Clinical Practice Guidelines for School Mental Health Program

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This draft document is intended for policy makers and leaders of the country at the state, regional and local levels within and outside of the education system who have a relevant interest in the effective learning and development of all students. This provides directions towards setting up an ingenious co-curricular support which the system has to provide for the students towards enhancing their efficiency and preventing the education becoming a mechanical exercise and a fragmented one. The support would be for all children and targeted towards a healthy and competent learning and living.

Introduction:

Children and adolescents form a major proportion of our country. According to the 2001 census the population of India is 1.028 billion. 46.7% of this population is below the age of 20 years.

Learning is an important developmental aspect of Man during all stages of his/her life span; the learning curve is on an upswing during childhood and adolescence. In a civilized society, education is a method by which learning is ensured and enhanced in children and adolescents; schools are the system set up to meet this goal of learning through education.

Article 45 of the Indian Constitution states that, “The State shall strive to provide free and compulsory education to all citizens up to the age of 14.” At present, all political parties have expressed their commitment to convert this Directive Principle into the Fundamental Right to Education. This famous 83rd Amendment, introduced in 1997, has not yet been enacted, but hopefully will soon be. By 1993, 94.45 per cent of the rural population already had access to a primary school or section within one kilometer of their habitation and 84.98 per cent of the rural population had access to upper primary schooling facilities within three kilometers of their habitation. When we look at the daunting size of this country and its population, this is by no means an ordinary achievement. It needs to be firmly kept in mind as an indication of success possible through the commitment of successive governments to providing elementary education to the children of India. The outcome of this persistent commitment has increased the literacy rate to 65.8% in the country. Gross Enrolment Rate is 93.2% and the drop out rate is consistently declining (ASER 2003). Currently it is 39% in primary school stage and 66% at secondary school stage (7 All India Educational Survey –NCERT 2002).

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Having achieved this feet, there is relevance in the scrutiny of the content, component and the process of education in schools and colleges.

‘Real education has to draw out the best from the boys and girls to be educated. This can never be done by packing ill-assorted and unwanted information into the heads of the students. It becomes a dead weight crushing all originality in them and turning them into mere automata’

Mahatma Gandhi – Harijan 1 December 1933.

Rights of the Child (UN Convention 1989) also has reiterated the need for education to go beyond providing knowledge. Competence building and skills development are recognized as the milestones; positive self
Esteem and a well-adjusted personality are seen as the goals of education.

### Enhancing Development - Child Policies Available in India

Various policies present in India recognize the need for holistic development of children. It is mandatory that the various national and regional programs need to be planned and implemented towards this goal.

A short review of the policies is below

**Table - 1**

<table>
<thead>
<tr>
<th>Policy/Program</th>
<th>Year</th>
<th>Areas Covered</th>
<th>Implementation with Reference to Children</th>
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</table>
| National Policy for Children (NPC)      | 1974-| Comprehensive Health for all Children  
Non Formal Education for out of school children  
Education, Treatment, Training & Rehabilitation for socially deprived, Physically and Mentally Challenged children and facilities towards this  
Focus on the Family to enable children | Planning, review and coordination - Central/State level Children's Board  
Anganwadi for every 1000 population - Nutrition, immunization, health check-ups, referral, non formal preschool education |
| Integrated Child Development Services (ICDS) | Welfare Sector | Early Intervention – Physical, Psychological and Social Development of the Child |                                        |
| Integrated Education for the Disabled Children (IEDC) | Equal Educational Facilities for Orthopaedically Challenged, Mild Sensory Impaired, Mild Developmentally Delayed, Learning Disabled, Multiple Handicaps. | Promotion of integration of the differently abled children into the mainstream school wherever possible.  
Capacity Building of Special Teachers and Establishment of Resource Rooms/ teachers in regular schools for differently abled children. |
| District Rehabilitation Center Scheme (DRC) | Ministry of Welfare | Identification, assessment, home training, vocational training, Self Help initiatives for those with disabilities | Sensitization of the Rehabilitation Workers at the various levels towards the psychological aspects of children with mental retardation & disabilities.  
More as a Program and not a Policy with continuous implementation. |
| National Health Policy                  | 1983 | Stress on Primary Health Care with emphasis on Preventive, Promotive and Rehabilitative Aspects | Improvement of Mother Child Health, Decrease in Infant Mortality.  
Minimal focus on School Health Program  
Child Mental Health addressed indirectly only |
| National Policy on Education             | 1968 | Equal Educational Opportunities to everybody.  
Free Education at school level | Uniformity of the system throughout the country  
Differentiation of the Preschool, |
Child Labour Act (1986) and Juvenile Justice Act (Care and Protection of Children) (2000) are the other two important Acts that deal with the Rights of the Children in India according to the UN Convention on the Rights of Children (1989). Both acts protect the basic rights of the child – however, mental health is not explicitly stated.

