Work and Health
https://www.sciltp.com/journals/wah

Article

'Informal Counsellors' in the Factory: Experiences from Workplace Mental Health Trainings in South India

Sakthi Arasu, Bobby Joseph and Nancy Angeline *

Division of Occupational Health, Department of Community Health, St John's Medical College, Bangalore 560034, India
* Correspondence: nancy.ag@stjohns.in; Tel.: +91-9108551783

How To Cite: Arasu, S.; Joseph, B.; Angeline, N. 'Informal Counsellors' in the Factory: Experiences for Workplace Mental Health Trainings in South India. *Work and Health* **2025**, *1*(2), 9. https://doi.org/10.53941/wah.2025.100009

Received: 15 January 2025
Revised: 4 March 2025
Accepted: 25 August 2025
Published: 26 August 2025

Abstract: Access to mental health in India is limited due to a shortage of professionals, societal stigma, and social inequities. Female workers in the manufacturing industry might be particularly affected. The provision of workplace mental health services through trained professionals may not always be feasible. Hence, we aimed to train selected factory employees on informal counseling services. We collected the initial case histories handled by trained workplace's informal counsellors among the predominantly female workforce of 4 garment manufacturing plants in South India. A thematic analysis addressed how the workers accessed these services. Workers utilised the 'informal counsellors' services. The main issues were marital problems, workplace issues, and interpersonal issues leading to stress and anxiety. Even though the workers were initially hesitant, they opened up to the counsellors who were equipped with skills such as active listening, a non-judgmental attitude, and empathy. Challenges encountered included addressing stigma, balancing mental health services alongside production, and the dilemma about whether to intervene or not. Family, social, and occupational stress factors can disrupt workers' mental well-being, which in turn affects productivity at work and Society as a whole. The female workforce is particularly vulnerable to these issues. Training informal workplace counsellors to address stress and mental health issues among colleagues could be beneficial for workers and employers alike.

Keywords: informal counsellors; factory workers; work-related stress; mental health; women; working

1. Introduction

The World Health Organization (WHO) defines mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It has intrinsic and instrumental value and is integral to our wellbeing" [1]. Mental health issues are related to multifactorial risk factors, including domestic and occupational factors, and everything in between.

Awareness, diagnosis and treatment gaps of mental health problems are prevalent in Low and Middle Income Countries (LMICs) [2,3]. In India, about 1 in 20 people suffer from depression, and 1% of the whole population is at high suicidal risk [4]. Almost 75% people with a severe mental disorder experience significant disability in their work, social and family life [4]. However, the treatment gap is vast, ranging from 28% to 83% for mental disorders and 86% for alcohol use disorders [4]. This gap is partly due to a lack of awareness and partly to insufficient mental health treatment. In India, there are 0.3 psychiatrists, 0.7 mental health nurses, 0.06 social workers and 0.07 psychologists for every 100,000 population [5]. Combined with this, the stigma around mental health adversely affects the likelihood of people seeking help [6,7].

India is a hub in the supply chain for global brands and the apparel manufacturing sector, significantly contributing to the country's Gross Domestic Product (GDP) [8]. These factories are spread across the country but are mainly concentrated in and around the Tirupur district of Tamil Nadu, South India. These factories cover processes such as spinning, knitting, printing, cutting, stitching, checking and packing. Traditionally, women make up 70% of the workforce. For women, employment in this industry means decent pay, dignified work, and the ability to provide for children's education [9]. On the other hand, exploitation, harassment, including sexual harassment, violence, and abuse, are frequent for women working in the textile industry [10–13]. Mental health in the workplace has gained significant attention in recent years, as suggested by the importance given to this topic by the International Labour Organization (ILO) [14] and WHO [15,16]. WHO estimates that workplace mental health problems result in a loss of productivity amounting to approximately 1 trillion USD annually. Furthermore, interventions aimed at improving mental health yield a return on investment that is four times greater [17]. The workplace is uniquely positioned to provide long-term support for personal issues, and interventions in this setting have demonstrated effectiveness in enhancing workers' mental well-being [18]. Mental health issues can lead to decreased productivity, increased absenteeism, frequent mistakes, and, sometimes, presenteeism among workers [19]. Additionally, depression accounts for the highest per capita health expenditures in a factory setting [20]. Evidence suggests that counseling interventions can produce positive outcomes, particularly in LMICs [21,22].

