

Mental Health Burden in Urban Jaipur: A Population-Based Assessment of Prevalence and Healthcare Accessibility

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Abstract

Background

Mental health disorders such as anxiety, depression, and stress are increasingly prevalent in urban India due to rapid urbanization, socio-economic pressures, and limited access to mental healthcare. However, community-based evidence on mental health burden and healthcare accessibility remains inadequate in many urban settings, including Jaipur.

Objectives

The study aimed to assess the prevalence of anxiety, depression, and stress among urban residents of Jaipur and to examine their association with socio-demographic and psychosocial factors, along with barriers to mental healthcare access.

Methods

A population-based cross-sectional study was conducted across five assembly constituencies of Jaipur Municipal Corporation Greater using multi-stage random sampling. Data were collected from 460 respondents through structured household interviews. Mental health status was assessed using the Hindi version of the Depression, Anxiety, and Stress Scale (DASS-21). Descriptive statistics and Chi-square tests were applied for analysis.

Results

Mental health awareness was low, with only 43% of respondents demonstrating basic awareness. Depression was significantly associated with gender and age, showing higher prevalence among women and individuals aged 29–38 years. Education showed a significant association with anxiety, depression, and stress, with the highest prevalence among respondents with intermediate education. Stress was significantly linked to occupation, marital status, financial debt, and domestic violence. Substance use, particularly tobacco, was strongly associated with anxiety, while bereavement was linked to both anxiety and depression. Social stigma and structural barriers, including affordability and limited service availability, constrained mental healthcare access.

Keywords: Mental Health, Anxiety, Depression Stress, Urban Jaipur, Healthcare Accessibility.

Introduction

Mental health is a fundamental component of overall well-being, influencing how individuals think, feel, behave, and cope with daily life challenges. Good mental health enables people to function productively, manage stress, maintain relationships, and contribute meaningfully to society. Conversely, mental disorders involve significant disturbances in cognition, emotional regulation, or behavior, often resulting in distress and impairment in personal, social, or occupational functioning (American Psychiatric Association, DSM-5, 2013).

The World Health Organization (WHO, 2018) defines mental health as a state of well-being in which individuals realize their abilities, cope with normal stresses of life, work productively, and contribute to their community. Mental health conditions such as anxiety, depression, and stress have increased substantially across all age groups, genders, and social backgrounds. In 2019, the WHO estimated that nearly 970 million people worldwide were affected by mental health disorders, making them one of the leading causes of global disease burden. Despite this, mental health remains under-prioritized due to stigma, limited awareness, and inadequate service availability.

Globally, access to mental healthcare is highly unequal. According to the WHO Mental Health Atlas (2020), more than 75% of individuals in low- and middle-income countries do not receive timely or adequate mental health treatment. On average, only about 2% of national health budgets are allocated to mental healthcare, and many countries face an acute shortage of trained mental health professionals, reflecting serious policy and resource gaps.

In India, mental health has historically received limited attention, although recent policy initiatives indicate gradual progress. The National Mental Health Survey (NMHS) 2015–16 reported that 13.7% of the population requires active intervention for mental health conditions, while over 70% of those affected lack access to appropriate care. Urban areas, in particular, experience a higher burden of mental health disorders due to factors such as rapid urbanization, socioeconomic stress, and lifestyle changes.

Rajasthan, especially urban centers like Jaipur, has witnessed a rising trend in reported cases of anxiety, depression, and stress-related disorders. Although recent large-scale population surveys are limited, data from the District Mental Health Programmed (DMHP) and hospital records indicate a steady increase in outpatient mental health cases. A cross-sectional study by Jain et al. (2020) found that approximately 35% of adult women living in Jaipur's slums exhibited symptoms of depression or anxiety, with nearly 25% hesitating to seek professional help. Furthermore, reports under the National Health Mission (2022) highlighted depression and stress as the most commonly reported mental health conditions in outpatient settings across the state.

Material and Methods

Study Design and Data Sources

The present study is based on both primary and secondary data sources. Population characteristics and health facility information were collected from relevant records and reports, while primary data were obtained through a field-based household survey. The collected data were tabulated and statistically analyzed using SPSS and Microsoft Excel.

