

What Does It Take to Heal? Impact of the Juveniles Accessing Mental Health Services (JAMS) Program on Youth in Institutional Care in India

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Note: Authors are listed alphabetically with the faculty mentors listed last.

Cover photo: A boys’ CCI building in Sivaganga, Tamil Nadu (photo by Katie Langmore)



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Executive Summary

Institutionalized youth represent one of India's most underserved populations in mental health policy. Youth residing in child care institutions (CCIs) face compounding psychological stressors, including trauma, family separation, and social stigma. When children leave CCIs, their mental health is fundamental to their ability to build healthy relationships, regulate their emotions, and effectively transition into adulthood. However, institutionalized youth remain largely excluded and underrepresented from national mental health programs.

To address these challenges, Schizophrenia Research Foundation (SCARF) India, a local nongovernmental organization, developed the Juveniles Accessing Mental Health Services (JAMS) program. Delivered across the Indian states of Tamil Nadu and Odisha, JAMS is a community-focused initiative that supports young people living in CCIs through a three-pronged approach to mental health: enhance the mental health literacy of CCI staff and children, create youth-friendly spaces, and improve screening and partnerships with local mental health services.

Our research interrogated how and to what extent the JAMS program improves the access and outcomes of youth mental health support in CCIs in India. Despite barriers such as resistance to change, stigma surrounding mental health, directive organizational structures within CCIs, and limited public mental health infrastructure, JAMS plays an important role in reducing mental health stigma, improving staff attitudes, and strengthening pathways to care for young people.

The JAMS program offers valuable insights for other institutional care contexts to adopt educational and collaborative approaches to reduce mental health stigma and strengthen mental health outcomes. Our findings highlight five key lessons applicable for

mental health interventions within similar settings. Supporting children's mental health starts with the adults around them; cascading training models such as Training of Trainers (ToT) are effective strategies for delivering at scale within resource-constrained environments; embedding lived experience into program design and implementation is crucial; designing around rather than against institutional constraints holds potential for greater impact; and sustainable mental health stigma reduction requires policy embedding.

Context: Youth Mental Health in Institutional Care in India

India is home to the world's largest population of children and adolescents, with young people accounting for a substantial proportion of the country's population. Estimates suggest that around 20 million children are orphaned or destitute out of a total child population of 472 million, underscoring the scale of challenges facing vulnerable young people.¹ Extreme poverty, widening socioeconomic inequality, and adverse childhood experiences (ACEs) continue to place many children at a heightened risk of:

- neglect and exploitation
- poor educational outcomes
- emotional and behavioural difficulties
- substance use disorders
- engaging in criminal activity
- developing mental health conditions.

¹ Evergreat Wanglar, "Assessment of Child Care Institutions in India: Perspectives from Children Who Have Transitioned from Institutions," *Child and Family Social Work* 31, no. 1 (2026): 214–24.

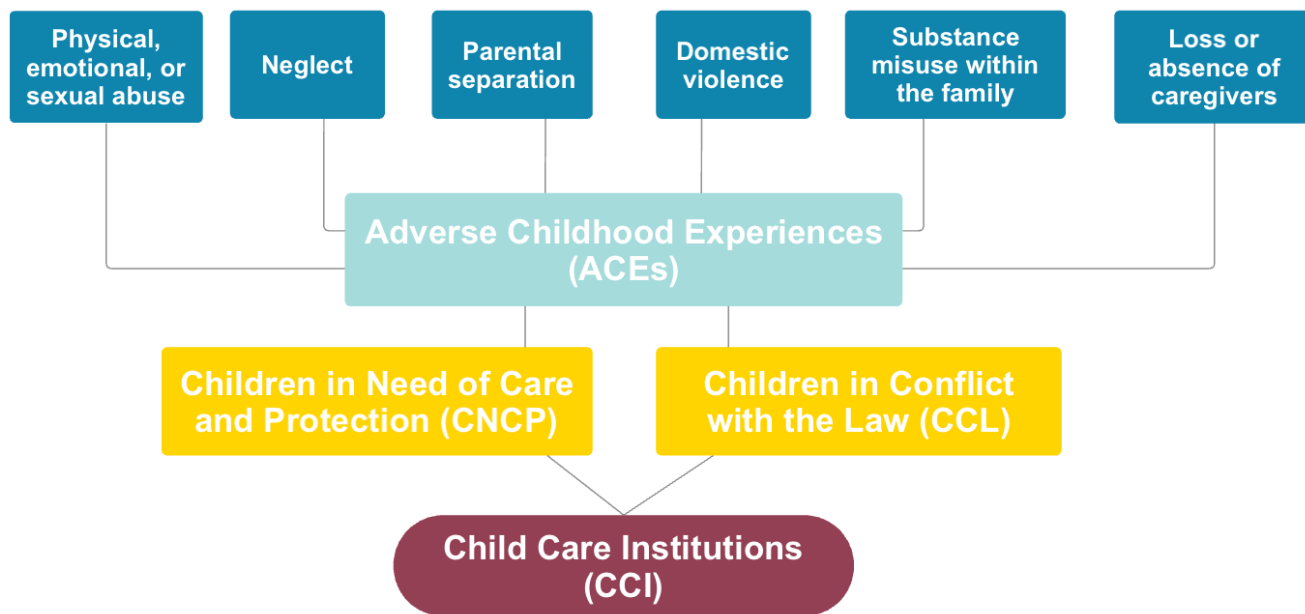


Figure 1. A child's journey into a child care institution (CCI)

These are the circumstances that increase the likelihood of young people entering child protection and juvenile justice systems. In India, this means residing in institutional care — called a child care institution (CCI) — until they turn 18 years old.² Ultimately, it is this journey that shapes their long-term development and well-being. Addressing these challenges is critical not only for child welfare but for progress on India's and the United Nation's development goals.

Evolution of Child Protection in India

India's child protection framework has transformed in recent decades. Historically, children facing significant challenges were treated as offenders or as recipients of welfare. With the turn of the 21st century, India moved toward a rights-based approach underpinned by the United Nations Convention on the Rights of the Child (UNCRC).³ A significant milestone in this evolution by the Government of India was introducing the *Commissions for Protection of Child Rights (CPCR) Act, 2005*. This was the first piece of legislation to explicitly adopt the

comprehensive legal definition of child rights from the UNCRC and create an institutional oversight mechanism to enforce them.

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The act laid the foundation for the *Juvenile Justice (Care and Protection of Children) Act, 2015*. This legislation mandated the compulsory registration

² Amod K. Kanth, “Children in Need of Care and Protection — Their Rights Deserve the First Call,” in *Child Protection in India: Assessing Multi-disciplinary Response Mechanisms*, edited by Paromita Chatteraj (New York: Routledge, 2025), 13–38.

³ Kanth, “Children in Need,” 14.



Figure 2. A girls' CCI building in Sivaganga, Tamil Nadu (photo by Shrreyas Saluja)



Figure 3. A boys' CCI building in Sivaganga, Tamil Nadu (photo by Katie Langmore)

of all CCIs to establish higher standards of care that address immediate safety needs and provide access to basic services for children in conflict with the law or children in need of care and protection.⁴ Recent government surveys indicate that nearly 9,600 CCIs across India house approximately 370,000 children, though distribution is highly uneven across states.⁵

Child Care Institutions and Mental Health

Given the nature of a child's referral into institutional care, most children are exposed to significant psychological distress before they ever enter CCIs.⁶ They have complex mental health and psychological support needs in addition to the CCIs addressing children's immediate safety needs and access to basic services.

Research suggests that many children residing in CCIs experience feelings of insecurity, loneliness, grief, and emotional distress linked to previous trauma.⁷ Studies have also found high rates of mental health concerns among youth in institutional settings, including anxiety, depression, behavioural difficulties, trauma-related symptoms, and emotional dysregulation.⁸ For instance, one study across seven CCIs in Tamil Nadu and Odisha found that at least one adverse childhood experience (ACE) was confirmed by 86.7 per cent of children, with 71.7 per cent reporting at least one instance of bullying, and approximately 70 per cent of the juvenile population studied experiencing mental health issues.⁹ A separate study of adolescent girls across five CCIs in Goa and Mumbai found a 17 per cent prevalence of moderate-to-severe depression. It identified 52 per cent of girls as requiring a referral to a mental health

4 Evergreat Wanglar, "Child Care Institutions in India: Investigating Issues and Challenges in Children's Rehabilitation and Social Integration," *Children and Youth Services Review* 122 (2021) [DOI](#); Kanth, "Children in Need," 14.