Counseling is defined as an interaction between two individuals: one seeking help and the other listening and providing it [23–25]. This process is built on a foundation of mutual trust and respect between the counsellor and the counselee, which facilitates personal change and helps the individual find solutions for her/his own problems. While counseling is particularly effective in addressing the social causes of mental health issues, it can be challenging to provide the services of a trained counsellor in resource-constrained settings, especially at a single workplace [26]. In such cases, informal counsellors can take on the role of psychologists, counsellors, and health professionals by providing emotional support and helping individuals navigate their stress and mental health challenges [27,28].

Task transfer in mental health typically involves training community health workers at the grassroots level and supporting them in conducting screenings and referrals with their community [29]. However, there is limited literature on training factory employees to become "informal counsellors" and the types of counseling sessions they could offer in their workplace. Further research is needed to evaluate the acceptability and accessibility of implementing a workplace mental health program based on practical experiences. The objective of this study was to describe the initial results of an "informal counsellor" intervention, to explore the personal characteristics of workers seeking informal counseling, to identify their mental health issues, and to examine the interventions provided by the "informal counsellors".

2. Materials and Methods

Four garment manufacturing factories, with a total workforce of about 1400 located in the Tirupur district of Tamil Nadu, South India, were selected based on their willingness to support the implementation of the program. Once the factories were chosen, their management received instructions regarding the activities involved in the program and the corresponding timeline. The management then proposed several employees based on our selection criteria, which included being a factory employee for more than one year, having the ability to interact with coworkers, being proactive in workers' committees, and expressing a willingness to participate. A total of 22 individuals from workplaces were selected ed introduced to the program, and their roles and responsibilities were clearly explained. Following this, the participants were personally interviewed to gauge their interest and consent to join the program. They were also asked the following questions related to the selection criteria:

- Attitude towards the program.
- Expected number of years they plan to continue working in the same factory.
- Availability of another skilled worker to replace them while training.
- At least 5 years of education.
- Willingness to travel for training.
- Willingness to undergo training and participate in the program.
- Willingness to take on the role of "informal counsellor" and to use personal time, beyond regular factory work, to listen and support others.
- Willingness to do this without monetary compensation.

Medical doctors trained the selected individuals as part of their residency program in preventive and social medicine, occupational health and community psychiatry. The authors developed in-house training modules based on the World Health Organization mhGAP [30] modules and concepts from sociology. These modules covered

the basics of mental health and counseling, interpersonal communication, stress management, crisis management, and problem-solving. To enhance learning, methods of adult learning were utilized, including a participatory approach, group activities, and role plays. Feedback from participants was collected from each module to assess which methodologies were effective and which were not, allowing for improvements to be applied in the subsequent training sessions. Each module lasted two days. Upon completion, participants gained awareness of mental health issues, became confident in providing counseling, improved their interpersonal communication skills, and developed the ability to identify individuals experiencing stress and support them in overcoming it. The same instructors provided the same training to all participants. Additionally, the counsellors had the option to seek guidance from the trainers for cases that required clarification or referral.

These 'informal counsellors' were introduced to factory employees through an awareness session focusing on mental health and its impact on personal and work life. They were trained to obtain informed consent and to document the counseling session without using any identifying information. We collected the initial case experiences handled by our trained 'informal counsellors', ensuring the anonymity and confidentiality of the counselees.

The "informal counsellors" followed the six steps for effective counseling: building rapport, gathering information, encouraging questions, paraphrasing and checking for understanding, assisting in decision-making or problem solving, and discussing available support systems and referrals. The counsellors adhered to the four ethical pillars of counseling: Autonomy, Beneficence, Non-maleficence, and Justice.