Study Area and Sampling Procedure

The study was conducted in Jaipur Municipal Corporation Greater, covering five assembly constituencies-Vidyadhar Nagar, Jhotwara, Sanganer, Malviya Nagar, and Bagru- comprising a total of 150 wards. From these, 15 wards (approximately 10%) were selected based on population size and ward characteristics. Subsequently, 5% of households from each selected ward were chosen proportionately using a multi-stage random sampling technique. A total of 1,724 households were surveyed.

Data Collection

Data were collected through door-to-door household surveys using a structured, pre-tested questionnaire. Households were selected randomly, starting from the first house in each ward. After obtaining informed consent, one eligible participant from each household was interviewed. The questionnaire included socio-demographic details and information on selected psychosocial factors such as domestic violence, substance use (alcohol and tobacco), and family-related history.

To assess mental health status, the Depression, Anxiety, and Stress Scale (DASS-21) was administered. DASS-21 is a standardized screening tool used to measure symptoms of depression, anxiety, and stress over the preceding one-week period. The Hindi version of DASS-21 was used to ensure better comprehension among respondents.

Only participants who completed all sections of the questionnaire were included in the final analysis. Accordingly, data from 460 respondents were considered for the study.

Assessment of Mental Health Awareness

The first section of the questionnaire focused on assessing general awareness regarding mental health. It included questions related to respondents' understanding of mental health, awareness of mental health facilities in their locality, and perceived factors influencing mental health. These responses were used to evaluate the current status of mental health awareness across the study areas, with area-wise findings presented in the subsequent tables.

Mental Health Awareness

Table 1 presents area-wise distribution of mental health awareness among respondents. Overall, 198 individuals (43.0%) reported awareness regarding mental health, while a larger proportion, 262 individuals (57.0%), lacked such awareness. This indicates substantial gaps in basic understanding of mental health concepts across the study areas. Limited awareness may be influenced by socio-economic conditions, educational attainment, and household environment. To contextualize these findings, Table 2 outlines the socio-demographic profile of the respondents.

Table 1: General Spectrum Regarding Mental Health Awareness

Area	Yes	No
Vidhyadhar Nagar	31	41
Malviya Nagar	57	33
Sanganer	42	75
Bagru	29	61
Jhotwara	39	52
Total	198	262

Source: Primary survey 2025

Socio-demographic Characteristics

Table 2 summarizes the socio-demographic characteristics of the study population (N = 460). Females constituted the majority of respondents (73.04%), while males accounted for 26.96%. Participants were fairly distributed across age groups, with the highest representation in the 29–38 years category (29.35%). Educational attainment varied considerably, with 22.17% having intermediate-level education and 20.87% completing high school, while 19.13% of respondents were illiterate.

In terms of religion, 66.52% identified as Hindu and 30.65% as Muslim. Occupational status revealed diverse engagement, with 37.61% employed, 26.96% students, 12.17% homemakers, and 23.26% non-working. Slightly more than half of the respondents belonged to joint families (53.26%). Most participants were married (51.30%), followed by unmarried (31.96%), separated (10.43%), and widowed (6.30%).

Nearly half of the respondents reported substance use, with tobacco being the most common. Housing conditions showed that 59.13% owned their homes, while 40.87% lived in rented accommodation. Overcrowding was reported by 36.74% of respondents. Financial debt was prevalent in 73.70% of households, and 17.61% acknowledged the presence of domestic violence. Additionally, 16.74% reported the loss of a close family member in the past year.

Table 2: Socio-demographic Characteristics of participants Jaipur (N = 460)

Characteristics	Number	Percentage (%)
Gender		
Male	124	26.96
Female	336	73.04
Total	460	100.00
Age Group		
18–28 years	107	23.26
29–38 years	135	29.35
39–48 years	122	26.52
49–58 years	96	20.87
Total	460	100.00
Education Level		
Graduate & above	76	16.52
Intermediate	102	22.17
High School	96	20.87
Middle School	63	13.70
Primary School	35	7.61
Illiterate	88	19.13
Total	460	100.00
Religion		
Hindu	306	66.52
Muslim	141	30.65
Other	13	2.83
Total	460	100.00
Occupation		
Working	173	37.61
Homemaker	56	12.17
Student	124	26.96
Non-working	107	23.26

