RESEARCH PAPER

Redefining Mental Health Education: Toward a Culturally Grounded Framework for India

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ABSTRACT

Background

The global rise of Mental Health Literacy (MHL) has catalyzed efforts to improve awareness and reduce stigma. However, its Western biomedical orientation and cognitive emphasis often fail to resonate within culturally diverse, low- and middle-income countries like India. This paper critiques the conceptual and contextual limitations of MHL and introduces a more inclusive, culturally grounded alternative—Mental Health Education (MHE).

Objective

To propose an operational definition of MHE that is pedagogically inclusive, emotionally resonant, and socially relevant for the Indian context, serving as the conceptual foundation for the Indian Mental Health Education Scale (IMES).

Methods

A funnel-structured literature review was conducted to examine the evolution of MHL, followed by a thematic analysis of qualitative inputs from mental health professionals, educators, and community health workers (n=15). These insights were triangulated to inform the construction of a culturally valid MHE framework.

Findings

Stakeholder responses emphasized five key dimensions of MHE: (1) holistic understanding of mental health and its cultural determinants; (2) emotional and social competence; (3) strategies for internal and external stigma reduction; (4) civic and systemic awareness; and (5) action-oriented learning. These informed the development of a multidimensional operational definition of MHE that extends beyond knowledge transmission to include empathy, agency, and contextual responsiveness.

Conclusion

MHE represents a paradigm shift from literacy to education, cognition to action, and individualism to collectivism. It holds promise for transforming public mental health discourse in India by informing curriculum design, community engagement, and national policy. The framework and definition presented here lay the groundwork for culturally valid assessment tools and evidence-based interventions tailored to India's unique mental health landscape.

Keywords: Mental Health Education; Operational Definition; Culturally Adapted Framework; Public Mental Health; Stigma Reduction; Mental Health Literacy.

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1. Introduction

Mental health issues are a growing global public health concern and contribute substantially to the global burden of disease. The magnitude of this challenge is particularly evident in India. The National Mental Health Survey of India (2015–16) reported that nearly 14% of the adult population required active mental health interventions, with common mental disorders such as depression, anxiety, and substance use disorders being especially prevalent (Gururaj *et al.*, 2016). Despite this burden, treatment gaps remain alarmingly high, ranging from 70% to 92% depending on the condition (World Health Organization [WHO], 2021). These gaps are further intensified by low awareness, stigma, inadequate mental health infrastructure, and a persistent reluctance to seek help, particularly in rural and underserved communities (Patel *et al.*, 2016; Thirunavukarasu & Thirunavukarasu, 2010). In this context, improving public understanding of and engagement with mental health has become critically important for both policy and practice.

The concept of Mental Health Literacy (MHL), first introduced by Jorm *et al.* (1997), emerged as a strategic response to promote early intervention and community-level awareness. MHL refers to people's knowledge and beliefs about mental disorders, including their ability to recognize symptoms, understand risk factors and treatments, and engage in appropriate help-seeking behavior (Jorm, 2000; Wei *et al.*, 2013). Over time, MHL has evolved into a broader and more multidimensional concept, at times including stigma reduction and the promotion of self-help efficacy (Furnham & Swami, 2018; Kelly *et al.*, 2007). It has been widely adopted in public health campaigns, school curricula, and mental health advocacy efforts across many high-income countries (Kutcher *et al.*, 2016; Pinfold *et al.*, 2003). Importantly, its application has demonstrated effectiveness in improving mental health knowledge and reducing prejudicial attitudes (Corrigan & Watson, 2002).

However, critics have questioned the limitations of MHL, particularly when applied to low- and middle-income countries such as India. Existing MHL frameworks are largely rooted in Western biomedical paradigms that emphasize individual-level cognition, linear knowledge transmission, and decontextualized symptom recognition (Kirmayer & Pedersen, 2014; Summerfield, 2012). Such approaches often overlook the sociocultural, linguistic, and communal dimensions that shape mental health understanding in collectivist settings (Patel & Kleinman, 2003; Raguram *et al.*, 1996). Research in South Asia has shown that mental health beliefs are deeply intertwined with local idioms of distress, family structures, religious values, and traditional healing systems—factors that are often absent from standard MHL models (Das & Rao, 2012; Kohrt & Hruschka, 2010). Furthermore, framing literacy as merely the acquisition of clinical knowledge may alienate populations with limited formal education and reinforce hierarchies between "experts" and laypersons (Brijnath, 2015).