This study utilized a combination of narrative and thematic analysis to explore and analyse the counsellor's experiences in managing counselees with work-related issues. Five individual cases were purposefully selected and documented to provide in-depth insights into the counseling process and its impact. The selection criteria included diversity in gender, work department, and the nature of the presenting problem. Data were collected from counseling case records, such as counsellor notes, session summaries, and follow-up documentation. Where necessary, counsellors were consulted to clarify contextual details. No direct interviews with counselees were conducted for this study. Initially, each case was analyzed individually to construct a narrative account. Following this, a thematic comparison was made across the five cases to identify patterns and divergences in the issues faced, the counseling interventions applied, and the post-counseling outcomes. Each case is presented narratively under consistent thematic headings to ensure coherence across cases while preserving the unique aspects of each individual case.

Ethics Approval Statement

This study is part of a research project that received approval from the institutional ethics board of St. John's Medical College (reference number 66/2021). The research was conducted in accordance with the World Medical Association's Declaration of Helsinki. All personal identifiers have been anonymized to safeguard the counselee's confidentiality. No audio recordings were utilized in the preparation of case summaries.

3. **Results**

In line with the high prevalence of women among the Tamil Nadu area garment manufacturing workforce, a significant majority of female workers (15 out of 24) sought assistance from informal counsellors. The average age of these workers was 31.8 years (SD: 6.4), were married and lived in three-generation households with their in-laws. The average years of education among the counselees was 9.2 years (SD: 2.7). Their median monthly salary was around INR 10,000 (about 125 USD), which falls within the lower-middle range of the socioeconomic scale.

3.1. Approach to Counsellors

In several instances, counselees had heard about the factory's informal counsellors and reached out to them, while in other instances, the counsellors approached the counselees themselves. The problems reported at work included frequent mistakes, slow performance, or conflicts with coworkers along the production line. However, the most common issues mentioned by the initial cases were personal, stemming from family and relationship issues, such as mental and physical abuse by a drunken husband or the husband blaming the counselee for his own life difficulties. A married woman experienced anger and frustration from her husband, which led her to contemplate suicide. A few unmarried women reported issues of possessiveness and miscommunication that hampered their friendships.

Both in active and passive counseling, counselees initially hesitated to open up about their emotions and problems. The counsellors employed their rapport-building skills to establish trust and ensure confidentiality. This approach encouraged counselees to gradually share what was troubling them. Sometimes, the counsellor would listen to the counselee in a private, enclosed space away from the production area, while at other times,

conversations would take place in common areas, like canteens or parking lots. One counsellor recalled a moment "*…when one woman broke down crying. I gave her some water, asked her to take a few deep breaths and taught her a deep breathing exercise. It was only after that that she was able to put words together and explain…*".

3.2. Workplace Issues

The informal counsellors also addressed workplace issues of work-related stress, primarily stemming from harsh reprimands given by supervisors in front of colleagues. This behavior caused the employees to feel humiliated and unable to perform at the same level at work, leading to more mistakes, and creating a vicious cycle of further verbal abuse. Workplace gossip also negatively impacts employees and disrupts their regular work: *"…when people younger than me talk bad about me behind my back based on a rumour, it hurts me the most as I see them as my own children…"*. In one case, a counsellor handled a collective issue affecting employees: women from a specific area were arriving late at work due to delays in their household water supply, which forced them to wait for water collection.

3.3. Counseling

Counsellors were instructed to begin with rapport-building and providing reassurances to encourage the counselees to open up. They practiced active listening with a non-judgmental attitude and empathy. These vital qualities are crucial for establishing trust, allowing counselees to express themselves freely. Counsellors also needed to ensure that their listening was acknowledged by the counselees through body language and head nods. They consistently encouraged counselees to come up with multiple solutions and guided them in brainstorming their options. Additionally, counsellors paraphrased what the counselees shared, confirming their understanding of the situation and the emotional impact it had on them.

Whenever the counsellors faced uncertainty in guiding a counselee, they referred to the ethics of counseling. For example, they considered an autonomy vs. non-maleficence attitude to counsel a woman affected by her abusive, alcoholic husband. In situations where the counselee felt overwhelmed by stress or grief, the counsellors utilized their 'crisis handling skills' to offer support through 'guided deep breathing' exercises or tapping techniques. They also encouraged the counselee to reflect on positive memories of the person they were struggling with, which could be crucial for facilitating apologies or reconciliations. At the end of each session, counsellors would always say *"…you are always welcome to come talk to me when you go through similar situations…"*.