Total	460	100.00
Type of Family		
Nuclear	215	46.74
Joint	245	53.26
Total	460	100.00
Marital Status		
Married	236	51.30
Unmarried	147	31.96
Separated	48	10.43
Widowed	29	6.30
Total	460	100.00
Addiction of Harmful Substance		
Alcohol	33	7.17
Tobacco/Smoking	129	28.04
Both	45	9.78
No Addiction	253	55.00
Total	460	100.00
Tenure of House		
Own	272	59.13
Rented	188	40.87
Total	460	100.00
Overcrowding		
Yes	169	36.74
No	291	63.26
Total	460	100.00
Financial Debts in Family		
Yes	339	73.70
No	121	26.30
Total	460	100.00
Domestic Violence in Family		
Yes	81	17.61
No	379	82.39
Total	460	100.00
Loss of a Loved One (Past Year)		
Yes	77	16.74

No	383	83.26
Total	460	100.00

Source: Primary survey 2025

Behavioral Health Factors

Table 3. highlights behavioral and lifestyle-related factors associated with mental well-being. A majority of respondents (69.78%) reported experiencing physical health issues. Poor sleep patterns were observed in nearly half of the participants (50.43%). Regular physical exercise was reported by only 23.04% of respondents, while 76.96% did not engage in any routine physical activity. Similarly, inadequate nutrition was common, with 59.13% reporting poor dietary practices. These findings suggest a widespread lifestyle imbalance that may contribute to adverse mental health outcomes.

Table 3: Behavioral Health Factors Among Respondents (N = 460)

Characteristics	Yes (n)	Yes (%)	No (n)	No (%)	Total
Physical health issues	321	69.78	139	30.22	460
Poor Sleep	232	50.43	228	49.57	460
Physical Exercise (Any Regular Form)	106	23.04	354	76.96	460
Good Nutrition	188	40.87	272	59.13	460

Source: Primary survey 2025

Obstetric History of Female Respondents

Table 4 presents obstetric and maternal health characteristics among female respondents (N = 336). At the time of the survey, 19.05% of women were pregnant, and 12.50% reported a history of abortion or stillbirth. Social pressures were evident, with 16.96% reporting pressure to bear a male child. Early marriage was also prevalent, as 26.19% of women were married before the age of 18.

Utilization of maternal healthcare services was notably low. Only 14.58% reported receiving prenatal care, while postnatal care utilization was limited to 9.52%. These findings indicate significant gaps in maternal health service access, which may have implications for women's mental health.

Table 4: Obstetric History of Female Respondents (N = 366)**Association between Socio-Demographic Factors and Mental Health Outcomes**

Characteristics	Yes (n)	Yes (%)	No (n)	No (%)	Total
Currently Pregnant	64	19.05	272	80.95	336
Recent History of Abortion/Stillbirth	42	12.50	294	87.50	336
Pressure for Male Child	57	16.96	279	83.04	336
Age of Marriage (<18 years or not)	88	26.19	248	73.81	336
Pre-Natal Care	49	14.58	287	85.42	336
Post-Natal Care	32	9.52	304	90.48	336

Source: Primary survey 2025

Table 5: Association of mental health illness with social-demographic and surroundings factors

Characteristics		Anxiety				Depression			At df = 3 and $\alpha = 0.05$, the critical value = 7.815	Stress			At df = 3 and $\alpha = 0.05$, the critical value = 7.815
		Yes N, %	No N, %	Total		Yes N, %	No N, %	Total		Yes N, %	No N, %	Total	
Gender	Male	47	77	124	At df = 3 and $\alpha = 0.05$, the critical value = 7.815 Since 3.310 < 7.815, we fail to reject the null hypothesis	44	80	124	7.815 Since 12.117 > 7.815, we reject the null hypothesis	53	71	124	7.815 Since 3.147 < 7.815, we fail to reject the null hypothesis
		10.2 2%	16.7 4%	26.9 6%		9.57 %	17.3 9%	26.9 6%		11.5 2%	15.4 3%	26.9 6%	
	Female	112	224	336		82	254	336		128	208	336	
		24.3 5%	48.7 0%	73.0 4%		17.8 3%	55.2 2%	73.0 4%		27.8 3%	45.2 2%	73.0 4%	
	Total	159	301	460		126	334	460		181	279	460	