Dr. R. Srinivasamurthy in his review and appraisal of the policies pertaining to children in India (1993) has pointed out the lack of clear focussed policy/ies on child mental health. According to him the uncoordinated efforts of the various sectors, changing goals and not having targets which are reality based to the India scene are the reasons for that.

He also has noted the clinical preoccupation of the available mental health professionals of the country and the delay of these professionals to spearhead work towards rectifying this major lacuna in liaison with the sectors like welfare, education, labour, health, law over the years.

**CHILD MENTAL HEALTH IN INDIA**

Child Mental Health Services is at a nascent stage in India currently. Awareness of childhood mental health issues and child developmental issues is low but increasing. The sparse child mental health services which are available currently are restricted to the metropolitan cities where large or well established institutions with psychiatric facilities are present, For example National Institute of Mental Health & Neurosciences, Bangalore, Post Graduate Insitute at Chandigarh, Department of Psychiatry, Lucknow, All India Institute of Medical Sciences, New Delhi, Mumbai, Chennai. Training and capacity building towards child mental health services is restricted to the above centres. Non Governmental Organizations play an important role in providing services especially to school children as Career Counseling and Counseling for emotional problems. They also contribute to capacity building by conducting counseling courses. However these are also restricted to big cities. In the rural and semi urban areas child and adolescent work is mainly confined to nutritional, medical developmental aspects. Adolescent Girls are provided services often under the Adolescent Reproductive and
Sexuality Health Program of the NGOs and INGOs. Srinath et al (2005) found 12.5% of children and adolescents suffering from Mental & Behavioral Disorders.

Epidemiology of psychiatric disorders among the Indian children both in and out of school will be dealt with by Dr. Nagpal in another paper of the same series.

SCHOOL MENTAL HEALTH PROGRAM IN INDIA
Kapur (1997) has elegantly traced the early pinings of the School Mental Health Program in India in her book Mental Health in Indian Schools. As seen above developmental policies and programs prevailed in the independent India. Awareness regarding the psychological issues of children and adolescents was meagre and school mental health program was not present till the seventies. Since the late seventies there has been initiatives by Child Psychiatry or Psychiatrists towards a School Mental Health Program in the major metropolition cities like Mumbai, Delhi and Bangalore. Below is a brief review of the initiatives

Most initiatives have focussed on increasing the awareness of the teachers and/or parents about child mental health issues.

NIMHANS Initiatives
Teachers’ Orientation Program
The initiative was set up the by Child Psychiatry Unit of NIMHANS in Bangalore under the leadership of Dr. M. Kapur and Dr. I. Cariappa in 1976.

The then school mental health program was one of Orientation of 28 School teachers in Bangalore in childhood/adolescent mental health problems over 13 sessions. Case discussions, discussions, lectures, role plays and use of resource materials were the techniques used. Constructive evaluation was done of the training to modify the program. It was observed that teachers found lectures and case discussions as interesting methods of learning. It was also evident by that program that teachers could be trained effectively in basic mental health aspects and problems of children and adolescents; they could be provided with skills to identify psychological problems in their students and handle them effectively.