3.4. Post Counseling

After the counseling session, the counselees may or may not have found a specific solution, but they felt better equipped to cope with their situations. One woman, who had been considering taking her own life, said *"…. I feel more positive and I feel that I should live and take care of my child…".* Another male counselee realized through counseling that he had not been considering his wife's perspective when making decisions that affected them both. Many of the counselees felt hopeful about their ability to work through their situations after the counseling.

3.5. Challenges Faced by the Counsellors

Implementing the informal mental health support system in the workplace presented several challenges. Informal counsellors faced a dilemma when workplace problems required escalation to management; they had to decide whether to take action while maintaining confidentiality. Additionally, it was difficult to explain to supervisors how family-related stress impacted employees' performance without revealing personal information. To generate awareness and reduce the stigma surrounding mental health and counseling, the team utilized posters, role plays, and skits. Another significant challenge was balancing counselling and awareness sessions with meeting production targets, as it was challenging to find time in busy work schedules.

4. **Discussion**

The initial cases handled by the counsellors highlight the various issues which can impact workers' mental health. In India, the legal guideline known as "The Factories Act, 1948" [31] outlines standards for the workplace, workers' rights, and welfare; however, it lacks sufficient provisions for mental health. The informal counseling program discussed in this paper could support these legal provisions and contribute to creating healthier workplaces.

The issues highlighted by these case stories reflect the conditions in and around Tirupur, dubbed the garment manufacturing hub of South India. The majority of the workforce in this industry consists of women who must balance work and family life. According to the 2017–2022 World Value Survey, only 29.5% of the Indian interviewees

disagreed or strongly disagreed with the statement "Men should have more right to a job than women" [32]. This cultural environment can lead to a lack of family support for women who are the family breadwinners, contributing to workplace stress and creating a fragile married life, riddled with arguments and fights, sometimes escalating to violence. Domestic violence and suicide rates are reportedly high in this area owing to various reasons, from work stress to alcohol abuse [33,34].

Another big challenge was the stigma associated with mental health [35] and the workers' reluctance to speak about it. Additionally, the outdated belief that a woman should tolerate her husband despite whatever he does contributes to the normalization of abuse faced by women [36], which in turn discourages them from seeking help. Female workers view the workplace as a community where they can be themselves, express their personality, and share their feelings with their peers. Often, the workplace offers a respite that is glaringly lacking in their home lives, thereby promoting their mental health [37,38]. On the other hand, it is a frequent male attitude to fail to acknowledge their own mental health issues [39,40]. Men tend to downplay their troubles, mask their feelings, and bottle up their emotions, which can inadvertently affect their physical health, work performance and behaviour. Trainers and trained counsellors addressed this issue through a series of awareness sessions at the workplace, utilizing various methodologies, including skits, stories, and role-plays to engage employees effectively.

4.1. Lessons Learned from the Counsellors' Experience

Establishing mental health services in the workplace provides employees with a space to express their concerns and discuss what is stressing them. This process might allow them to clear their minds and focus better on their tasks, reducing mistakes and the need for reworking garment pieces. Additionally, the 'informal counsellor', from his position on the shop floor, can address most interpersonal conflicts, alleviating pressure on the human resources department and decreasing the time required for conflict resolution. A workplace that prioritizes the mental health of its employees fosters a sense of belonging, which can lead to lower attrition rates. Future studies should explore whether informal counselling can indirectly enhance productivity while also improving employees' well-being.

Although not formally qualified as psychologists or psychiatrists, the "informal counsellors" are trained to assist their fellow workers handle their problems. Their training emphasized the importance of confidentiality and anonymity, which are essential elements of the program. Workers tend to trust and be open to their trained colleagues rather than seeking help from outsiders, regardless of their qualifications. During the training, the guiding ethics of counselling are taught through various scenarios, which help them make informed decisions.

4.2. Scope for Scaling Up Research

The study findings pave the way for future research on mental health interventions in various workplace sectors, particularly in factories, and how these interventions might impact workers' mental health. Additionally, by analyzing the issues that the counsellors address, stakeholders can develop targeted mental health programs tailored to their specific work environments. Understanding and proactively addressing the factors that influence workers' mental health might significantly enhance work productivity. Implementing mental health training programs should be especially considered in large industrial settings. Key factors for the successful execution of such programs include designing factory buildings with training facilities, providing induction training, establishing worker committees and grievance channels, maintaining a committed management and fostering a supportive environment on the production floor.