Age	18-28	32	75	107	$\chi^2 = 3.305$ df = 3 Critical Value = 7.815 Failed to reject Null Hypothesis	31	76	107	$\chi^2 = 12.090$ df = 3 Critical Value = 7.815 Null Hypothesis: Failed to reject	43	64	107	$\chi^2 = 3.121$ df = 3 Critical Value = 7.815 Null Hypothesis: Failed to reject
		6.96 %	16.3 0%	23.2 6%		6.74 %	16.5 2%	23.2 6%		9.35 %	13.9 1%	23.2 6%	
	29-38	51	84	135		44	91	135		60	75	135	
		11.0 9%	18.2 6%	29.3 5%		9.57 %	19.7 8%	29.3 5%		13.0 4%	16.3 0%	29.3 5%	
	39-48	47	75	122		38	84	122		46	76	122	
		10.2 2%	16.3 0%	26.5 2%		8.26 %	18.2 6%	26.5 2%		10.0 0%	16.5 2%	26.5 2%	
	49-58	29	67	96		13	83	96		32	64	96	
		6.30 %	14.5 7%	20.8 7%		2.83 %	18.0 4%	20.8 7%		6.96 %	13.9 1%	20.8 7%	
	Total	159	301	460		126	334	460		181	279	460	

Education	Graduate & Above	32	44	76	At df = 5 and $\alpha = 0.05$, the critical value = 11.070 Since 16.87 > 11.070, we reject the null hypothesis	23	53	76	At df = 5 and $\alpha = 0.05$, the critical value = 11.070 Since 13.88 > 11.070, we reject the null hypothesis	52	24	76	At df = 5 and $\alpha = 0.05$, the critical value = 11.070 Since 36.04 > 11.070, we reject the null hypothesis
		6.96 %	9.57 %	16.5 %		5.00 %	11.5 %	16.5 %		11.3 %	5.22 %	16.5 %	
	Intermediate	36	66	102		31	71	102		48	54	102	
		7.83 %	14.3 %	22.1 %		6.74 %	15.4 %	22.1 %		10.4 %	11.7 %	22.1 %	
	High School	26	70	96		19	77	96		33	63	96	
		5.65 %	15.2 %	20.8 %		4.13 %	16.7 %	20.8 %		7.17 %	13.7 %	20.8 %	
	Middle School	36	27	63		26	37	63		22	41	63	
		7.83 %	5.87 %	13.7 %		5.65 %	8.04 %	13.7 %		4.78 %	8.91 %	13.7 %	
	Primary School	8	27	35		9	26	35		12	23	35	
		1.74 %	5.87 %	7.61 %		1.96 %	5.65 %	7.61 %		2.61 %	5.00 %	7.61 %	
	Illiterate	21	67	88		18	70	88		14	74	88	
		4.57 %	14.5 %	19.1 %		3.91 %	15.2 %	19.1 %		3.04 %	16.0 %	19.1 %	
	Total	159	301	460		126	334	460		181	279	460	

Religion	Hindu	112	194	306	At df = 2 and $\alpha = 0.05$, the critical value = 5.991 Since 2.05 < 5.991, we fail to reject the null hypothesis	88	218	306	At df = 2 and $\alpha = 0.05$, the critical value = 5.991 Since 1.07 < 5.991, we fail to reject the null hypothesis	136	170	306	At df = 2 and $\alpha = 0.05$, the critical value = 5.991 Since 6.72 > 5.991, we reject the null hypothesis
		24.3 %	42.1 %	66.5 %		19.1 %	47.3 %	66.5 %		29.5 %	36.9 %	66.5 %	
	Muslim	45	96	141		36	105	141		43	98	141	
		9.78 %	20.8 %	30.6 %		7.83 %	22.8 %	30.6 %		9.35 %	21.3 %	30.6 %	
	Other	2	11	13		2	11	13		2	11	13	
		0.43 %	2.39 %	2.83 %		0.43 %	2.39 %	2.83 %		0.43 %	2.39 %	2.83 %	
	Total	159	301	460		126	334	460		181	279	460	

