affect children's ability to enjoy their rights. Family conflict, unsafe homes, adult alcoholism, digital addiction and academic pressure are creating high levels of stress among children and adolescents. Many struggle emotionally but lack safe spaces to speak, seek support or heal. Stigma and silence around mental distress further isolate them, affecting their rights to education, protection, participation, health and development.

In response, CWC has facilitated community-based initiatives that create safe spaces for children to express themselves through play and dialogue, build emotional literacy among children and caregivers, focus on developing and strengthening their identity, self-reliance and self-worth, and train frontline workers and local governance actors to recognise and respond to distress. The aim is to equip children and communities with practical tools for emotional awareness and healthy coping, while building a strong local support system. Through "good helper" and vigilant community models, children in need are supported to access professional and clinical care where required.

CWC also actively strengthens children's agency and citizenship. Children and adolescents engage with local self-governments and local legislators and enforcers to actively demand for and access their entitlements; they have develop state-level recommendations to duty-bearers on their rights and wellbeing and with the support of CWC and collaborative partners, dialogue to ensure pathways of accountability; they have participated in the International Movement of Working Children, which highlights the agency and wellbeing pathways for working adolescents globally. As a global founding member of the International Day of Play, CWC has supported children to shape the Right to Play movement and articulate the impact of play on their overall health and wellbeing, where their recommendations were combined with inputs from over 10,000 children worldwide in a global Call to Action⁹. Young people have also partnered in anchoring the Young Voices National Movement¹⁰ and the National Adolescents as Ambassadors of Change Movement¹¹ that have made strong national and regional policy pathways on aspects of age of consent, age of marriage, adolescents and work, their rights to safety, security and development and the cumulative impact on their well-being.

By strengthening both children's voices and the wider community ecosystem — including adult access to livelihoods and citizenship rights — the initiative works to create a safer, more enabling environment where young people can realise their full rights and wellbeing.

⁸ The local governing body of a village in India and the foundational unit of the local self governance model

⁹ <https://www.concernedforworkingchildren.org/news/2024/03/united-nations-general-assembly-adopts-the-international-day-of-play-call-to-action/>

¹⁰ <https://www.concernedforworkingchildren.org/news/2020/07/young-voices-national-report-15-states-nearly-2500-young-people-submission-to-the-task-force-examining-age-of-marriage-and-other-concerns-july-2020/>

¹¹ <https://www.concernedforworkingchildren.org/news/2021/04/petition-by-working-adolescents-demanding-attention-and-child-rights-friendly-response-from-the-state-on-the-29th-april-2021-the-eve-of-national-child-labour-day-india/>