5 Shiva Prakash Srinivasan, Chiranjeevi Arumugam, Ananya Anandan, and Padmavati Ramachandran, "Do Past and Present Adverse Experiences Impact the Mental Health of Children? A Study Among Children in the Juvenile Justice System in India," *Indian Journal of Psychiatry* 65, no. 8 (2023): 869–77.

6 Ibid., 870.

7 Wanglar, "Assessment of Child," 219.

8 Aijaz Ahmed Bhat, Sadaqat Rahman, and Nasir Mohammad Bhat, "Mental Health Issues in Institutionalized Adolescent Orphans," *International Journal of Indian Psychology* 3, no.1 (2015): 57–77.

9 Srinivasan et al., "Do Past and Present," 869.

specialist, well above rates in the general adolescent population.¹⁰

At the same time, children's experiences of institutional care are not universally negative. Some children report feeling safer in CCI than they did in previous home environments. Nevertheless, the literature highlights the opportunity to enhance mental health supports that address children's psychosocial well-being alongside their physical care and protection.¹¹

According to the *Juvenile Justice Act 2015*, CCIs must provide high-standard safety for children who fall into two categories: Children in Conflict with the Law (CCL) and Children in Need of Care and Protection (CNCP). CCL refers to children who are suspected or proven to have committed a crime and are not yet 18 years old at the time of the crime, while CNCP refers to children who face adverse conditions such as abandonment, vulnerability to drug abuse, trafficking and child labour, abuse, mental illness, or terminal illness, and have no one to safely support their care.¹² These children range in age from infancy to 18 years old.

Youth within Child Care Institutions in India as Hard to Reach

"I have to face children with the most traumatic experience ... These children are vulnerable." (master trainer)

"Working with the vulnerable community is a legal landmine." (JAMS program designer)

Conversations with the master trainers and JAMS program designers working with children at child care institutions (CCIs) add important nuance to the data. They reveal that children in these institutions are vulnerable, not only from a policy perspective, but in the eyes of the society around them. These children have the same potential to thrive as any other children, yet the stigma society attaches to them limits their opportunities.

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The children arrive carrying adverse childhood experiences that make them vulnerable before they even enter a CCI. Society's perception of their background attaches a stigma that pushes them further into invisibility.

The children arrive carrying adverse childhood experiences that make them vulnerable before they even enter a CCI. Society's perception of their background attaches a stigma that pushes them further into invisibility. With a limited family support system and stigma working against them, children become dependent on government protection and CCIs for their basic needs. It is this combination — dependency layered with stigma and trauma — that makes CNCP and CCL not just vulnerable, but among the hardest to reach by the system, including the government, mental health programs and professionals, and even society.

10 Priyanka Halli, Prachi Khandeparkar, Suman Kanougiya, and Bernadette Pereira "An Exploratory Study of the Prevalence of Mental Health Symptoms Among Girls Living in Five Childcare Institutions in Goa and Mumbai," *Clinical Epidemiology and Global Health* 9 (2021): 179–83.

11 Neethu Prakashan and Bidisha Banerjee, "Expressing Through Creativity: An Intervention for the Mental Health of Children Living at Child Care Institutions in Goa, India," *Residential Treatment for Children and Youth* 42, no. 1 (2024): 142–69.

12 Shiva Prakash Srinivasan, Alok Datta Behra, Chiranjeevi Arumugam, et al., "Juveniles Accessing Mental Health Services: A Novel Approach to Enhance Mental Health Among Vulnerable Adolescents," *Journal of Indian Association for Child and Adolescent Mental Health* 19, no. 2 (2023): 143–51.

Despite the guidance of the *Juvenile Justice Act 2015*, implementation and technical gaps remain. These gaps result in unfavourable living conditions and a lack of well-being for the children. Many exit the CCI without a stable family to return to and without sufficient transitional support. For these children, leaving the CCI does not mean stepping into freedom but rather stepping into another form of invisibility and vulnerability.

Stigmatization and Institutional Barriers

CCL and CNCP face compounding barriers produced by two intersecting dimensions: pervasive stigmatization and institutional barriers. These intersecting barriers produce a population that becomes structurally rendered invisible.¹³

Stigmatization — the neglected and the deviant.

Stigmatization operates at both economic and sociocultural layers. Most CCI residents are drawn from families in extreme material deprivation so institutionalization of children in this context means they are already carrying the developmental and psychosocial consequences of economic disadvantage,¹⁴ and that economic stigma does not resolve upon exit because after-care provisions are weak and unsystematic.¹⁵

On a sociocultural level, CNCP and CCL bear different marks of stigma. Most CNCPs are the survivors of abuse or trafficking, which can lead others to view them primarily through the lens of their trauma and to perceive them as “damaged.” These children are dependent on the state, and reintegration with the community is challenging because they can be perceived as broken or neglected.¹⁶ By contrast, CCLs are institutionalized

because of alleged criminal activity. Their stigma is criminalizing and fear-based, where they are marked as dangerous and morally defective.¹⁷ For CCLs, the barrier of reintegration is social rejection, which excludes them from participating in society. One study noted that boys have higher representation in the CCL group, while girls have higher representation in the CNCP group in CCIs. This representation is not arbitrary — it reflects deeper societal norms in which boys are criminalized and girls are “rescued.”¹⁸ The differing stigmas between CNCP and CCL shape how staff interact with them, how communities receive them upon reintegration, and how they come to internalize their institutionalized identity.¹⁹

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Institutional barrier — Can a child activate their own rights? The *Juvenile Justice Act, 2015* is considered progressive and comprehensive in intent. It mandates Child Welfare Committees to exercise the rights of children to receive care, rehabilitation, and reintegration support. In practice, however, resourcing challenges result in implementation challenges. When infrastructure is chronically under-resourced, the legal framework becomes less a

13 Crenshaw Kimberle, “Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color,” *Stanford Law Review* 43, no. 6 (1991): 1241–99.

14 Kanth, “Children in Need,” 27.

15 Wanglar, “Child Care Institutions,” 8.

16 Kanth, “Children in Need,” 27.

17 Devi Sekar and Mohanraj Bhuvanewari, “The Intricate Dynamics of Personality, Emotional Intelligence, and Family in Adolescent Tendencies towards Delinquent-Prone Behavior,” *Journal of Human Behavior in the Social Environment* 36, no. 4 (2026):189–200.

18 Srinivasan et al., “Do Past and Present,” 873.

19 Wanglar, “Child Care Institutions,” 9–10.

guarantee of what will happen than a description of what should happen.

This resourcing gap points to a deeper structural design problem. In the absence of parents, the guardian that serves as an intermediary is the institution itself. The law protects children *through* institutions rather than *from* them, so the framework that exists to protect them is administered by the same institution that may have an interest in limiting scrutiny.

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How stigmatization and institutional barriers compound. Stigmatization actively works against the children’s legal protection, which is how the barriers compound their marginalization. The legal framework’s functioning assumption that children and families would seek help through official channels if they need it clashes with societal stigmas leading to neglect of the very indicators of distress. Children in CCIs who have internalized the stigma of institutionalization are unlikely to invoke their rights through a formal process administered by those who control their daily lives.

A child can hold legal rights-holder status under the *Juvenile Justice Act, 2015* and still remain invisible to the support meant to reach them. No matter what, a child is dependent on intermediaries to access the help that they need. With a formal rights framework built on the assumption that children can self-advocate, the system they depend on will fail to help them to access rights they are supposed to have.²⁰

About the Intervention: Juveniles Accessing Mental Health Services (JAMS) Program

Despite progressive legislative reforms, significant challenges remain in the delivery of mental health services within child care institutions (CCIs). Many CCIs face limited funding, workforce shortages and high staff turnover, limited access to specialized mental health services, and mental health stigma. Furthermore, several CCI staff have limited or no formal mental health training or understanding, limiting their ability to recognize and refer young people experiencing mental distress. Together, these barriers reduce opportunities for the early identification and treatment of mental health conditions among institutionalized youth.

Recognizing this gap, the Schizophrenia Research Foundation (SCARF), a nonprofit mental health organization based in Chennai, India, developed the Juveniles Accessing Mental Health Services (JAMS) intervention. JAMS is a low-intensity, three-pronged program developed specifically for resource-constrained settings, such as CCIs in India, where access to formal psychiatric services is limited.

The intervention consists of three key components:

- Youth-friendly spaces (YFS) for adolescents in CCIs
- Mental health literacy for CCI staff and administrators

20 Martha Albertson Fineman, “The Vulnerable Subject: Anchoring Equality in the Human Condition,” *Yale Journal of Law and Feminism* 20, no. 1 (2008): 1–23.

- Mental health screening and partnerships with local mental health services.

JAMS supports adolescents aged 12 to 17 years and provides a model of mental health support for young people in institutional care. The program was co-designed by psychiatrists together with adolescents living in CCIs to ensure that the model, delivery, tools, and materials were informed by both professional and lived experience.