FURTHER WORK
Over the years several Orientation Programs were conducted by the Child Mental Health Unit of NIMHANS both in the city of Bangalore and the surrounding rural areas including institutions for special children – hearing impaired and orthopedically challenged. The orientation programs often were modified to suit the need of the school, age of the students and the program under which the mental health orientation was done. Mental Health Orientation was done over a range of 6 sessions to 20 sessions. Mental Health Orientation was done both for primary and/or secondary school teachers. No continuing program has been instituted in any of the trained schools exclusively for mental health. However since the trained teachers were also trained in counseling techniques they were expected to identify and intervene at the school level where possible and refer to a child mental health unit in other cases.

SKILLS TRAINING FOR TEACHERS
As a second step of the school mental health initiative, the Child Mental Health Group of NIMHANS offered to train willing sensitized teachers in counseling skills. The program was voluntary and necessitated participation over a year in discussion of cases and management issues.

Student Enrichment Program
Community Mental Health Unit of NIMHANS, under the guidance of Professor Parthasarathy developed a
Student Enrichment Program for the rural adolescents. Students in a rural secondary school were provided with guidance over 25 sessions on

**Clinical Model** or the **Disease Model** in mental health though important is not sufficient. As noticed earlier 12-13% (ICMR 2001) of the children/adolescents have emotional and behavioural problems and would be covered by a well established and effective clinical model of school mental health. The other children are not provided with any system of addressing their mental health needs. The restricted perpective of this ‘Clinical Model’ was recognized and a Promotional Model of Mental Health among Adolescents was initiated by a core group of professionals in NIMHANS in the nineties. WHO introduced the concept of 10 generic Life Skills in 1995 as means to address issues like HIV, Substance Abuse. With the recognition of importance of Life Skills Education for adolescents in India a workshop - Life Skills Education Orientation and Planning Workshop was conducted in 1998 at NIMHANS, Bangalore. One of the recommendations of the workshop was to develop a model Life Skills Education Program specific to the Indian set up and develop resource materials based on the model.

Department of Psychiatry, NIMHANS Bangalore (Srikala Bharath, KVK Kumar 2000) developed a Cascade Model of Life Skills Education after extensive need assessments and focus group discussions with adolescents in secondary schools, secondary school teachers, parents, NGOs, social scientists, bureaucrats and policy makers working with adolescents. Resource materials were developed for the teachers in secondary schools who would be trained as Life Skills Facilitators. A program of Life Skills Education for adolescents has been developed by using this model as a project over the last 4-5 years (Bharath, Kumar 2007).

**HIGHLIGHTS OF NIMHANS MODELOFLIFE SKILLS EDUCATION**

1. The model was developed with inputs from the end users – adolescents and other stakeholders concerned with the health and development of adolescents.
2. The model and resource materials were reviewed by experts.
3. The resource materials were tested in 2 workshops by 57 secondary schools teachers from Karnataka government schools.
4. The model is an integrated one using already available resources of schools, teachers as Life Skills Facilitators and Master Trainers.
5. It is promoted as a co-curricular activity for 8-9 and 10+ standard students by teachers over 52 hours.
6. The classes are mainly through activities among students facilitated by the Life Skills Teacher.
7. Life Skills mentioned are identified in the activities and practiced.
8. It is a participative program focusing on experiential and peer learning.
9. The activities are based on various developmental themes of Nutrition, Hygiene, Academics, Interpersonal Relationships, Substance Use, Gender Issues, Career, Social Responsibility.
10. It is a comprehensive program - All developmental themes pertinent to adolescent have been addressed.
There is no focus only on certain issues like HIV/AIDS or Substance Abuse.
11. The activities are planned from simple to complex.
12. Life Skills Classes are held every week for an hour by the teacher over the academic year.
13. Cultural sensitivity is mentioned in the activities.
14. The model can be used by trained personnel for out of school adolescent population also – used extensively by program developers with tribal, out of school children and children at risk – children of fathers with alcoholism, children affected by disasters.
15. Feedback and Evaluation are built into the model both at the training and implementation stages.
16. The resource materials are available in vernacular languages – Kannada, Gujarati. It is being translated into Hindi and Marathi currently.