4.3. Limitations

This study presents a few findings from the limited number of cases observed during the initial phases of the program. A thorough analysis of all the available case stories will provide more insights into the workers' mental health and the factors influencing it. Additionally, the feasibility and acceptability of the program in different sectors and geographic areas should also be explored.

5. **Conclusions**

Our study suggests that, when employees are made aware of mental health issues and have access to support, they are more likely to utilize the mental health services offered at their workplace. Skills such as rapport building, active listening, maintaining a non-judgmental attitude and demonstrating empathy, which were taught during the training of informal counsellors, proved essential in the counseling sessions. Counsellors also referenced ethical guidelines on counseling when facing a dilemma on how to proceed with a session. Since mental health impacts

the individuals, their family, work productivity, and society as a whole, it is crucial to invest in the mental well-being of workers.

In our study, shifting the responsibility of workplace mental health services to selected employees yielded promising results, with many counselees reaching out to the counsellors. Raising awareness about mental health, combating stigma and encouraging employees to seek help for their mental health challenges has significantly progressed since the program's initiation. Workers came to recognize the importance of seeking mental health support, and embraced their fellow colleagues trained as counsellors. The biggest takeaway was the feasibility of a mental health program, whose acceptability was uplifted by facilitating its accessibility at the workplace.

Author Contributions

S.A.: data curation, writing—original draft preparation, investigation; B.J.: conceptualization, methodology, supervision; validation; writing—reviewing and editing; N.A.: conceptualization, methodology, supervision; validation; writing—reviewing and editing. All authors have read and agreed to the published version of the manuscript.

Funding

The study is part of a welfare project funded by Primark under ABF Investments PLC.

Institutional Review Board Statement

This study is part of a research project that received approval from the institutional ethics board of St. John's Medical College (reference number 66/2021).

Conflicts of Interest

The authors declare no conflict of interest. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript; or in the decision to publish the results.

References

1. World Health Organization. Mental Health. Available online: https://www.who.int/health-topics/mental-health (accessed on 25 August 2023).
2. Kohn, R.; Saxena, S.; Levav, I.; Saraceno, B. The Treatment Gap in Mental Health Care. *Bull. World Health Organ.* **2004**, *82*, 858–866. https://doi.org/10.2471/blt.04.019075.
3. Patel, V.; Maj, M.; Flisher, A. J.; et al. Reducing the Treatment Gap for Mental Disorders: A WPA Survey. *World Psychiatry* **2010**, *9*, 169–176. https://doi.org/10.1002/j.2051-5545.2010.tb00305.x.
4. Gururaj, G.; et al. *National Mental Health Survey of India, 2015–2016*: *Summary*; National Institute of Mental Health and Neurosciences: Bengaluru, India, 2016.
5. World Health Organization (WHO). *Mental Health Atlas*; World Health Organization: Geneva, Switzerland, 2018.
6. Corrigan, P. How Stigma Interferes with Mental Health Care. *Am. Psychol.* **2004**, *59*, 614–625. https://doi.org/10.1037/0003-066X.59.7.614.
7. Hatzenbuehler, M. L.; Phelan, J. C.; Link, B. G. Stigma as a Fundamental Cause of Population Health Inequalities. *Am. J. Public Health* **2013**, *103*, 813–821. https://doi.org/10.2105/AJPH.2012.301069.
8. Ministry of Commerce & Industry. *Threads of Progress: How Make in India is Shaping the Future of Textiles and Apparel Industry*; PIB Delhi: New Delhi, India, 2025. Available online: https://pib.gov.in/PressReleasePage.aspx?PRID=2117470 (accessed on 4 May 2025).
9. Fashion Revolution. Exploitation or Emancipation? Women Workers in the Garment Industry. 2015. Available online: https://www.fashionrevolution.org/exploitation-or-emancipation-women-workers-in-the-garment-industry/ (accessed on 25 August 2023).
10. Kelly, A. Bangladesh's Garment Workers Face Exploitation, but Is It Slavery? *The Guardian* (Global Development), 16 May 2013. Available online: https://www.theguardian.com/global-development/poverty-matters/2013/may/16/bangladesh-garment-workers-exploitation-slavery (accessed on 25 August 2023).
11. Human Rights Watch. Combating Sexual Harassment in the Garment Industry. Available online: https://www.hrw.org/news/2019/02/12/combating-sexual-harassment-garment-industry (accessed on 25 August 2023).
12. International Labour Organization. *Sexual Harassment at Work: Insights from the Global Garment Industry*; International Labour Organization: Geneva, Switzerland, 2019.
13. World Health Organization. *Healthy Workplaces: A Model for Action*; World Health Organization: Geneva, Switzerland, 2010. Available online: https://www.who.int/publications/i/item/9789241599313 (accessed on 24 June 2020).