The first component of the program is youth-friendly spaces (YFS) — dedicated spaces within each CCI where adolescents participate in mental-health-related activities. These include leisure activities like crafts, games, and experiential sessions focused on well-being, time management, social connection, and maintaining positive mental health. The aim is to support emotional regulation, and build resilience and autonomy while providing a safe, relaxed space for the adolescents — a space that feels different from a classroom or counselling room.

SCARF developed a manual for CCI staff and children outlining how YFS should be established and facilitated, including suggested activities and session plans. As part of this component, SCARF also developed six animation videos covering trauma, substance use, depression, and seeking help to improve children’s mental health literacy. These videos are accompanied by a guided discussion to reinforce understanding. Children can join organized activities or use the space for recreation. Older children either volunteer or are selected to help run the space, support younger peers, and create an inclusive environment, fostering leadership and peer support.

The second component aims to improve mental health literacy among CCI staff and administrators. They receive 12 hours of training across six two-hour sessions using case studies and role play. The training covers foundational mental health concepts, recognizing signs and symptoms of mental distress, effective communication with children, and responding appropriately to emotional or behavioural crises within CCIs. JAMS is the first program specifically designed to improve staff understanding of mental health within CCIs.

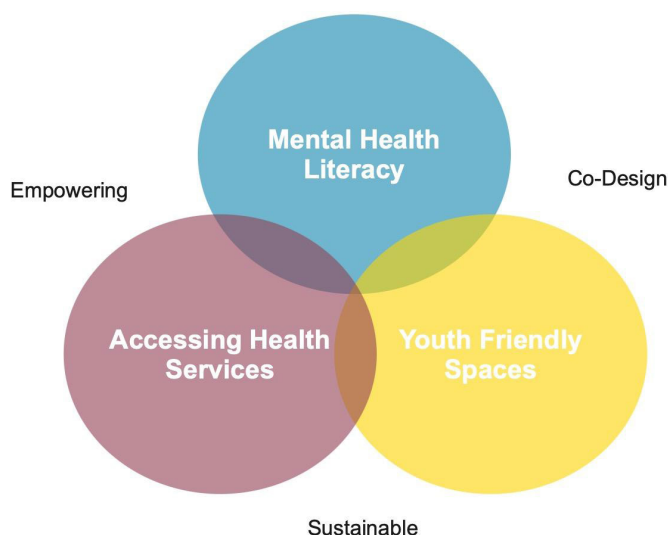


Figure 4. Overview of the JAMS model

A major change introduced in the second phase of the program, JAMS 2.0, was the adoption of a master trainer model to support implementation at scale. During the initial pilot, JAMS 1.0, SCARF staff delivered training directly to CCI staff. However, this approach became difficult to sustain as the program expanded. Under JAMS 2.0, the program staff in discussion with government agencies identified district-level “master trainers” who attended a two-day learning program covering training content, facilitation methods, and an opportunity to practise delivering the sessions. These master trainers were then responsible for delivering the training within their districts and received an honorarium for each CCI. JAMS 2.0 also introduced a self-care module to support CCI staff well-being and reduce burnout.

The final component of JAMS involves mental health screening and strengthening links between CCIs and local mental health services. All adolescents between the ages of 12 and 17 were screened for identifiable and treatable mental health conditions using a standardized self-report screening tool (Strengths and Difficulties Questionnaire). Following screening, children assessed as requiring additional support were identified to CCI administrators, who could facilitate referrals to appropriate mental health services if required. The program introduced a stepped-care support model, a commonly used framework that offers patients the least intensive method of treatment, escalating to more intensive

support as needed.²¹ The first point of help was trained older child volunteers in the youth-friendly spaces, followed by mental-health-trained CCI staff. Where additional help was needed, children were referred to local mental health services.

This program was piloted across seven CCIs in the Indian states of Tamil Nadu and Odisha between April 2021 and September 2023. These states were chosen for their highest prevalence of CCIs relative to other Indian jurisdictions. Four CCIs worked with CNCP and three with CCL. During the pilot, 312 adolescents were screened, while 70 staff members and 22 administrators received training. The intervention's effectiveness was assessed using validated pre- and post-intervention well-being measures collected six months after implementation. Across participating institutions, there was a statistically significant increase of 20.6 points on the Warwick-Edinburgh Mental Wellbeing Scale, a 1.7-point reduction on the Perceived Stress Scale, and a 0.5-point increase on the Mental Health Knowledge Schedule.²² The intervention proved effective in enhancing adolescent well-being and reducing stress, while simultaneously building mental health knowledge.

Following the successful pilot, JAMS 2.0 was implemented between July 2024 and June 2026 with the goal of scaling to four new districts each in Odisha and Tamil Nadu. Master trainers were to be trained across all eight districts, with direct intervention planned in 16 CCIs (two in each new district). Capacity was strengthened by the introduction of the master trainer model, closer partnerships with the government to improve sustainability, and collaborations with external organizations to extend the program into other states and districts.

By integrating mental health promotion, early intervention, and capacity building within existing child protection structures, JAMS addresses a critical gap within institutional care settings. The program recognizes that improving mental health outcomes

requires more than individual clinical interventions — it also requires supportive institutional environments, informed caregivers, and systems capable of responding to children's diverse emotional and psychological needs.



Figure 5. The Reach Alliance University of Melbourne team with the Schizophrenia Research Foundation (SCARF) India team (photo by Galuh Valencia)

About Our Research

This ethnographic case study was conducted by a team of six student researchers from the Reach Alliance team at the University of Melbourne, in partnership with the Schizophrenia Research Foundation (SCARF) in India. Guided by a collaborative research approach, we sought to understand how and to what extent the Juveniles Accessing Mental Health Services (JAMS) program improved the access and outcomes of youth mental health support in the target child care institutions (CCIs). By answering this research question, we

21 Anthony Jeitani, Paul P. Fahey, Michael Gascoigne, Abha Darnal, and David Lim, "Effectiveness of Stepped Care for Mental Health Disorders: An Umbrella Review of Meta-Analyses," *Personalized Medicine in Psychiatry* 47 (2024): 100140.

22 Shiva Prakash Srinivasan, Alok Datta Behera, Chiranjeevi Arumugam, et al., "The Effect of a Low Intensity Intervention on the Wellbeing of Children in the Juvenile Justice System in India: Results from a Pilot Study," *Asian Journal of Psychiatry* 108 (2025): 104491.

aimed to create actionable insights regarding how similarly underserved young people might achieve better outcomes at such a critical juncture in their lives.

Relevant SDGs

Our research on the JAMS program focuses on the following United Nations Sustainable Development Goals.



- **SDG 3 good health and well-being** — by promoting mental health support
- **SDG 4 quality education** — by enabling improved engagement and learning outcomes
- **SDG 10 reduced inequalities** — by addressing systemic disadvantage among institutionalized youth
- **SDG 16 peace, justice and strong institutions** — by strengthening child protection systems and institutional accountability within CCI and generating evidence to inform more transparent, rights-based governance of alternative care systems for institutionalized youth

Pre-Fieldwork Preparation and Co-Design

Before travelling to Tamil Nadu, we undertook rigorous training to prepare for culturally sensitive and ethical fieldwork. The research design involved an iterative process, shaped with input from SCARF representatives. This foundational work ensured that our research questions and methodologies were developed in partnership to be respectful, relevant, and of genuine value to the community.

Fieldwork Methodology

During our week-long fieldwork in Tamil Nadu, we conducted three focus group discussions with 15 young people (Children in Need of Care



Figure 6. The Reach Alliance University of Melbourne team (photo by Erik Nadir)

and Protection — CNCP only) and several semi-structured interviews with 10 adult participants, enabling a combination of individual and collective insights to emerge. Our study engaged 25 participants across four groups:

- **SCARF staff:** We interviewed staff who implemented the JAMS intervention to understand program design, implementation challenges, lessons learned, and future opportunities for youth mental health support.
- **Youth residing in CCIs:** Young people aged 12 to 17 residing in CCIs where JAMS operates participated in focus group discussions. Rather than being direct recipients of clinical intervention, these young people live and interact daily with staff who have undergone JAMS mental health literacy training. Discussions explored whether the young people had observed changes in how CCI staff engaged with them, whether they felt more supported, and how mental health was understood and talked about within their CCI.
- **CCI staff:** Because all CCI staff undertook the mental health training regardless of their role, we interviewed both administrative and front-line staff. These conversations focused on the training design and delivery, how staff mental health literacy had developed across iterations of the program, observed changes in staff behaviour and confidence, and the challenges of



Figure 7. The research team's introductory meeting with staff at a girls' CCI in Sivaganga, Tamil Nadu (photo by Erik Nadir)



Figure 8. A mural on the wall of a boys' CCI building in Sivaganga, Tamil Nadu (photo by Katie Langmore)

embedding mental health awareness sustainably within institutional settings.