PROGRAM SO FAR BY NIMHANS

1. Using the Cascade Model 30 Master Trainers have been for the Department of Education, Karnataka. 69 Master Trainers have been trained for the Navodaya Model School System – Southern Region. Master Trainers have been trained for other states like Kerala and Tamilnadu; other countries like Bhutan, Cambodia. Training of Master Trainers is over 5 days.
2. The Master Trainers of the Department of Education, Karnataka in turn have trained more 1500 secondary school teachers as Life Skills Facilitators. The training for Life Skills Facilitators is for 3 days. Many volunteers and community level workers (CLWs) have been trained as facilitators of Life Skills Education. especially CLWs working with children affected by disasters.
3. The program is run in 4 districts of the state in 265 government secondary schools of Karnataka. Navodaya Schools (Southern Region) also have initiated the LSE in their schools.
4. Sensitization of the concerned Block Educational Officers and Head Masters has been done.
5. Impact of the program was assessed at the end of one year in the state run government schools. It was found that students in the LSE program having better adjustment at school and with teachers; their perceived coping is better than students not in the program.

BOMBAY EXPERIENCE

School Mental Health of Bombay has been spearheaded by Dr. H.S. Dhavale, Department of Psychiatry, B.Y.L. Nair Children’s Hospital in 1979. Direct consultation of the selected schools’ children by a multidisciplinary team of psychiatrists, clinical psychologists and psychiatric social workers. Inputs were made for teachers and parents on psychological issues in children.
A school mental health clinic 1982, continued the orientation work and provided intervention for referred children with psychological problems. The clinic has continuously attempted to increase awareness of poor scholastic performance among students – the reasons for the backwardness, need for assessment, setting up of resource centres etc.
Student Enrichment Program:
The above mentioned had a 3 year time bound period of work with adolescents who were underachievers but intelligent.

Delhi Experience

EXPRESSIONS – A Comprehensive Model of School Mental Health
“Expressions” is an innovative movement which has been set up in the last decade by Dr. Nagpal, Prasad. The group along with the technical support of Ministry of Human Resources and NCERT has been actively working in this field.
The Objectives of this Life Skills Education and Mental Health Awareness Program have been

(a) Sensitization of school children and adolescents about relevant psychosocial issues on the threshold of the new millennium.

(b) Promotion of life skills as abilities for adaptive and positive behavior enabling children to deal effectively with challenges of everyday life.

(c) To initiate and maintain a dialogue between students, teachers and parents about their mutual concern of psychosocial adaptation in a changing environment, for prevention of difficulties associated with behavioral and learning problems.

(d) To identify and assess the social, emotional, school & family needs through structured questionnaires and scales.

(e) Implementation of the model - Comprehensive Life Skills Education and School Mental Health Program

**PROJECT BY EXPRESSIONS**

1. It is a school based project, holistic and is divided into two parts, Junior Section for children below 10 years and The Adolescent Section for 10 to 19 years.
2. The one for the children below 10 years - Orientation Workshops, seminars and camps are organized for teachers, parents and counselors in the primary & middle school sections on Common Childhood Developmental, Emotional and Behavioral Problems. The trainees are provided with skills to classroom and family management strategies for these problems, so that these children can continue to be in mainstream schooling.
3. A Cascade Strategy for disseminating Life Skills Education is used in the adolescent population. Interested teachers are trained as Life Skills Educators who initiate the program in schools and run it.
4. Interested and competent students are identified as “Peer Educators” and trained on life skills training to impart Life Skills to other students.
5. Evaluation – both qualitative and quantitative are carried out.
6. A 3 module Resource Material has been prepared and made available towards this.