Occupation	Working	54	119	173	At df = 3 and $\alpha = 0.05$, the critical value = 7.815 Since 4.53 < 7.815, we fail	42	131	173	At df = 3 and $\alpha = 0.05$, the critical value = 7.815 Since	85	88	173	At df = 3 and $\alpha = 0.05$, the critical value = 7.815, $\chi^2 = 32.27$
		11.7 %	25.8 %	37.6 %		9.13 %	28.4 %	37.6 %		18.4 %	19.1 %	37.6 %	
	Homemaker	23	33	56		18	38	56		15	41	56	
		5.00 %	7.17 %	12.1 %		3.91 %	8.26 %	12.1 %		3.26 %	8.91 %	12.1 %	
	Student	52	72	124		38	86	124		60	64	124	
		11.3 %	15.6 %	26.9 %		8.26 %	18.7 %	26.9 %		13.0 %	13.9 %	26.9 %	

	Non-Working	30	77	107	to reject the null hypothesis	28	79	107	1.60 < 7.815, we fail to reject the null hypothesis	21	86	107	Since 32.27 > 7.815, we reject the null hypothesis
		6.52 %	16.7 4%	23.2 6%		6.09 %	17.1 7%	23.2 6%		4.57 %	18.7 0%	23.2 6%	
	Total	159	301	460		126	334	460		181	279	460	

Type Of Family	Nuclear	74	141	215	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.00188 < 3.841, we fail to reject the null hypothesis	58	157	215	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.0243 < 3.841, we fail to reject the null hypothesis	80	135	215	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.4755 < 3.841, we fail to reject the null hypothesis
		16.0 9%	30.6 5%	46.7 4%		12.6 1%	34.1 3%	46.7 4%		17.3 9%	29.3 5%	46.7 4%	
	Joint	85	160	245		68	177	245		101	144	245	
		18.4 8%	34.7 8%	53.2 6%		14.7 8%	38.4 8%	53.2 6%		21.9 6%	31.3 0%	53.2 6%	
	Total	159	301	460		126	334	460		181	279	460	

Marital Status	Married	84	152	236	At df = 3 and $\alpha = 0.05$, the critical value = 7.815 Since 0.4752 < 7.815, we fail to reject the null hypothesis	65	171	236	At df = 3 and $\alpha = 0.05$, the critical value = 7.815 Since 0.2418 < 7.815, we fail to reject the null hypothesis	78	158	236	At df = 3 and $\alpha = 0.05$, the critical value = 7.815 Since 34.8 > 7.815, we reject the null hypothesis
		18.2 6%	33.0 4%	51.3 0%		14.1 3%	37.1 7%	51.3 0%		16.9 6%	34.3 5%	51.3 0%	
	Unmarried	51	96	147		40	107	147		38	109	147	
		11.0 9%	20.8 7%	31.9 6%		8.70 %	23.2 6%	31.9 6%		8.26 %	23.7 0%	31.9 6%	
	Separated	14	34	48		12	36	48		45	3	48	
		3.04 %	7.39 %	10.4 3%		2.61 %	7.83 %	10.4 3%		9.78 %	0.65 %	10.4 3%	
	Widowed	10	19	29		9	20	29		20	9	29	
		2.17 %	4.13 %	6.30 %		1.96 %	4.35 %	6.30 %		4.35 %	1.96 %	6.30 %	
	Total	159	301	460		126	334	460		181	279	460	

Addiction of Harmful	Alcohol	20	13	33	At df = 3 and $\alpha = 0.05$, the critical	9	24	33	At df = 3 and $\alpha = 0.05$,	11	22	33	At df = 3 and $\alpha = 0.05$, the
		4.35 %	2.83 %	7.17 %		1.96 %	5.22 %	7.17 %		2.39 %	4.78 %	7.17 %	
	Tobacco/Smoking	59	70	129		35	94	129		45	84	129	

Substance		12.8 3%	15.2 2%	28.0 4%	value = 7.815 Since 37.6 > 7.815, we reject the null hypothesis	7.61 %	20.4 3%	28.0 4%	the critical value = 7.815 Since 0.0407 < 7.815, we fail to reject the null hypothesis	9.78 %	18.2 6%	28.0 4%	critical value = 7.815 Since 2.0121 < 7.815, we fail to reject the null hypothesis
	Both	30	15	45		13	32	45		16	29	45	
		6.52 %	3.26 %	9.78 %		2.83 %	6.96 %	9.78 %		3.48 %	6.30 %	9.78 %	
	No Addiction	50	203	253		69	184	253		109	144	253	
		10.8 7%	44.1 3%	55.0 0%		15.0 0%	40.0 0%	55.0 0%		23.7 0%	31.3 0%	55.0 0%	
	Total	159	301	460		126	334	460		181	279	460	