- **Government officials:** Representatives from relevant district-level government bodies participated in semi-structured interviews exploring the youth mental health and child protection policy environment, their awareness of JAMS, and their views on its potential to scale across CCIs.

Data Analysis and Community Validation

Following the fieldwork, we conducted a thematic content analysis of the focus group discussions and interview transcripts to identify any recurring patterns relating to the reach, accessibility, implementation, and perceived impact of the JAMS program. This enabled us to identify common experiences, challenges, and opportunities for improvement across stakeholder groups. We also shared our preliminary findings with the implementing organization, SCARF, to cross-check our findings and incorporate their feedback where appropriate.



Figure 9. Translation of focus group discussion data with the interpreter team (photo by Erik Nadir)

Impact: Mental Health Literacy for Staff

The staff mental health literacy component was designed to sensitize all child care institution (CCI) staff, from administrators, wardens, and



Figure 10. An interview with a counsellor at a boys' CCI in Sivaganga, Tamil Nadu (photo by Erik Nadir)



Figure 11. An interview with a government representative at a girls' CCI in Sivaganga, Tamil Nadu (photo by Erik Nadir)

superintendents to front-line staff such as cooks and security guards, about mental health in general and about children and adolescents in particular. Its primary aim was to strengthen caregivers' capacity to recognize, respond to, and appropriately refer children experiencing mental health challenges. Although staff play a central role in caring for young people in CCIs, many have limited formal mental health training and sometimes hold misconceptions about mental illness that influence how they view children's behaviour and emotional needs.

The training therefore sought to challenge these misconceptions while equipping staff with the knowledge and confidence to recognize emotional and behavioural difficulties and make appropriate referrals to counsellors. The 12-hour structured training program covered communicating with children, youth mental health, mental illnesses and neurodevelopmental disorders, emotional and behavioural problems, and strategies for managing these concerns.

Implementation and Findings

Building staff knowledge and confidence.

This program is the first intervention to focus on improving staff mental health literacy in institutional settings. This is particularly important because CCI staff interact with the children daily while CCI counsellors are contractual. However, interviews with JAMS program designers revealed that many staff have little knowledge about mental health, making this a critical gap to address, given the vulnerability

of the young people they support. Prior to the training, staff noted in their interviews that they often interpreted challenging behaviours as an intentional act leading to "negative" interactions with them. Following the training, many described viewing these behaviours through a mental health lens and recognizing that such behaviours might reflect underlying emotional or psychological difficulties. This made staff more empathic and supportive. Across interviews, staff consistently described the training as informative and useful, noting that it improved their understanding of mental health and ability to recognize signs and symptoms of mental health concerns.

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Across interviews, staff consistently described the training as informative and useful, noting that it improved their understanding of mental health and ability to recognize signs and symptoms of mental health concerns.

Importantly, JAMS 2.0 introduced a self-care component for staff which is critical considering that many staff reported feeling stressed and emotionally

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The training successfully translated increased mental health knowledge into practical changes in staff behaviour by improving their confidence in recognizing concerns and facilitating appropriate referrals.

exhausted due to the long hours and demanding nature of supporting these children while meeting their own personal and administrative demands. The JAMS program designers highlighted that they added this component in response to staff feedback, citing that after gaining initial mental health literacy regarding the children, staff wanted to better learn to care for their own well-being alongside that of others.

Strengthening recognition and referral practices.

Several staff reported that the training increased their confidence in recognizing mental health concerns, engaging in conversations with children — including those showing signs of mental distress — and referring them to appropriate support. One practical tool that participants highlighted was the traffic light system, which provided a simple framework for categorizing the severity of children’s mental health presentations and determining the appropriate response. The framework helped the staff to distinguish between situations when the children were able to self-regulate, those in which staff were able to support them, and those requiring immediate referral to a mental health professional.

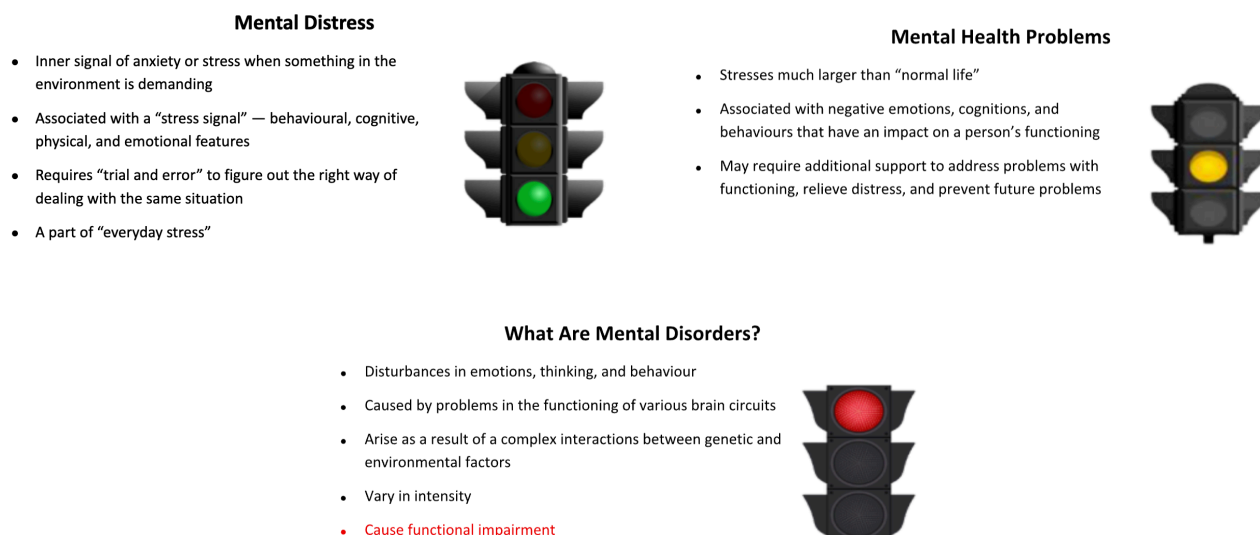
One cook explained that she had noticed when children were eating less or appeared emotionally withdrawn but she described being “afraid of triggering them as they are sensitive,” fearing she might make the situation worse and overstep her role. Following the training, she said that she felt “more voluntary in her actions,” which often encouraged the youth to open up and enabled her to refer those who required further support.

Similarly, a teacher described becoming more attentive to behavioural changes, such as children becoming unusually withdrawn or angry, and reported these to the counsellor. She noted that this was not something she would have done before the training. These examples suggest that the training successfully translated increased mental health knowledge into practical changes in staff behaviour by improving their confidence in recognizing concerns and facilitating appropriate referrals.

Improving scalability. The introduction of the master trainer model in JAMS 2.0 was a significant strength that improved program scalability. Rather than relying on Schizophrenia Research Foundation (SCARF) staff to deliver training across all districts, government-appointed master trainers completed an intensive two-day training before delivering the program to CCIs within their districts. This model reduces reliance on SCARF and makes the program more sustainable for future government adoption. It also allows a relatively small group of master trainers to train a larger workforce, making it more feasible to expand the program across other states and districts nationwide. These master trainers located in each of the respective districts are also a cohort that can be tapped into for future health literacy training.

Delivery and scheduling challenges. Scheduling emerged as one of the most significant obstacles to delivering the training. At one CCI, a master trainer explained that coordinating a time that suited all 13 or 14 staff members proved extremely difficult, given that sessions had to work around childcare duties, school drop-offs, and shift patterns. Night shift staff were repeatedly identified as the hardest group to accommodate. Both a teacher and a cook noted that night shift workers were required to attend training in the morning, which reduced their rest hours.

However, this challenge was not experienced uniformly. One accountant reported no scheduling difficulties at all, and a cook at another CCI noted her master trainer would call ahead privately and wait until her work was completed before beginning the session. Some master trainers, particularly at smaller CCIs, were willing to adapt, suggesting that the scheduling experience depended more on individual trainers’ approach and staff size than on any standardized process.



Source: Department of Youth Mental Health at SCARF, “Mental Health Primer: A Training of Trainers (ToT) Manual for the JAMS Project” (Internal Document, JAMS 2026)

Figure 12. The traffic light system to categorize the severity of children’s mental health presentations

At the program design level, this scheduling strain traces back to a broader resourcing mismatch. SCARF originally proposed piloting JAMS in four to five government-run CCLs, but the government directed the program to scale to over 200 CCLs across government, NGO, and privately run institutions. This rapid expansion resulted in thinly stretched funds and staffing.