In response to these limitations, there is growing agreement that public engagement with mental health must be reimagined through a culturally grounded and pedagogically inclusive lens. This has led to the emerging concept of Mental Health Education (MHE) as a more contextually appropriate framework for India. Unlike literacy, which often implies one-way information transfer, education suggests a dialogical, participatory, and values-based approach that resonates more strongly with India's pluralistic traditions of community learning and social reform (Freire, 1970; Vygotsky, 1978). MHE may be understood as encompassing not only factual knowledge, but also emotional intelligence, critical consciousness, ethical reasoning, and collective empathy—qualities essential for sustainable and socially meaningful mental health awareness in diverse settings (Noddings, 2005; Weiss *et al.*, 2001). It also aligns more naturally with India's National Education Policy 2020, which emphasizes holistic, integrated, and context-sensitive learning (Ministry of Education, 2020).

This paper aims to develop a theoretically grounded and empirically informed conceptual framework for Mental Health Education (MHE) rooted in Indian realities. Specifically, it seeks to: (i) critique the epistemological assumptions and cultural limitations of existing MHL models; (ii) generate qualitative insights from Indian mental health professionals and community stakeholders regarding what constitutes meaningful mental health learning; and (iii) propose a comprehensive operational definition of MHE that may guide future scale development and public health interventions.

2. Literature Review: Mental Health Literacy and Its Limitations

The concept of Mental Health Literacy (MHL) emerged from the work of Jorm and colleagues in the late 1990s, who defined it as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm *et al.*, 1997). Over time, this definition expanded to include six major components: (1) recognition of specific disorders or psychological distress; (2) knowledge of risk factors and causes; (3) knowledge of self-help interventions; (4) knowledge of professional help available; (5) attitudes that facilitate recognition and help-seeking; and (6) knowledge of how to seek mental health information (Jorm, 2000; Jorm *et al.*, 2006). MHL has since become a foundational framework in mental health promotion, informing educational campaigns, workplace interventions, and school-based programmes across several high-income countries (Jorm, 2005; Kutcher *et al.*, 2016; Wei *et al.*, 2013). Several studies have reported that MHL interventions, particularly those using multimedia, peer-based, or curriculum-integrated approaches, can significantly improve mental health knowledge, reduce stigma, and strengthen help-seeking intentions (Mendenhall & Frauenholtz, 2015; Pinfold *et al.*, 2005; Swami *et al.*, 2011; Yamaguchi *et al.*, 2013). Systematic reviews and meta-analytic evidence further support these findings, especially among adolescents and young adults, where MHL has been associated with earlier recognition of psychological distress and more proactive engagement with mental health services (Farrer *et al.*, 2013; Gulliver *et al.*, 2010). International organizations such as the World Health Organization (WHO, 1994) and UNICEF (2006) have also emphasized the importance of integrating mental health and life-skills education into school systems as a preventive public health strategy.

Despite its relevance, MHL has been criticized for its Western-centric orientation. Most MHL tools and frameworks were developed in Australia, the United

Kingdom, and the United States, where mental health is commonly understood through a biomedical lens focused on individual symptom recognition, diagnostic categories, and professional treatment pathways (Furnham & Swami, 2018; Kirmayer & Pedersen, 2014; Reavley *et al.*, 2018). Such models may overlook cultural idioms of distress, community-based healing systems, and religious or spiritual frameworks that remain central to mental health understanding in many non-Western societies (Aggarwal *et al.*, 2013; Raguram *et al.*, 1996). When implemented in low- and middle-income countries, MHL programmes often struggle to bridge the epistemological divide between modern psychiatric discourse and local belief systems (Jain & Jadhav, 2009; Kohrt & Hruschka, 2010; Summerfield, 2008). For example, in many rural Indian communities, psychological distress may be attributed to supernatural causes, karma, or family disharmony rather than to psychological or neurobiological disorders (Das & Rao, 2012; Padhy *et al.*, 2014). As a result, MHL initiatives that fail to engage with these explanatory models may not only prove ineffective but may also unintentionally alienate the very populations they are intended to support.