14. International Labour Organization; World Health Organization. *Mental Health at Work: Policy Brief*; World Health Organization: Geneva, Switzerland, 2022. Available online: https://www.ilo.org/sites/default/files/wcmsp5/groups/public/@ed_protect/@protrav/@safework/documents/publication/wcms_856976.pdf (accessed on 22 November 2023).
15. International Labour Organization. WHO and ILO Call for New Measures to Tackle Mental Health Issues at Work. *Press Release*, 28 September 2022. Available online: https://www.who.int/news/item/28-09-2022-who-and-ilo-call-for-new-measures-to-tackle-mental-health-issues-at-work (accessed on 22 November 2023).
16. World Health Organization. *World Mental Health Report: Transforming Mental Health for All*; World Health Organization: Geneva, Switzerland, 2022. Available online: https://www.who.int/publications/i/item/9789240049338 (accessed on 7 December 2023).
17. Chisholm, D.; Sweeny, K.; Sheehan, P.; et al. Scaling-Up Treatment of Depression and Anxiety: A Global Return on Investment Analysis. *Lancet Psychiatry* **2016**, *3*, 415–424. https://doi.org/10.1016/S2215-0366(16)30024-4.
18. Proper, K.I.; Van Oostrom, S.H. The Effectiveness of Workplace Health Promotion Interventions on Physical and Mental Health Outcomes—A Systematic Review of Reviews. *Scand. J. Work Environ. Health* **2019**, *45*, 546–559. https://doi.org/10.5271/sjweh.3833.
19. Lerner, D.; Henke, R.M. What Does Research Tell Us About Depression, Job Performance, and Work Productivity? *J. Occup. Environ. Med.* **2008**, *50*, 401–410. https://doi.org/10.1097/JOM.0b013e31816bae50.
20. Goetzel, R.Z.; Pei, X.; Tabrizi, M.J.; et al. Ten Modifiable Health Risk Factors Are Linked to More Than One-Fifth of Employer–Employee Health Care Spending. *Health Aff.* **2012**, *31*, 2474–2484. https://doi.org/10.1377/hlthaff.2011.0819.
21. Patel, V. The Future of Psychiatry in Low-And Middle-Income Countries. *Psychol. Med.* **2009**, *39*, 1759–1762. https://doi.org/10.1017/S0033291709005224.
22. Patel, V.; Chowdhary, N.; Rahman, A.; et al. Improving Access to Psychological Treatments: Lessons from Developing Countries. *Behav. Res. Ther.* **2011**, *49*, 523–528. https://doi.org/10.1016/j.brat.2011.06.012.
23. Ohlsen, M.M.; Proff, F.C.; Roeber, E.C. Counseling and Adjustment. *Rev. Educ. Res.* **1956**, *26*, 292. https://doi.org/10.2307/1169363.
24. Shertzer, B.; Stone, S.C. *Fundamentals of Guidance and Counselling*; Houghton Mifflin Co.: Boston, MA, USA, 1976. Available online: http://www.sciepub.com/reference/154590 (accessed on 25 August 2023).
25. Hahn, M.E.; MacLean, M.S. Counselors and Counseling. In *Counseling Psychology*, 2nd ed.; McGraw-Hill Book Company: Columbus, OH, USA, 2014; pp. 1–22. https://doi.org/10.1037/14490-001.
26. World Health Organization. *Task Shifting Global Recommendations and Guidelines HIV/AIDS*; World Health Organization: Geneva, Switzerland, 2008. https://apps.who.int/iris/bitstream/handle/10665/43821/9789 (accessed on 26 August 2023).
27. van Rensburg, J.M. Defining Lay Counselling. *New Voices Psychol.* **2008**, *4*, 5–13.