Curriculum and training structure. Several interviewees identified a mismatch between training content and audience composition. One master trainer explained that superintendents and counsellors were frequently trained alongside cooks and helpers, despite holding very different levels of prior psychological knowledge. It required her to compress material to avoid disengaging higher-educated staff while cooks and helpers, who often had little prior exposure to psychological concepts, wanted further elaboration. She suggested separating sessions by role, with one track for leadership staff such as wardens and superintendents, and a second foundational track for cooks and cleaning staff. Change management literature suggests such tracks would benefit from a brief joint session beforehand where leadership visibly participates, signalling institutional commitment to training before splitting by role. We

identified an accessibility gap in a staff interview, where a cook described difficulty distinguishing between mental health symptoms, explaining that “it is difficult to identify different symptoms of ADHD, anxiety, and depression because they look similar.” She suggests that visual aids, such as illustrated or animated content, would have supported her understanding.

A further recurring concern was that the training equipped staff to identify symptoms but offered comparatively limited guidance on how to respond beyond referral. Program designers acknowledged this trade-off, explaining the training’s intended scope was symptom identification, with treatment considered the responsibility of counsellors and psychiatrists, though this distinction was not always clearly communicated to, or accepted by, ground staff. Staff also struggled to distinguish genuine symptoms from feigned behaviour. While infrequent, this behaviour falls outside the traffic light framework and exposes a gap in staff confidence when applying the training to ambiguous, real-world situations.

Limited follow-up. The absence of structured follow-up support was raised independently by multiple staff across different CCLs. One master trainer explained that staff had “no option to ask questions”

if uncertainties arose two or three months after training, once they were applying the material to an actual case. A teacher separately suggested that the six-week program should be followed by a refresher course. Program designers echoed this concern, noting that without a channel for staff to raise questions after training concluded, there was no way to confirm whether staff were correctly applying what they had learned once trainers were no longer present.

This finding connects to a broader monitoring gap identified by one master trainer who raised concerns that oversight was currently limited to WhatsApp groups, where staff and trainers sent photos of sessions as informal proof of delivery, with no reliable way to verify that training was delivered with comparable rigour. This gap was compounded by how data was handled: feedback collected from staff after each session was shared with the JAMS project team, but the findings were not fed back to the master trainers. Sharing these findings could have supported both learning and continued engagement among the master trainers. She said that “there has to be some kind of monitoring other than WhatsApp groups.”

Institutional barriers. Resistance to the training was a recurring theme in interviews (to varying degrees). One master trainer described CCI staff initially perceiving her as “pinpointing” or criticizing them, resulting in “ego issues” that limited engagement, until she reframed her role as being present to help rather than teach. Similarly, a teacher admitted she was initially skeptical of the training because the master trainer was younger than her, assuming this reflected inexperience. However, she found the content valuable once she engaged with it.

The willingness of CCI leadership to support the program also varied significantly. One counsellor, who both received training from SCARF and delivered it to CCI staff, noted that some administrators did not see value in training programs generally. She described the challenge as being less about “seeding the seed” and more about the quality of “the land where we seed it,”

reflecting how receptiveness depended heavily on the leadership culture of the specific CCI. This was seen when she repeatedly flagged a child requiring an intellectual disability assessment, but administration failed to act despite multiple requests, and the case was eventually escalated to the Child Welfare Committee without resolution. This shows that decision-making authority ultimately sits with administrators, limiting the training’s impact even when concerns are correctly identified.

Underlying these findings is a funding and governance structure limiting SCARF’s control over delivery consistency. Staff pay depends on each CCI’s funding level, meaning that better-resourced institutions retain staff more easily while others remain underpaid and burnt out regardless of training quality. Program designers noted JAMS currently runs on limited financial support from the government but legal and regulatory support via a memorandum of understanding was available. Without full government support and integration into the learning system, SCARF must keep seeking funding and legal re-approval every two years. This is a sustainability risk sitting above, and independent of, the implementation challenges seen at individual CCIs.

Youth-Friendly Space (YFS): Design and Intention

The Youth-Friendly Space (YFS) is intended to provide young people with a self-led space to engage in activities and games that aim to increase mental health awareness, promote recovery, encourage help seeking, and boost pride and connection. The intent is to support young people to build habits of mental wellness and care for their peers. Beyond these direct benefits, it also provides youth with the opportunity to learn about autonomy, choice, and organizational skills, since participants must form committees or groups to run an activity.²³

The main tool of the YFS is the YFS Activity Manual — a book with step-by-step instructions. It is also complemented by six educational animation videos

23 ALIVE National Centre for Mental Health Research Translation, *Three Approaches to Stigma Reduction Initiatives: Implementation Brief* (Victorian Collaborative Centre for Mental Health and Wellbeing, 2026). 

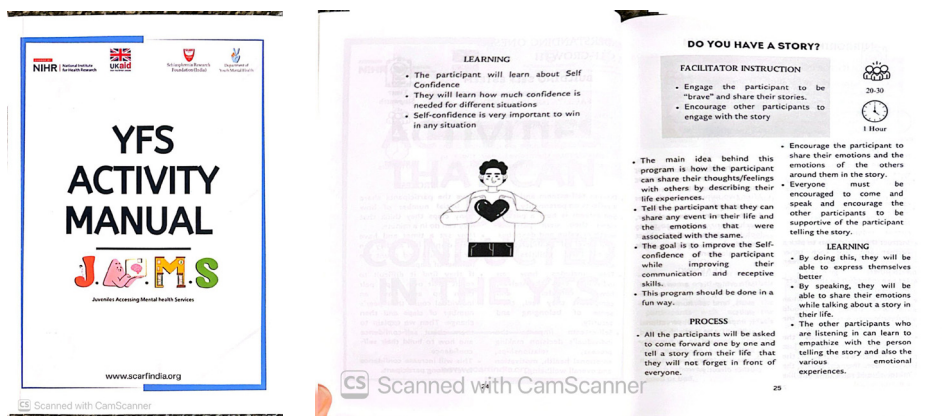


Figure 13. YFS Activity Manual's cover and content

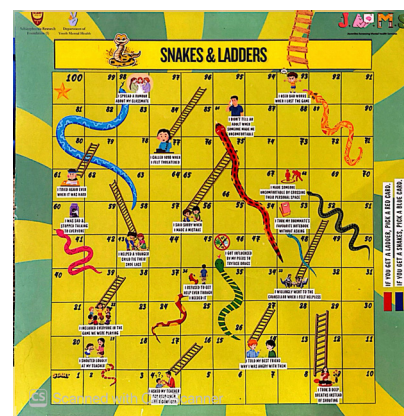


Figure 14. YFS snakes and ladders game

introducing children to common psychosocial conditions and mental health practices.

Implementation and Findings

Implementation conditions determine whether autonomy is possible. Youth-led interventions like YFS depend on structural conditions that program designers themselves often cannot control. Where the delivering organization, in this case the CCI, cannot consistently provide time, space, and administration support, implementation fidelity is likely to vary regardless of program quality. What follows are the structural barriers to implementation that we observed in the fieldwork.

Institutional environment and resourcing. The first factor is the institutional environment of the CCI itself. Decisions about space and scheduling are typically made at the administrator level, meaning the success of YFS largely depends on whether a CCI administrator is able to prioritize space and time for children to engage. When interviewed, a CCI staff member explained that the institution's busy schedule is intended to provide structure and routine for the children. Despite the intended reasoning, the rigid structure can also undermine the conditions required for YFS to operate as intended. Under Rule 32 of the Juvenile Justice (Care and Protection of Children) Model Rules in 2016, every CCI is required to maintain a structured daily routine. This

regulatory requirement shapes the operating context for any program introduced into CCIs, such as JAMS or YFS where session timing is not negotiated independently with youth but must be fitted around a schedule set by the institution that predates the intervention.²⁴ Because of this, engagement with CCIs to jointly identify opportunities for flexibility in the schedule would benefit the implementation of JAMS.

For young people in CCIs, autonomy does not come naturally because self-initiated activity sits outside the existing rhythms of institutional life. In interviews, children consistently indicated that homework took priority over the YFS activities, engaging with it only "if there was time" after academic obligations were met. When children do have free time, they typically prioritize conventional entertainment and familiar games, such as watching TV or playing hide and seek, over YFS. During exam seasons, some noted that "there would not be an opportunity to even watch TV." This pattern is worth distinguishing from genuine autonomy since it gravitates toward what is already familiar and endorsed by CCI leadership, not a choice exercised against alternatives. In this context, choosing to watch TV instead of joining a YFS activity may reflect familiarity and the existing structure of free time, rather than an active preference expressed after considering a range of alternative activities. When asked whether YFS activities had benefitted them, children cited "discipline" and "identifying their

24 Juvenile Justice (Care and Protection of Children) Model Rules, 2016, G.S.R. 898(E), 21 September 2016, rule 32, Ministry of Women and Child Development, India. ²⁵

talents” as benefits. Neither is indicative of a mental health outcome, but instead reflects values already prioritized within the CCI environment. This suggests that children’s framing of benefits is still shaped by institutional vocabulary that is familiar to them rather than the mental health understanding that YFS intended to build.