Moreover, the term "literacy" itself has been criticized for its hierarchical and instrumental connotations. It often reflects a deficit-based model in which experts "educate" supposedly "illiterate" populations, while neglecting experiential, emotional, and culturally grounded forms of knowledge (Brijnath, 2015; Kokanovic *et al.*, 2008). In communities marked by low formal education or historical marginalization, this may reinforce top-down educational approaches that lack contextual relevance and participatory legitimacy (Jacob, 2011; Vygotsky, 1978). Scholars have also questioned whether MHL adequately addresses the emotional and relational dimensions of mental health, including empathy, resilience, and moral reasoning, all of which are essential for genuine attitudinal and behavioural change (Davies, 2015; Seligman & Csikszentmihalyi, 2000).

Emerging scholarship has therefore called for more inclusive, dialogical, and culturally responsive frameworks. Concepts such as mental health promotion, emotional well-being education, and psychosocial competence have been proposed to better capture the holistic and values-based nature of mental health learning (Barry *et al.*, 2015; Sharma & Petosa, 2014; Ten Have *et al.*, 2009). This need is especially urgent in India, where mental health perceptions are profoundly shaped by linguistic diversity, religious worldviews, caste relations, and family structures (Kumar & Srivastava, 2015; Noddings, 2005; Patel & Kleinman, 2003). Although the National Mental Health Programme (Directorate General of Health Services, 2014) and the WHO's Mental Health Gap Action Programme (WHO, 2008) both acknowledge the importance of awareness generation and community engagement, they offer limited conceptual guidance on how such engagement should be understood and implemented at scale.

There is, therefore, a strong rationale for moving beyond Mental Health Literacy toward a broader and more contextually grounded concept of Mental Health Education (MHE)—one that is participatory, culturally embedded, and socially transformative. As conceptualized in this paper, MHE seeks to integrate the cognitive, emotional, and social dimensions of learning, while redefining what it means to be "mentally healthy" across diverse Indian settings. The key differences between Mental Health Literacy (MHL) and Mental Health Education (MHE) are presented in Table 1

Table 1. Key Differences Between Mental Health Literacy (MHL) and Mental Health Education (MHE)

Dimension	Mental Health Literacy (MHL)	Mental Health Education (MHE)
Origin	Western, biomedical tradition (Jorm *et al.*, 1997)	Indigenous, socio-cultural, pedagogical frameworks
Focus	Cognitive knowledge of mental disorders, recognition, help-seeking	Holistic learning: knowledge + emotional understanding + social values
Learning Approach	Information transmission (often didactic)	Dialogical, participatory, and experiential
Role of Culture	Often culturally neutral or universalist in assumptions	Deeply contextualized in local beliefs, languages, practices, and systems
Target Skills	Disorder recognition, stigma reduction, referral awareness	Critical thinking, emotional regulation, community empathy, inclusive attitudes
Assessment Tools	Standardized scales emphasizing individual-level metrics	Mixed methods: quantitative and qualitative; includes community narratives and relational indicators
Application Contexts	Schools, media campaigns, health literacy programs (mostly urban or institutional settings)	Community-based interventions, family structures, school curricula, peer support models

Dimension	Mental Health Literacy (MHL)	Mental Health Education (MHE)
Education Style	Expert-driven, often top-down	Co-created with communities, reflexive, aligned with lifelong learning principles
Limitations	May alienate or overlook non-biomedical worldviews; less suitable for collectivist cultures	Designed to integrate local epistemologies and enhance sustainability in culturally diverse environments