28. Dewing, S.; Mathews, C.; Schaay, N.; et al. Improving the Counselling Skills of Lay Counsellors in Antiretroviral Adherence Settings: A Cluster Randomised Controlled Trial in the Western Cape, South Africa. *AIDS Behav.* **2014**, *19*, 157–165. https://doi.org/10.1007/s10461-014-0781-4.
29. Armstrong, G.; Kermode, M.; Raja, S.; et al. A Mental Health Training Programme for Community Health Workers in India: Impact on Knowledge and Attitudes. *Int. J. Ment. Health Syst.* **2011**, *5*, 17. https://doi.org/10.1186/1752-4458-5-17.
30. World Health Organization. *mhGAP Training Manuals: Mental Health Gap Action Programme*; World Health Organization: Geneva, Switzerland, 2017. Available online: https://www.who.int/teams/mental-health-and-substance-use/data-research/mhgap-training-manuals (accessed on 25 March 2025).
31. Ministry of Labour and Employment. *The Factories Act*; Ministry of Labour and Employment: New Delhi, India, 1948.
32. Haerpfer, C.; Inglehart, R.; Moreno, A.; et al. (Eds.). *World Values Survey: Round Seven—Country-Pooled Datafile Version 6.0.0*; JD Systems Institute: Madrid, Spain; WVSA Secretariat: Vienna, Austria, 2024. https://doi.org/10.14281/18241.24.
33. Manoranjitham, S. D.; Rajkumar, A. P.; Thangadurai, P.; et al. Risk Factors for Suicide in Rural South India. *Br. J. Psychiatry* **2020**, *196*, 26–30. https://doi.org/10.1192/bjp.bp.108.063347.
34. Rocca, C. H.; Rathod, S.; Falle, T.; et al. Challenging Assumptions About Women's Empowerment: Social and Economic Resources and Domestic Violence among Young Married Women in Urban South India. *Int. J. Epidemiol.* **2009**, *38*, 577–585. https://doi.org/10.1093/ije/dyn226.
35. Shidhaye, R.; Kermode, M. Stigma and Discrimination as a Barrier to Mental Health Service Utilization in India. *Int. Health* **2013**, *5*, 6–8. https://doi.org/10.1093/inthealth/ihs011.
36. Dandona, R.; Gupta, A.; George, S.; et al. Domestic Violence in Indian Women: Lessons from Nearly 20 Years of Surveillance. *BMC Womens Health* **2022**, *22*, 128. https://doi.org/10.1186/s12905-022-01703-3.
37. Kelloway, E.K.; Dimoff, J.K.; Gilbert, S. Mental Health in the Workplace. *Annu. Rev. Organ. Psychol. Organ. Behav.* **2023**, *10*, 363–387. https://doi.org/10.1146/annurev-orgpsych-120920-050527.
38. Bergefurt, L.; Weijs-Perrée, M.; Appel-Meulenbroek, R.; et al. The Physical Office Workplace as a Resource for Mental Health—A Systematic Scoping Review. *Build. Environ.* **2022**, *207*, 108505. https://doi.org/10.1016/j.buildenv.2021.108505.

39. Otten, D.; Tibubos, A.N.; Schomerus, G.; et al. Similarities and Differences of Mental Health in Women and Men: A Systematic Review of Findings in Three Large German Cohorts. *Front. Public Health* **2021**, *9*, 553071. https://doi.org/10.3389/fpubh.2021.553071.
40. Bonell, S.; Trail, K.; Seidler, Z.; et al. "There's No Sewing Classes, There's No Bedazzling Seminars": The Impact of Masculinity on Social Connectedness and Mental Health for Men Living in Inner-Regional Australia. *Sex Roles* **2023**, *88*, 52–67. https://doi.org/10.1007/s11199-022-01329-7.