Table 1. A sample CCI schedule as described in a group discussion with older adolescents

Time	Activity
3:00 am	Wake up
3:00–6:00 am	Study/pray/yoga
6:00–8:00 am	Morning routine/breakfast
8:00 am–4:00 pm	School
4:00–5:00 pm	Rest/free time
5:00–7:00 pm	Chores/study
7:00–8:00 pm	Dinner
8:00–9:30 pm	Study
9:30 pm	Sleep

Resources are the second YFS implementation barrier and vary widely across CCIs and shape how effectively YFS can be implemented. Some CCIs have a dedicated space for children to run activities, whereas others do not and result in outside activities only. Some explained that YFS activities “only occur when the master trainer comes” and “currently, [they] do not have a private space.” Spaces become unavailable because new learning activities take priority and the schedule and spaces become occupied. Additionally, staff may not have the capacity to support the children to engage in YFS activities in addition to their regular duties.

Building autonomy requires scaffolding rather than immediate self-direction. We also identified an opportunity to strengthen the design of the YFS manual: the children’s uptake of the YFS manual in its current format was limited, suggesting there is scope to make it more user centred. Its language and structure make it better suited to an adult facilitator rather than for children to use independently with

ease. In an interview, we asked children specifically about how often they engaged with YFS manual activities. Their responses indicated infrequent engagement.

By contrast, YFS activities worked well when facilitated by adults directly, with children visibly enjoying the activities. CCI staff similarly suggested that an adult facilitator periodically running YFS activities would improve engagement. Although this addresses the immediate problem, it also undermines the program’s original intent of being run and sustained by children themselves.

The educational mental health literacy animation videos received a more positive reception, and their scalability suggests that youth-friendly, low-burden materials can improve usability and engagement and support more effective implementation.

Taken together, these findings suggest that ownership should be built progressively through facilitated participation, rather than assumed from the outset. Children are unlikely to self-direct unless the necessary preconditions such as time, space, administration support, and age-appropriate materials are first in place to sustain that ownership.

Mental Health Screening and Referral: Design and Intention

The mental health screening and referral in the JAMS program is intended to support the various CCIs and their staff in linking them with local government hospital psychiatry for the children who need mental health services. These screenings are conducted at six-month intervals, before and after the intervention’s implementation. For JAMS 1.0, a common referral and follow-up form was created after discussion with the CCIs and psychiatry departments to enable continuity of care for the children’s mental health.²⁵ Then, for JAMS 2.0 to support further scale-up of referrals for mental health services, the JAMS program team conducted a district-wide mapping of available government

25 Srinivasan et al., “Juveniles Accessing Mental,” 148.

mental health services to equip the CCI staff with a comprehensive directory of referral options.²⁶

According to the JAMS program designers, the mental health screening and referral process has four steps:

1. Preliminary mental health screening is conducted on CCI children using six scales, two of which are particularly relevant to the mental health of children in CCIs: the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS) and the Strengths and Difficulties Questionnaire (SDQ). The WEMWBS measures aspects of positive affect, functioning, and interpersonal relationships as components of well-being and is used as the primary outcome measure for the children, and the SDQ is a self-report screening tool for evaluating mental health difficulties (emotional, conduct, hyperactivity, and peer problem domains).²⁷
2. The JAMS team analyses the scales and identifies children with low scores. JAMS then provides this data to CCI staff, typically the counsellor or superintendent.
3. JAMS maps the available mental health services, including outpatient providers and government-based services to the CCIs.
4. CCIs decide what to do next with SCARF's recommendation regarding which children require additional care and which mental health services are best placed to assist, since JAMS manages only the screening and referral process.

Figure 16 illustrates the flow of mental health screening and referral steps.

Implementation and Findings

Identifying children who need mental health services. Before JAMS, children had no standardized evaluations or check-ins in place to measure their general stress levels, well-being, or existing mental health challenges in these conditions. The mental health screening and referral component of JAMS allows individual-level data regarding well-being

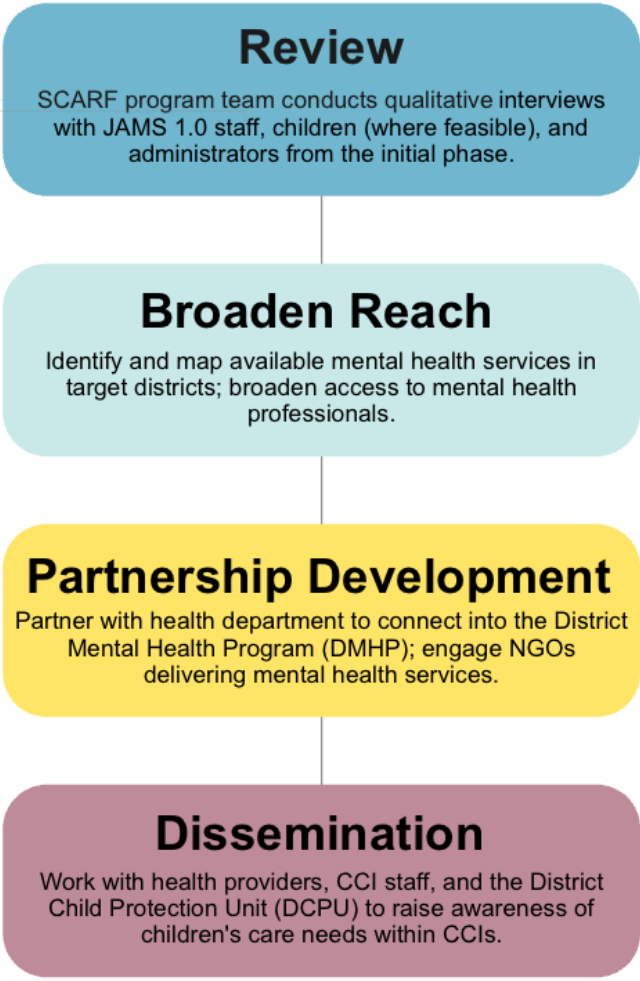


Figure 15. The different elements involved in scaling up the mental health screening and referral process for JAMS 2.0

and mental health to surface for counsellors/superintendents in CCIs, giving referral and action a chance, despite existing systemic gaps.

One of the counsellors in the CCI also talked about legal and administrative barriers because they themselves do not have the authority to refer or take action regarding children; they can only make recommendations to the CCI administration. Delays in this process can result in long wait times before the appropriate action is taken. While the screenings may improve identification, limited autonomy within counsellors' roles, particularly their inability to independently refer children for further support, remains a barrier.

²⁶ "JAMS Transition to Scale Protocol" Schizophrenia Research Foundation (Internal Document, SCARF, 2024).

²⁷ Ibid.

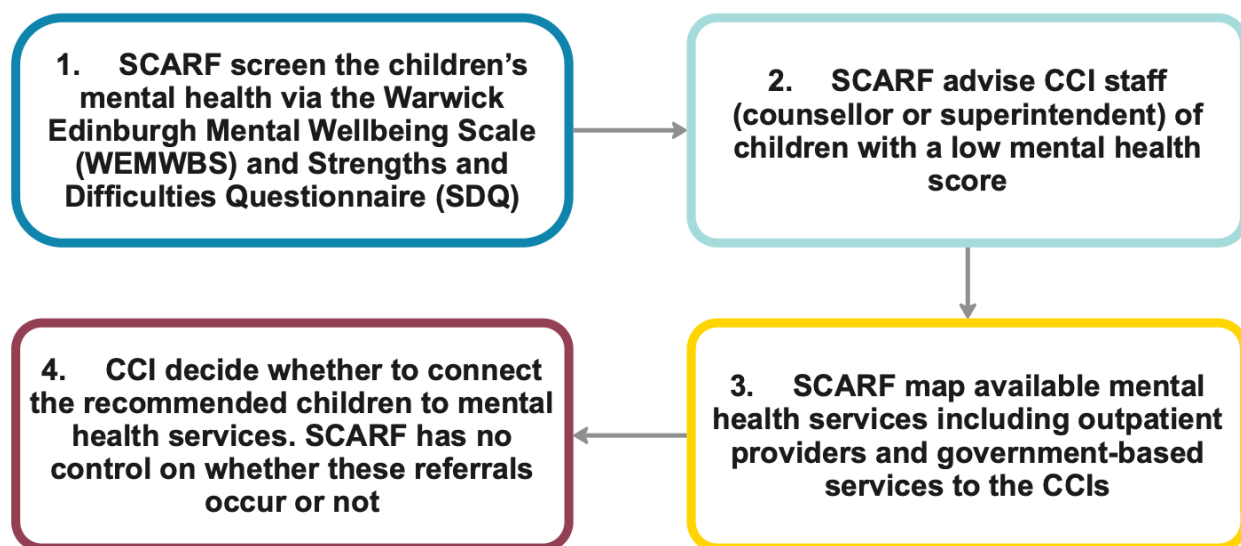


Figure 16. The flow of mental health screening and referral steps

Equipping staff with necessary tools/scales to measure specific needs of children. An interview with a government official suggested that children dealing with mental health concerns “will be referred to government counsellors and government hospitals. But they still don’t have specific tools and scale to assess the specific needs of the children.” This component of the JAMS program provides counsellors with essential tools and scales to evaluate these needs and establish referral pathways, thereby facilitating the escalation of cases that require further attention.