3. The Need for an Indigenous Framework: What Mental Health Education Offers

Although Mental Health Literacy (MHL) has provided an important starting point for engaging with mental health promotion, its limitations in non-Western contexts highlight the urgent need for a more culturally grounded and pedagogically inclusive framework. In the Indian context, where understandings of mental health are shaped by pluralistic knowledge systems—including Ayurveda, folk healing, spiritual traditions, and community-based ways of living—the continued reliance on a Western biomedical literacy model risks being reductionist and ineffective (Jain & Jadhav, 2009; Patel & Kleinman, 2003; Raguram *et al.*, 1996). Furthermore, India's vast sociolinguistic diversity, along with disparities in educational attainment and digital access, requires an approach that moves beyond clinical terminology and actively values local systems of meaning and knowledge (Das & Rao, 2012; Jacob, 2011; Kirmayer & Swartz, 2014).

Mental Health Education (MHE) emerges as a compelling alternative because it offers a more dialogical, integrative, and holistic orientation. Unlike MHL, which primarily emphasizes the cognitive acquisition of mental health knowledge, MHE understands learning as a transformative process that involves the mind, emotions, relationships, and the wider social environment. In this sense, education is not limited to the transmission of correct information; it also involves cultivating critical awareness, emotional resilience, social empathy, and ethical responsibility (Ten Have *et al.*, 2009; Vygotsky, 1978; Dewey, 1938). These dimensions are particularly relevant in Indian settings, where mental well-being is often understood in relation to family harmony, social obligations, and spiritual balance rather than only through individual symptom recognition (Bhugra *et al.*, 2016; Kohrt & Hruschka, 2010; Padhy *et al.*, 2014).

The pedagogical foundations of MHE may also be located within Indian traditions of dialogic and value-based education, particularly in the writings of Tagore and Gandhi, both of whom emphasized moral development, experiential learning, and social responsibility (Gandhi, 1951; Tagore, 1961). This orientation also resonates strongly with Paulo Freire's critique of the "banking model" of education and his vision of learning as a means of liberation and social transformation (Freire, 1974). From this perspective, MHE can be understood not as a narrow academic exercise, but as a socially responsive, ethically grounded, and community-rooted educational practice. It may therefore be enacted through storytelling, local idioms, group discussion, theatre, ritual practices, and shared lived experiences.

Importantly, framing mental health learning as education rather than literacy also makes space for the emotional and relational dimensions that are often neglected in biomedical frameworks. Shame, guilt, fear of exclusion, and social stigma are deeply embedded in the experience of mental distress in India, especially among marginalized caste groups, religious minorities, and gender-diverse populations (Math *et al.*, 2015; Nambi, 2005). An educational approach allows these emotional and ethical experiences to be acknowledged, named, and worked through collectively. It also creates space for integrating insights from positive psychology and health promotion—such as self-worth, hope, mindfulness, and meaning-making—which are increasingly recognized as relevant across culturally diverse settings (Choudhury & Kirmayer, 2016; Seligman & Csikszentmihalyi, 2000; Sharma & Petosa, 2014).

MHE also aligns well with recent shifts in national policy. India's National Education Policy 2020 emphasizes values-based, inclusive, experiential, and holistic education aimed at preparing learners not only for employment, but also for life, citizenship, and collective well-being (Ministry of Education, 2020). Integrating MHE into school curricula, teacher education, and community health platforms therefore presents a strategic opportunity to embed mental health awareness in ways that are both culturally meaningful and developmentally appropriate.

Mental Health Education (MHE), therefore, represents more than a semantic refinement of Mental Health Literacy. It marks a broader paradigm shift—from individual to collective, from biomedical to biopsychosocial-spiritual, and from information-centred to education-centred approaches. This philosophical foundation sets the stage for the conceptual framework and operational definition of MHE proposed in the next section.