Tenure Of House	Own	95	177	272	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.0255 < 3.841, we fail to reject the null hypothesis	72	200	272	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.2084 < 3.841, we fail to reject the null hypothesis	102	170	272	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.5953 < 3.841, we fail to reject the null hypothesis
		20.6 5%	38.4 8%	59.1 3%		15.6 5%	43.4 8%	59.1 3%		22.1 7%	36.9 6%	59.1 3%	
	Rented	64	124	188		54	134	188		79	109	188	
		13.9 1%	26.9 6%	40.8 7%		11.7 4%	29.1 3%	40.8 7%		17.1 7%	23.7 0%	40.8 7%	
	Total	159	301	460		126	334	460		181	279	460	

Overcrowding	Yes	63	106	169	Anxiety vs Overcrowding At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.0669 < 3.841, we fail to reject the null hypothesis	50	119	169	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 2.2314 < 3.841, we fail to reject the null hypothesis	67	102	169	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 1.7083 < 3.841, we fail to reject the null hypothesis
		13.7 0%	23.0 4%	36.7 4%		10.8 7%	25.8 7%	36.7 4%		14.5 7%	22.1 7%	36.7 4%	
	No	96	195	291		76	215	291		114	177	291	
		20.8 7%	42.3 9%	63.2 6%		16.5 2%	46.7 4%	63.2 6%		24.7 8%	38.4 8%	63.2 6%	
	Total	159	301	460		126	334	460		181	279	460	

Financial Debt In Family	Yes	123	216	339	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.1608 < 3.841, we fail to reject the null hypothesis	95	244	339	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 1.0649 < 3.841, we fail to reject the null hypothesis	134	205	339	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 4.7054 > 3.841, we reject the null hypothesis
		26.7 4%	46.9 6%	73.7 0%		20.6 5%	53.0 4%	73.7 0%		29.1 3%	44.5 7%	73.7 0%	
	No	36	85	121		31	90	121		47	74	121	
		7.83 %	18.4 8%	26.3 0%		6.74 %	19.5 7%	26.3 0%		10.2 2%	16.0 9%	26.3 0%	
	Total	159	301	460		126	334	460		181	279	460	

Domestic Violence in Family	Yes	33	48	81	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.0002 < 3.841, we fail to reject the null hypothesis	29	52	81	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.0979 < 3.841, we fail to reject the null hypothesis	60	21	81	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 12.48 < 3.841, we reject the null hypothesis
		7.17 %	10.4 3%	17.6 1%		6.30 %	11.3 0%	17.6 1%		13.0 4%	4.57 %	17.6 1%	
	No	126	253	379		97	282	379		121	258	379	
		27.3 9%	55.0 0%	82.3 9%		21.0 9%	61.3 0%	82.3 9%		26.3 0%	56.0 9%	82.3 9%	
	Total	159	301	460		126	334	460		181	279	460	

Loss of a Loved One (Past Year)	Yes	55	22	77	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 35.8 < 3.841, we reject the null hypothesis	52	25	77	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 45.3 > 3.841, we reject the null hypothesis	32	45	77	At df = 1 and $\alpha = 0.05$, the critical value = 3.841 Since 0.6164 < 3.841, we fail to reject the null hypothesis
		11.9 6%	4.78 %	16.7 4%		11.3 0%	5.43 %	16.7 4%		6.96 %	9.78 %	16.7 4%	
	No	104	279	383		74	309	383		149	234	383	
		22.6 1%	60.6 5%	83.2 6%		16.0 9%	67.1 7%	83.2 6%		32.3 9%	50.8 7%	83.2 6%	
	Total	159	301	460		126	334	460		181	279	460	

								hypot hesis			null hypothesis
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Source: Primary survey 2025

This table presents the association between socio-demographic variables and the prevalence of anxiety, depression, and stress, assessed using the Chi-square test. Gender and age showed a statistically significant association with depression. Depression prevalence was highest among individuals aged 29–38 years (9.57%), followed by 39–48 years (8.26%), 18–28 years (6.74%), and lowest in the 49–58 years group (2.83%). Gender-wise analysis revealed a higher prevalence of depression among women (17.83%) compared to men (9.57%).