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Resource constraints affect the quality of data.

Two factors currently affect the quality of the data obtained through the screening. First is the length of the questionnaires. While only two tests are directly linked to mental health assessment, the children had to complete six lengthy test questionnaires, collectively requiring around 1.5 hours as JAMS also attempted to capture information about other aspects of their mental health. JAMS program designers noted that children experienced cognitive fatigue leading to an impact on the way the questionnaires were completed.

Second, we noted that the lack of staffing to conduct the assessments also affected their quality. JAMS is limited in terms of the number of personnel who could conduct screenings for all CCIs across the two states it currently functions in, so scaling a centralized approach would be untenable. Hence, screening is conducted by these contractual counsellors in CCIs who have a limited time allocated for diagnosis, counselling, and writing reports for all children. With already scarce time resources with the children, it becomes difficult for counsellors to schedule blocks where they can conduct the screenings for all children.

Both the lengthiness of the questionnaires and the lack of personnel to support the screening led to many screening tests received as either incomplete or blank. This creates difficulties for SCARF as well

as the guardians and counsellors of the children to obtain data that truly reflects the state of children's well-being across CCIs.

Lack of tracking. Following the screenings and identification of children in need of assistance, there is no system that tracks which children were referred to a mental health professional and the subsequent outcome of the referral. This gap acts as a hindrance in following through to measuring the impact of the screening and referral component of JAMS.

Administrative barrier. An interview with one counsellor revealed that even if the screening and referral pathways are facilitated successfully, another roadblock involves getting the approval of the CCI administration for referral to government mental health services for a child. This challenge exists because CCIs must also arrange both transport and personnel logistics for each referral, since many do not have easily accessible mental health facilities nearby and have limited personnel. A discrepancy also exists between private and government CCIs, where private CCIs may struggle more to get a referral to a mental health professional in the government facility than government CCIs.

roles in a mental health literacy training program. Importantly, the JAMS training is not limited to caregiver roles — it is provided to all institutional staff including teachers, cooks, accountants, and wardens. This is critical because all institutional staff engage with children to some degree. This means all institutional staff have the opportunity to identify behaviours that may indicate that a child requires additional care and subsequently refer them to the appropriate services. It is especially important because many of the staff have limited or no mental health training. Such training also creates awareness and understanding of children's signs and symptoms, enabling staff to use their enhanced mental health literacy to better respond to children experiencing mental ill-health or distress.

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Lessons Learned

The work of the Schizophrenia Research Foundation (SCARF) within child care institutions (CCIs) through the Juveniles Accessing Mental Health Services (JAMS) program offers valuable insights for institutional care settings seeking to reduce mental health stigma and improve well-being, highlighting the value of educational and collaborative approaches in achieving these outcomes.

Supporting Children Starts with the Adults Around Them

The unique value proposition of JAMS is that it's the first of its kind in India to include all CCI staff

To effect meaningful cultural change, interventions must target the system as a whole, not just those most disadvantaged by the current system. A whole-of-institution approach that offers mental health literacy support for all staff and children is a promising development for institutional care settings that seek to reduce mental health stigma and improve mental well-being in their contexts.

A Cascading Training Model Holds Potential for Delivering at Scale

CCIs and similar institutions often operate within resource-constrained environments. It can be difficult to meet the basic needs of children, let alone their mental well-being and psychosocial needs. A

strength of the JAMS 2.0 program was the Training of Trainer (ToT) model, which aimed to address this unmet need in the most resource-efficient way. ToT uses a cascading structure where a mental health expert trains a small group of master trainers, who then deliver the training to all staff across the CCIs in one region.

The strength of educational approaches such as the ToT model is affirmed by their role underpinning the World Health Organization's mhGAP Intervention Guide for scaling mental health care in low- and middle-income countries in effectively expanding service delivery of mental health interventions within resource-constrained environments, and remaining robust despite high staff attrition rates common in the human services sector.²⁸

Embedding Lived Experience into the Design and Implementation Is Critical

Embedding lived experience in program design and implementation is essential to create effective interventions, particularly in the human services sector.²⁹ Both JAMS 1.0 and 2.0 have been informed by the perspectives of the children, institutional staff, and the master trainers. There is an opportunity to uplift further, such as updating the YFS manual through co-design to create a product that the children reach for more often. In this sense, prioritizing the user would ensure that program design and implementation remain grounded in the lived context they are responding to. Ultimately, effective stigma reduction can be associated with meaningful and ongoing lived experience input, collaboration, and leadership across all levels of authority and throughout the intervention lifecycle.

Design Around Rather Than Against Institutional Constraints for Greater Impact

The success of interventions often depends on the environment they are implemented in. When a program's underlying goals are misaligned with the institutional culture hosting it, implementation risks breaking down regardless of how well-designed the program is. The YFS illustrates the tension when two logics are at odds. Although it is built around developing autonomy and self-direction, it operates within CCIs that have a directive institutional culture. This points to two possible paths forward. One is to work toward building an enabling environment, which is resource and time intensive, or to first understand the limitations of the existing environment, then design the intervention around its constraints. However, an investment paired with support from the government and institutional commitment toward creating an enabling environment will hold potential for significantly greater impact than what any intervention can do within existing constraints.

Sustainable Mental Health Stigma Reduction Requires Embedded Policy

Delivering effective interventions within an uncertain and volatile environment remains a common challenge for not-for-profit organizations that rely on external funding. Short funding cycles limit the potential for long-lasting impact, and changing funder priorities can result in otherwise effective programs being forced to stop — despite ongoing institutional need. This is a real risk for initiatives like JAMS. Where possible, interventions should be incorporated into public policy rather than treated as stand-alone projects. For instance, embedding the ToT model for staff mental health literacy training into core CCI staff training as a matter of institutional or government policy holds promise for widespread impact, ensuring continuity regardless of changes in personnel, funding cycles, or political priorities.

28 *mhGAP Intervention Guide — Version 2.0* (World Health Organization, 2016), 173. [↗](#)

29 "WPA Position Paper on Developing Partnerships with Persons with Lived Experience of Mental Health Conditions and Family and Informal Carers," World Psychiatric Association, 14 February 2023, 5. [↗](#)

It may be worth noting, however, that a modest but significant investment would be required to implement this effectively.

This is critical because policy embedding is only the first step. Meaningful cultural change takes time. Shifting institutional culture requires sustained effort well beyond a single funding cycle, and without it, hard-won gains risk being lost.

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Study Limitations

While the research we conducted in Tamil Nadu provided valuable insights, we acknowledge several limitations to provide a comprehensive understanding of the study's scope and constraints.

Small sample size and geographic constraints.

Due to the limited timeframe of the fieldwork, the sample size was small across all participant groups. In addition, both CCIs we visited were regional and located within the same district of Tamil Nadu. While this narrower scope allowed for richer, more in-depth discussions with participants, it may not have captured the full diversity of experiences with the JAMS program or broader approaches to mental health across different CCIs. Implementation might vary considerably across districts, states, and institutional contexts, meaning these findings should not be considered representative of all participating CCIs in the JAMS program.

Language and cultural barriers. Although experienced interpreters with social work backgrounds assisted with interviews and focus group discussions, language differences may have

influenced the teams' interpretation of participants' responses. Certain expressions, cultural nuances, or emotional sentiments can be difficult to translate directly, meaning that some intended meaning or context may have been lost in translation. This may have also limited our opportunities for follow-up questioning, particularly where participants used culturally specific language or concepts without a direct English equivalent.

Researcher presence and social desirability bias.