**PART 1:** School Mental Health Program in India – Introduction and Rationale

**PART 2:** Reference Manual on Common Developmental, Behavioral and Learning Problems in children for Teachers and Counselors (Focus on Pre-Primary, Primary and Middle School Children).

**PART 3:** Reference Manual on Life Skills Education & Mental Health Awareness in Schools for Adolescents – Workshops Manual for Peer Master Trainers, Teachers and Counselors.

Based on the available information a review of the School Mental Health Initiatives has been done. Information on many of the school mental health program has been very meager and not published. Many of the school mental health initiatives have been post graduate dissertations in disciplines like psychiatric social work, educational psychology or clinical psychology and not available for further information.
Table 2

<table>
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<tr>
<th>SCHOOL Authors</th>
<th>MENTAL Health Program/Project</th>
<th>HEALTH INITIATIVES Organization</th>
<th>IN Place</th>
<th>INDIA</th>
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<td>Chandrasekar C.R.</td>
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<td>Department of Psychiatry NIMHANS</td>
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<td>Srikala Bharath &amp; Kashore Kumar K.V.</td>
<td>Health Promotion using Life Skills Education for Adolescents in Schools</td>
<td>Department of Psychiatry NIMHANS</td>
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<td>Shekar Seshadri</td>
<td>Life Skills Education using Theatre</td>
<td>Department of Psychiatry NIMHANS</td>
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<td>Suman Verma</td>
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<td>Collin Yarham, A.Kak</td>
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<td>Shanthi Ranganathan</td>
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<td>Jhendra Nagpal</td>
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<td>U.V. Rao</td>
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<td>Dhavale</td>
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<td>Sexual Health &amp; Life Skills Development for Out of School Adolescents and Young Women</td>
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<td>State AIDS Prevention Societies</td>
<td>ARSH</td>
<td>UNICEF – NACO Collaboration NCERT/DSERT Implementing Organizations</td>
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(315)
The review revealed that the School Mental Health Programs are varied in their
1. Objectives
2. Structure
3. Content
4. Methodology
5. Target Population - Children/Adolescents.
6. Location - Private/Public Schools/Primary/Secondary/Junior Colleges
7. Evaluation of Impact

THE OBSERVATIONS ARE
• Most programs have been in urban areas.
• Most have used teachers as facilitators.
• Some have worked with the target population – children themselves – GHSC (Chandigarh), Student Enrichment Program (B’lore, Delhi)
• Follow-up has been short term in most of the groups.
• Few have been for 3-5 years GHSC, (Chandigarh), Student Enrichment Program, Health Promotion by LSE – (NIMHANS), Expressions, Student Enrichment Program (Delhi)
• Manuals have been prepared by the BMST and Health Promotion by LSE (Bangalore), Student Counseling (Bangalore), Expressions (Delhi) groups, ARSH - NACO.
• Most were run as projects with extra funding as projects and not as programs either co-curricular or integrated into the school system.
• Many more small projects have been conducted as pilot studies or dissertations in academic set-ups or by NGOs.
1. Need to be successful in their education
2. Grow up into productive adulthood.
3. Are healthy and socially competent with positive self esteem.

However not all children and adolescents are equally endowed with genetic benefits of intelligence, opportunities, nurturing stable environment of family, peers, school, culture and nation.

The mental health needs of children and adolescents is best seen as a continuum which is depicted below.

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**School Mental Health Program**

Health for all is the motto of World Health Organization. Mental Health and mental well being form a relevant and important part of the Health. Schools are apt and appropriate location to promote and deliver health care including mental health for

1. School recruitment being 93.2% (ASER 2003) most Indian children and adolescents attend schools some time in their lives.
2. Children and adolescents spend most of their waking time in schools and colleges.
3. Teachers play the role of surrogate role of parents and influence development in children and adolescents.
4. Educational system is a well established one in all the countries – be it developed, developed or underdeveloped countries including India
5. The infrastructure, capacity building and governance of the Educational System with its Manpower of teachers is in place in the country.
6. Over the past two decades individual School Mental Health Programs in various parts of the country have established the impact of the school mental initiatives.
7. Departments of Education and Health are currently sensitized to the need of initiating a School Mental Program as means to improve the quality of education and future generation.
8. There is expertise and experience among the mental health professional to take the initiative and make the school mental health program an integral part of school education.