Education demonstrated a significant association with all three mental health outcomes-anxiety, depression, and stress. The highest prevalence across all three conditions was observed among respondents with intermediate-level education (7.83%, 6.74%, and 10.43%, respectively).

Religion was significantly associated only with stress, with higher stress levels reported among Hindus (29.57%) compared to Muslims (9.35%). Occupational status also showed variation in stress levels, which were highest among working individuals (18.48%) and students (13.04%), followed by non-working individuals (4.57%) and homemakers (3.26%). Marital status revealed higher stress among married respondents (16.96%), followed by separated (9.78%), unmarried (8.26%), and widowed individuals (4.50%). Financial debt emerged as a major contributor to stress, affecting 29.13% of respondents, while domestic violence was associated with stress in 26.30% of cases.

Substance use exhibited the strongest association with anxiety. Anxiety prevalence was highest among tobacco users (12.83%), followed by individuals with no reported addiction (10.87%), those using both alcohol and tobacco (6.52%), and alcohol-only users (4.35%). Experiencing the loss of a loved one in the past year showed a significant association with both anxiety (11.96%) and depression (11.30%). No statistically significant association was observed between mental health outcomes and type of family, housing tenure, or overcrowding.

Factors Affecting Mental Health Accessibility (Table 6)

Multiple barriers to mental healthcare access were identified. Social factors included stigma, discrimination, and cultural beliefs that attribute mental illness to fate or supernatural causes. Structural barriers comprised limited availability of mental health services, affordability issues, and physical inaccessibility due to distance and lack of resources. At the individual level, inadequate knowledge and awareness further hindered timely help-seeking behavior.

Table 6: Factors affecting Mental Health accessibility among individuals

Main Factors	Sub-Factors	Brief Description
Social Factors	Stigma	Considering mental problems as a weakness, which prevents people from seeking help.
	Discrimination	Fear of being viewed differently by society towards people with mental problems.
	Cultural Beliefs	Attributing mental illness to karma, fate, or supernatural causes, which hinders seeking treatment.
Structural Factors	Availability	Lack of access to mental health services or specialists may lead to inability to seek help.
	Affordability	Inability to afford treatment, especially in low-income families.
	Accessibility	Distance, time, and lack of resources are barriers to accessing services.
Individual Factors	Knowledge & Awareness	Distance, time, and lack of resources are barriers to accessing services.

Source: Primary survey 2025

Discussion

The findings indicate that mental health outcomes are shaped by a complex interaction of socio-demographic, educational, occupational, and familial factors. Higher depression among women reflects persistent gender-based social roles, emotional labor, and limited support systems. Age-related variation suggests that individuals in early and middle adulthood may be more vulnerable due to economic responsibilities and life transitions.

Education emerged as a significant determinant of all mental health conditions, highlighting the dual burden of academic pressure among students and limited employment opportunities among those with lower educational attainment. Elevated stress among working individuals and married respondents may be attributed to workload, job insecurity, financial responsibilities, and work–life imbalance. The strong association between stress and domestic violence underscores the continued presence of gender-based violence and its severe psychological consequences.

Substance use, particularly tobacco, was strongly linked to anxiety, reflecting its impact on neurobiological and emotional regulation mechanisms. Similarly, bereavement was associated with heightened anxiety and depression, emphasizing the emotional vulnerability following major life events.

Conclusion

Mental health in urban Jaipur is influenced by a wide range of socio-economic, behavioral, and structural factors. Stress is primarily driven by education, occupation, financial debt, and domestic violence, while depression is closely associated with gender, age, and personal loss. Anxiety shows strong links with substance use and emotional trauma.

Persistent stigma, limited awareness, and inadequate availability and affordability of mental healthcare services continue to restrict timely diagnosis and treatment. Addressing the urban mental health burden requires a multi-dimensional approach that combines improved service accessibility, community awareness, economic support, violence prevention, and targeted psychosocial interventions. Strengthening these areas is essential to promote mental well-being and reduce unmet mental healthcare needs in urban populations.

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