4. Methodology

A qualitative research design using a thematic analysis approach was employed to empirically anchor the conceptualization of Mental Health Education (MHE) in the Indian context. A purposive

sample of 15 stakeholders - including clinical/ counselling psychologists (n = 5), community mental health professionals (n = 4), educators (n = 3), and public policy advisors from the health and education sectors (n = 3) participated in semi-structured interviews. Informed consent was obtained from all participants prior to their inclusion in the study. The stakeholders were informed about the purpose, procedures, potential risks, and benefits of the study, and their rights, including the right to withdraw at any time without penalty. Verbal informed consent was obtained and documented by the researchers before data collection commenced. Consistent with best practices in expert and purposeful sampling in qualitative health systems research, participants were selected based on their experience in grassroots mental health advocacy, educational systems integration, and culturally sensitive care (Palinkas *et al.*, 2015).

The interviews were conducted in English or regional languages, with the support of trained translators wherever required. They explored participants' perspectives on mental health knowledge, culturally embedded barriers to awareness, preferred modes of educational delivery, and the limitations of existing mental health literacy frameworks. In line with qualitative rigor standards for cross-cultural research, each interview was audio-recorded with prior consent, transcribed verbatim, and translated for analysis where necessary (Temple & Young, 2004). Each interview lasted approximately 45–60 minutes.

The data were analysed using Braun and Clarke's (2006) six-step thematic analysis framework in order to systematically identify recurring concepts, values, and sociocultural interpretations relevant to MHE. To strengthen reliability, two independent coders analysed the data, and differences were resolved through consensus-based discussion. NVivo 12 software was used to facilitate data organization, coding, and thematic management, consistent with qualitative research practice (Nowell *et al.*, 2017; Zamawe, 2015).

This study is an exploratory investigation aimed at developing an operational definition of mental health education using expert opinions obtained through structured interviews. No survey or intervention involving vulnerable populations was conducted. Ethical approval was not sought for this study as it involved voluntary participation of subject experts providing professional opinions, with no collection of sensitive personal data. All participants provided informed consent, and confidentiality and anonymity were maintained throughout the research process in accordance with standard ethical research practices.

5. Findings: Key Themes from Stakeholders Qualitative Insights Informing the Conceptualization of Mental Health Education

The qualitative feedback obtained from mental health professionals, educators, and community experts offered critical insights into how Mental Health Education (MHE) should be conceptualized within India's complex sociocultural landscape. Although formal responses were received from only a subset of the 30 professionals contacted, the thematic patterns that emerged from expert inputs and follow-up discussions were rich, consistent, and aligned with prior cross-cultural mental health scholarship (Creswell & Poth, 2018). Five major themes emerged from this consultative process:

5.1. The Need for a Culturally Grounded and Holistic Understanding

Experts emphasized that mental health education must extend beyond symptom recognition to include the broader ecological and cultural factors that shape mental well-being. These include family structures, religious beliefs, gender norms, caste-based discrimination, and poverty, all of which significantly influence how psychological suffering is understood in India (Jain & Orr, 2016; Patel & Kleinman, 2003). Participants stressed that distress is often expressed in relational, spiritual, or moral terms rather than through conventional clinical language, highlighting the importance of educational frameworks that respect such interpretations (Nichter, 2010; Raguram *et al.*, 1996).

5.2. Emphasis on Emotional and Social Competence

Mental health was consistently described by participants as a socially embedded phenomenon. Respondents highlighted the importance of fostering emotional literacy, empathy, and interpersonal sensitivity—capacities that are essential for psychological resilience and social cohesion in collectivist societies such as India (Noddings, 2005; Payton *et al.*, 2000). These competencies were seen as foundational to MHE and as necessary complements to factual knowledge about mental disorders and treatments.

5.3. Overcoming Internal and External Stigma

Both internalized and enacted stigma were identified as major barriers to disclosure, help-seeking, and recovery. Stakeholders argued that MHE should directly address discriminatory attitudes and harmful myths related not only to mental illness, but also to suicide, gender identity, and menstruation (Corrigan, 2004; Nambi, 2005; Padhy *et al.*, 2014). There was strong support for integrating myth-busting, open dialogue, and critical reflection into mental health education efforts, especially within family, school, and institutional contexts.