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Currently there is a lack of specific policy and program of School Mental Health in India though it is presumed that it is included in the various policies and program described above. There needs to be a consultation at the National Level to under the current situation and how each of the policy and program function towards fulfilling or not fulfilling an effective School Mental Health Program. Child and Adolescent Mental Health Experts, Experts in Child and Adolescent Development need to take leadership, liaise with the educational authorities and experts to promote School Mental Health Program as an integrated process.

THE PROGRAM

A two pronged School Mental Health program is envisaged currently at all levels of the educational system – Primary, Secondary, Higher Secondary levels.

Based on the need depicted in Figure 1, the two prongs would be

1. An Universal Program – which is promotional targeting all the children and adolescents to develop their
potentials – mainly psychosocial competence.

2. A Targeted Program focusing on children and adolescents with evidence requiring specific inputs from child mental health specialists or specifically trained personnel like special children with mental retardation, autism, attention deficit disorder, specific learning disabilities, psychiatric conditions including emotional disorder and conduct disorder.

Life Skills Education is a suitable promotional program which could be run as an Universal One. Departments of Women and Child Welfare, Department of Education (Primary and Secondary, Higher Secondary), Department of Health, Department of Youth Affairs and Sports, Department of Human Resource Development would be the stake holders. Parents, Teachers, Health Workers, NGOs would be the predominant partners.

Mental Health Orientation focusing on mental health disorders and counseling skill development with be the targeted part of the program. Inputs for identification, intervention if possible at the school level along with the liaison of the physician/paediatrician or mental health professional, referral to mental health professional if intervention is not possible at the school level and regular follow ups for identified children and adolescents with be the process that needs to be in place towards this. This would ideal program for population at risk – at risk due to bio-socio-economic-psychological reasons (children with cancer, HIV/AIDS, street children, children affected by disasters and conflicts, divorced or single parents etc.) and children/adolescents identified to be psychologically ill. Stakeholders would be same as above. Parents, teachers, health workers, PHC doctors, paediatricians, child mental health professionals would be partners in this section of population.

MAJOR RECOMMENDATIONS

Recommendations for Schools/Policy Makers

1. The Educational System in India needs to recognize the lack of mental and psychosocial component of the current School Health Program and initiate it.

2. The School Mental Health Program needs to be an inherent part of the National Mental Health Program while being a component of the School Health Program as mentioned above.

3. The School Mental Health Program (preventive strategies and mental health services) should be initiated as ongoing collaborative programs of the Departments of Education and Health in the country.

4. The school mental health program at the current juncture needs to have active involvement of multiple stakeholders – administrators, bureaucrats, policy makers and experts from the department of education, health, women and child welfare, juvenile justice system, young development teachers, it should be part of an integrated program as a cocurricular activity with other educational programs and other school-based health services.

5. Mental Health Professionals should plan preventive and intervention strategies together with school administrators and teachers as well as with families and community members.

6. Development of resource materials and capacity building should be included in the program in a planned manner.

7. The program needs to have a large preventive component which would be carried for all the children and adolescents in the primary, secondary and higher schools in a continuous manner.

8. Identification of mental health problems, intervention where necessary at the school and referral to mental health professionals should be a smaller but essential component of the program.

9. Preventive mental health programs should be developed that include a healthy social environment, clear rules, and expectations that are well publicized. Staff members should be trained to recognize stresses that may lead to mental health problems as well as early signs of emotional problems mental illness and refer these students to trained professionals within the school setting or mental health professionals nearby.