As external researchers and unfamiliar figures, our presence may have influenced participants' responses during interviews and focus group discussions. While we made every effort to ensure participants knew that their responses would remain confidential and to create an environment in which they felt comfortable speaking openly, some participants may still have been reluctant to discuss challenges or criticize JAMS or CCI staff. Similarly, participants may have altered their behaviour or responses because they were aware they were being observed, introducing the potential for social desirability bias to influence the data collected.

Conclusion

The Juveniles Accessing Mental Health Services (JAMS) program demonstrates how a low-intensity intervention can promote mental health and well-being among vulnerable young people in resource-constrained environments. Despite challenges including resistance to change, stigma surrounding mental health, directive organizational structures within CCIs, and limited public mental health infrastructure, our findings suggest that the program has played an important role in increasing mental health awareness, shifting staff attitudes, and strengthening pathways to care for young people.

More broadly, the JAMS program has helped bring conversations about mental health into CCIs serving an extremely vulnerable and underserved population. By building mental health literacy, strengthening staff capacity, and creating systems for recognition and referral, the program lays the foundation for longer-term change. However, to realize its full potential, the program would need to be adopted and sustained by the government.

This would reduce its reliance on international and philanthropic funding for programs such as JAMS, enabling the model to reach CCIs across India and improve access to mental health support for vulnerable youth at a national scale. As one JAMS program designer remarked, “The biggest goal is for JAMS to not exist anymore and to be integrated in government systems.”

Research Team



Georgia Lee is a master of public policy and management student with a strong interest in effective public policy and community development, shaped by her experience in the for-purpose sector. She works as a government relations advisor at a state government agency and with a not-for-profit supporting people experiencing substance use, incarceration, disability, and mental health challenges. These roles have given Georgia experience across direct service delivery and the policy and organizational systems that support it. As an Emerging Women in Leadership Scholarship recipient, she delivered a community project strengthening services for people experiencing homelessness and rough sleeping. Georgia has a demonstrated history of volunteerism, most recently as a mentor supporting young people facing barriers to obtain their driver's licence.



Yueran Meng is a commerce graduate with a strong interest in bridging gaps for underserved communities and financial inclusion initiatives, and she has developed skills in evidence synthesis. Her prior research and professional experience further equip her to handle the responsibilities and sensitivities of this project. Being a research intern at FemTech Partners, Yueran examined equity gaps in digital financial services, honing her ability to handle sensitive population data responsibly and communicate findings clearly to nonspecialist audiences. Her consultancy work with KYUP! Project involved an analysis of real-world outcomes affecting young Australians, requiring careful handling of organizational data and stakeholder sensitivities.



Erik Nadir is an international development professional focusing on strategic communications and management, with experience spanning NGOs, international human rights organizations, and the Asia Pacific civil society sector. He works closely with marginalized communities and brings lived experience to his research work. As an Australia Awards Scholar, he is currently completing a master of management at the University of Melbourne. He is passionate about press freedom and trans rights, and has spoken at the AWID International Forum, the ILGA World Conference, TEDx, and the G20 Youth Summit. With a background in visual arts, Erik produces creative media in various forms and brings a distinct creative lens to his research and communications work.



Shrreyas Saluja is a master of management (finance) student at the University of Melbourne, holding the Business and Economics Graduate Scholarship. Driven by an interest in working at the intersection of social impact, policy, and finance, he brings experience from an internship at Lochan & Co, where he contributed to a UNDP-aligned Public Financial Management report for Botswana, and from consulting work involving multi-stakeholder organizational analyses, which sharpened his ability to synthesize qualitative data and communicate findings clearly. He served as FBE Student Ambassador and General Representative on the UMSU Student Union Council, where he built strong interpersonal and cross-cultural communication skills well suited to conducting respectful, effective focus groups and interviews in this research context.



Diya Shah is a bachelor of commerce student at the University of Melbourne, majoring in economics and finance, with interests in social impact, public policy, and financial inclusion. She was awarded the Sidney Myer Centennial Scholarship, a full-ride merit scholarship, to pursue her studies. As project leader at the Melbourne Microfinance Initiative, she led a team developing financial inclusion initiatives for Indigenous women entrepreneurs, strengthening her skills in ethical research and stakeholder engagement. She also consulted for Mencap, a leading UK nonprofit supporting people with learning disabilities, conducting stakeholder analysis and operational research to develop data-driven recommendations balancing financial sustainability with long-term social impact. She is passionate about community-based research and advancing evidence-informed policy for meaningful social impact.



Galuh Valencia is an executive master of arts student at the University of Melbourne with a strong interest in leadership, project management, and community development. Before her studies, she worked as a trust and safety analyst at Accenture in Kuala Lumpur from 2021 to 2024 where she was responsible for analyzing and reviewing online user content and addressing complex safety issues. This experience strengthened her knowledge about digital policies, online community safety, and work responsibilities. She has a dream of building an educational foundation for underprivileged children in her hometown, Padang, Indonesia.



Maria Rodrigues is a co-founder and former director of Kindred, an international nonprofit organization that builds social and emotional well-being using a community development approach. Her experience as a researcher, educator, and development practitioner spans two decades working at the intersection of mental health, social justice, and cross-cultural peacebuilding. Maria has completed field research with Aboriginal communities in remote Australia, as well as postconflict settings in India, Kenya, Uganda, and Mozambique. She holds a BA in psychology from Elmira College and a PhD in applied ethics (global justice) from the University of Melbourne. Maria's research and consultancy work has contributed to toolkits, policy, and strategic documents for StrongMinds Uganda, the National Indigenous Australians Agency, the World Psychiatric Association, Relationships Australia, and Amnesty International.



Katie Langmore is programs manager at Kindred Global, an international nonprofit organization that partners with the University of Melbourne to deliver the Reach Program. With offices in Colombia and Australia, Kindred works with communities, organizations, and governments to deliver programs that promote mental well-being and strengthen social cohesion. Katie is a community development and engagement specialist with a passion for helping communities achieve their goals. She has a master's in social work and experience in counselling and supporting mental health programs in marginalized communities around the world. Alongside Kindred Global, Katie works with Orygen, Australia's Centre of Excellence in Youth Mental Health, and community development consultancy Community Works.



Kindred is an Australian organization working to build community-wide social and emotional well-being through collaborative partnerships with diverse organizations worldwide. Its approach draws on more than a decade of experience through Community Works, an Australian development consulting company, having partnered with organizations across nineteen countries on community mental health programming, early childhood development, and cross-sector, cross-cultural collaboration. Kindred focuses on creating connections between people and organizations who don't typically work together, and on bridging the gap between academic research and the communities where evidence-based practice is needed most.

www.kindredglobal.org



Founded in 1984 in Chennai, India, the **Schizophrenia Research Foundation (SCARF)** is a nongovernmental, nonprofit organization established by a group of mental health professionals and philanthropists led by Dr. M. Sarada Menon. SCARF has established itself as a centre of repute in rehabilitation and research in disorders of the mind, with its present team composed of psychiatrists, psychologists, social workers, rehabilitation personnel, and support staff. It is one of the few NGOs in the world named a Collaborating Center of the World Health Organization for Mental Health Research and Training.

www.scarfindia.org



The **University of Melbourne**, founded in 1853, is one of Australia's top public research universities, consistently ranked among the best globally. Located in Victoria, it offers a wide range of undergraduate and postgraduate programs across disciplines like arts, science, business, and medicine. Known for academic excellence, innovation, and global research impact, the university attracts a diverse student body and fosters strong industry partnerships contributing significantly to global research and education.

www.unimelb.edu.au



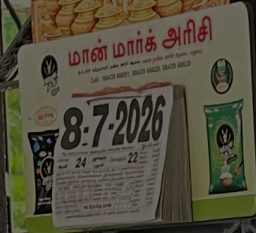
Founded in 1827, the **University of Toronto (U of T)** is Canada's leading institution of learning, discovery, and knowledge creation. One of the world's top research-intensive universities, its students learn from and work with pre-eminent thought leaders through a multidisciplinary network of teaching and research faculty, alumni, and partners. Consistently ranked among the top 10 public universities worldwide, U of T has remarkable strengths in disciplines that span the humanities, social sciences, sciences, and the professions. U of T's three campuses host 93,000 undergraduate and graduate students from 159 countries, who are taught by 15,000 faculty.

www.utoronto.ca



The **Center for Inclusive Growth** advances equitable and sustainable economic growth and financial inclusion around the world. The Center leverages the company's core assets and competencies, including data insights, expertise, and technology, while administering the philanthropic Mastercard Impact Fund, to produce independent research, scale global programs, and empower a community of thinkers, leaders, and doers on the front lines of inclusive growth.

www.mastercardcenter.org



Reach Alliance

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