5.4. Integration With Legal, Policy, and Systemic Awareness

Experts further suggested that MHE should include awareness of patient rights, legal protections, national mental health initiatives such as the National Mental Health Programme (NMHP) and

District Mental Health Programme (DMHP), and access points such as helplines and public services (Directorate General of Health Services, 2014; Saxena *et al.*, 2007). Many participants viewed this systems-level knowledge as essential for enabling individuals to advocate for themselves and others within healthcare, legal, and community structures. This reflects a broader move from passive awareness toward civic participation and public accountability.

5.5. A Life-Practical and Action-Oriented Approach

Finally, respondents strongly advocated for a practical and life-embedded model of MHE. Beyond awareness alone, they emphasized the need to equip individuals with the skills to identify distress, provide basic psychological support, practice self-care, and seek professional help when necessary (Kutcher *et al.*, 2016; WHO, 2013). Participants also stressed that mental health education should not remain confined to academic settings, but should extend to homes, workplaces, religious spaces, and digital platforms.

Taken together, these themes point to the need for a culturally grounded, emotionally intelligent, and systemically aware framework for mental health education in India. They directly informed the operational definition of MHE proposed below.

6. Proposed Operational Definition of Mental Health Education (MHE)

Drawing on the thematic synthesis of stakeholder perspectives and a critical review of existing Mental Health Literacy (MHL) frameworks, we propose the following operational definition of Mental Health Education (MHE), specifically tailored to the Indian sociocultural context: Mental Health Education is a dynamic process that enables individuals and communities to recognize and respond to psychological distress, address internalized and social stigma, engage meaningfully with mental health systems, and develop the emotional and social competencies necessary for living a stable, meaningful, and socially connected life. It promotes culturally grounded awareness, knowledge, values, attitudes, and practical skills needed to understand, manage, and support mental well-being at both individual and collective levels.

This definition intentionally extends beyond conventional literacy-based models in several important ways.

First, it acknowledges mental health as both an individual and a social concern. MHE integrates cognitive understanding with affective dimensions such as empathy, emotional regulation, and values clarification. Research in positive psychology and social-emotional learning has shown that emotional competence is a key contributor to mental well-being and adaptive functioning (Choudhury & Kirmayer, 2016; Payton *et al.*, 2000).

Second, unlike many conventional MHL models, MHE explicitly recognizes the importance of culturally embedded factors such as family roles, caste relations, spiritual traditions, and collective healing practices, all of which strongly influence mental health perceptions and behaviors in India (Jain & Orr, 2016; Nichter, 2010; Raguram *et al.*, 1996). This cultural inclusion is essential for improving the relevance, acceptability, and impact of mental health interventions across diverse Indian communities.

Third, MHE is not limited to awareness alone. It includes the ability to take timely and culturally appropriate action, whether through psychological first aid, help-seeking, self-care, or participation in preventive and supportive practices. This aligns with community-based models of mental health promotion that prioritize empowerment, participation, and behavior change (Kutcher *et al.*, 2016; WHO, 2013).

Fourth, the model recognizes that individuals must also be prepared to engage with mental health systems, legal protections, public entitlements, and policy initiatives. Awareness of rights, programmes, and access pathways helps people not only obtain support, but also advocate for themselves and for others. This civic dimension expands the democratic and socially transformative potential of mental health education (Directorate General of Health Services, 2014; Saxena *et al.*, 2007).

This operational definition serves as the conceptual foundation for the development of the Indian Mental Health Education Scale (IMES). The dimensions of the scale, currently under validation, are directly aligned with this framework and include domains such as understanding psychological and physiological functioning, identifying stressors, recognizing stigma, seeking help appropriately, and being aware of mental health policies and rights.

By situating MHE within a holistic, action-oriented, and culturally responsive framework, this paper seeks to advance a new paradigm for mental health learning—one that is not only psychometrically sound, but also socially just, ethically grounded, and contextually meaningful.

7. Implications for Practice and Policy

The reconceptualization of Mental Health Literacy (MHL) into a culturally grounded framework of Mental Health Education (MHE) carries significant implications for both practice and policy within India's diverse and evolving mental health landscape. By adopting an education-centred, values-driven, and socially embedded approach, MHE offers a means of democratizing mental health knowledge and strengthening community resilience beyond the limited boundaries of clinical and urban settings (Barry & Clarke, 2011; Kutcher *et al.*, 2016; Ministry of Education, 2020).