10. Schools need to support mental health interventions of students who are already identified to be ill – for example counselling for students with emotional problems, medication and follow up of Attention Deficit

12. Mental health referrals (within the school system as well as to community-based professionals and agencies) should be coordinated by using written protocols, should be monitored for adherence, and should be evaluated for effectiveness.

13. Roles of all the various teachers trained in preventive mental health and counseling who work on campus with students should be defined so that they are understood by students, families, all school staff members, and the mental health professionals themselves.

14. It should be documented that mental health professionals providing services on site in school (for example a teacher or special/resource teacher trained in counseling or a paediatrician) have at least minimum standard of training specifically in child and adolescent mental health (appropriate for students’ ages) and are competent to provide mental health services in the school setting.

15. Private, confidential, and comfortable physical space should be provided at the school site for mental health services (example special education resource rooms, counseling room). Often, this is not difficult for schools if mental health services are provided after school hours. Having school-based services should not preclude the opportunity for mental health services to be provided at nonschool sites for situations in which therapy at school for a student may be ill advised (e.g., a student who feels uncomfortable discussing a history of sexual abuse at the school setting). During extended school breaks, schools must provide continued access to mental health services.

16. Staff members should be provided with opportunities to consult with a child psychiatrist or clinical psychologist (on or off the school site) so that they may explore specific difficult situations or student behaviors and review school policies, programs, and protocols related to mental health.

17. Quality-assurance strategies should be developed for school mental health program provided at school, and all aspects of the school health program should be evaluated, including satisfaction of the parent, student, teachers and mental health professionals.

18. Confidentiality of health information should be maintained, as mandated by law.

19. Human Resource Development of Department of Education should move towards having a School Counselor on the roles of every government or private school in the state.

20. All schools – run by the government or private should have a Health Professional Team on roles consisting of a Paediatrician, School Counselor, Special Educator and a Mental Health Professional.

21. As the next step the School Mental Health Program should extend to children and adolescents who are not attending schools for various reasons – school drop-outs, working children, street children and ill children in hospitals.

**Recommendations for Pediatricians, Child Mental Professionals and Other Providers of Primary Care for Children and Adolescents**

The following recommendations are targeted to individual pediatricians and/or groups of physicians

1. An ecologic view of mental health should be taken, and support structures should be built not just for individual patients but also for the community. Pediatricians and Child Mental Health Specialists should recommend, advocate and help schools to develop comprehensive mental health programs with a strong preventive component that focuses on building strengths and resilience, not just on problems, and that involves students’ families.

2. Pediatricians and mental health professionals should develop a relationship with local schools, serve on school health advisory councils, and promote school-based mental health services (as outlined in “Recommendations for Schools”).

3. Management of one’s own clients/patients with mental health problems including developmental delay should be coordinated with school and concerned mental health professionals.

4. Mental health services should be included in individualized educational programs (IEPs) for child clients enrolled in a special education program.

5. PHC doctors, Pediatricians and Mental Health Professionals at the district level should work with schools to help identify strategies and community resources that will augment school-based mental
health programs. This would mean involving local Non Governmental Organizations actively for promoting school mental health program at all level – promoting awareness, training, resource and IEP package development and evaluation.

6. Outcomes-based research should be performed on the effectiveness of various school-based mental health models that are designed to improve psychosocial and academic outcomes.

7. Pediatricians, Physicians and mental health professionals through enhanced collaboration and communication with school mental health service professionals, can strengthen the medical-home model and improve the mental health of their client/patients, example special learning resources.

CONCLUSION:
Mental Health Program gaining more and more relevance and place in the Health Program and Budget of the country. The opportune is prime towards initiating a well integrated, comprehensive school mental health program across the country.

This would be a suitable investment in the future of India.

..every school should enable children at all level to learn critical health education and life skills .....Such education includes : ....comprehensive, integrated life skills education that can enable young people to make healthy choices and adopt healthy behavior throughout their lives -  (WHO 1997).

References
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