In educational practice, MHE aligns closely with the goals of India's National Education Policy 2020, which emphasizes holistic, experiential, and values-based learning aimed at nurturing well-rounded

individuals (Ministry of Education, 2020). Mental health education can be integrated into school and college curricula through context-sensitive modules that address not only mental disorders, but also emotional intelligence, ethical reasoning, stigma reduction, and stress management (Seligman & Csikszentmihalyi, 2000; Sharma & Petosa, 2014). Teacher education programmes can also be revised to include MHE-oriented training, enabling teachers to function as first-line gatekeepers for the early identification and support of psychological distress (Ramaswamy *et al.*, 2018; Saxena *et al.*, 2014).

Within community mental health programming, MHE provides a framework for culturally relevant interventions tailored to India's multilingual, religiously diverse, and socioeconomically stratified communities. Training community health workers—such as ASHAs, ANMs, and peer counsellors—in MHE content can facilitate the use of participatory methods such as storytelling, folk media, and local idioms of distress to communicate mental health knowledge in ways that are culturally meaningful and socially accessible (Hall & Midgley, 2004; Kohrt & Hruschka, 2010; Padhy *et al.*, 2014). Such a community-based orientation ensures that mental health learning remains grounded in lived realities and reflects the relational nature of well-being in collectivist societies.

At the policy level, institutionalizing MHE may help bridge the persistent awareness–action gap that has limited the effectiveness of initiatives such as the National Mental Health Programme (NMHP) and the District Mental Health Programme (DMHP) (Directorate General of Health Services, 2014; WHO, 2008). Integrating MHE into public awareness campaigns, Panchayati Raj institutions, and workplace mental health frameworks could shift the national conversation from reactive treatment toward proactive mental well-being promotion. In addition, the operational framework proposed in this paper offers a basis for developing culturally grounded assessment tools, such as the Indian Mental Health Education Scale (IMES), which may be used to assess awareness, stigma, and engagement at the population level (Jorm, 2005; Saxena *et al.*, 2007).

Adopting MHE as a national educational and public health strategy therefore holds transformative potential for India's mental health ecosystem. It enables individuals and communities not only to know about mental health, but also to engage with it, respond to it, and advocate around it. In doing so, it reframes mental health from being solely a medical concern to being a shared social responsibility embedded in everyday life and collective well-being.

8. Final Thoughts

This paper has argued for a fundamental rethinking of how mental health is understood, communicated, and acted upon in the Indian context. Although Mental Health Literacy (MHL) has served as a useful starting point for global mental health advocacy, its limitations—particularly its Western biomedical framing, individualistic orientation, and emphasis on cognitive knowledge transfer—necessitate the development of a more holistic and culturally congruent alternative. Through a synthesis of critical literature and qualitative insights from mental health professionals, this paper has proposed a comprehensive operational definition of Mental Health Education (MHE) that incorporates knowledge, attitudes, emotional competencies, stigma reduction, and community engagement.

MHE is not merely an academic rebranding of MHL; it represents a paradigm shift that places learning, context, and action at the centre of mental health promotion. By grounding this framework in India's sociocultural realities and educational values, MHE opens the possibility of more inclusive, participatory, and effective mental health interventions. It also provides the conceptual and practical foundation for the Indian Mental Health Education Scale (IMES), which seeks to assess mental health understanding in ways that are relevant to the populations it is designed to serve.

The adoption of MHE carries important implications for educational systems, community health initiatives, and policy frameworks alike. It positions mental health not as a distant clinical issue, but as a lived, learnable, and collective human experience. As India moves toward a future that places greater emphasis on mental well-being, MHE offers a pathway that is not only conceptually sound, but also culturally responsive, socially just, and practically meaningful.

Author Contributions

All authors contributed significantly to this work.

Si Pa Elantamil Komahan: Conceptualization and Design, Analysis and Interpretation, Draft of Original manuscript.

Dr Sunita Dhenwal: Review of draft manuscript, Supervision.

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