J. Indian Assoc. Child Adolesc. Ment. Health 2020;16(1):1-12

Editorial

School Mental Health Program: Scenario in India

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Globally, 10-20% of adolescents suffer from psychiatric illness, and about half of the psychiatric illnesses have their onset before fourteen years of age [1]. India has the largest number of children and adolescents in the world [2]. As per the National Mental Health Survey, the prevalence of psychiatric illness was about 7.3% in adolescents aged between 13-17 years [3]. Depression, anxiety disorders, substance use disorder, attentive deficit hyperactive disorder, conduct disorder are the common psychiatric illnesses in children and suicide is the leading cause of death in the adolescent age group in India [1].

The prevalence of psychiatric illness was found to be 6.5% in the community setting and 23.3% in the school setting in India [4]. The mental health gap is large, with less than 1% of children with psychiatric illnesses receiving treatment [4]. Stigma, poor mental health literacy, limited focus on child and adolescent mental health services are some of the barriers purported for this gap [1]. In the background of the significant burden of psychiatric illness and the disproportionately low treatment rates, there is an unwarranted need to focus on school mental health services (SMHS). It is necessary to understand that the improvement of the mental health of children can have multipronged effects on the family, society as well as the nation. Hence, there is a tremendous need to scale up the SMHS in India.

Concept and benefits of SMHS

SMHS can be defined as the mental health services delivered by persons belonging to school or community in the confines of the school environment [5]. SMHS should consist of activities that are student and family-friendly as well as culturally sensitive, tending to the needs of the students providing services ranging from health promotion to intervention with coordination between the schools, community, and policymakers [6]. There are three levels of SMHS. The first level i.e., " Tier 1" or "Universal" which is aimed at improving social and emotional learning in all the students. The second and third levels, namely " Tier 2" or "Selected," and "Tier 3" or "Indicated" caters to students at risk and students with diagnosed mental health problems, respectively [7].

World health organization had recommended the framework of health-promoting schools (HPS), where the school aims to create a healthy school climate with the help of parents and community for promotion and protection of the students' health [8]. There have been controversial findings of the effectiveness of HPS and SMHS on mental health [9,10]. However, they have been challenged against citing methodological issues [7].

A systematic review has noted that school-based mental health programs have been associated with a decrease in internalizing as well as externalizing symptoms and improving well-being [11]. Better accessibility and acceptability of mental health services, timely management, decreased stigma, the therapist being more familiar with the school environment of the patient are some of the benefits of SMHS [12].

SMHS: The global scenario and outcomes

"Positive Behavior Interventions and Supports", "FRIENDS", "Positive Action", "Promoting Alternative Thinking Strategies", "Skills for Life (SFL)", "Mind Matters", "Good Behavior Game (GBG)", "Cognitive-Behavioral Interventions for Trauma in Schools" are the various successful international SMHS primarily focussing on physical and psychological well-being,

resilience, social-emotional learning, and anti-bullying. Out of these, only FRIENDS, SFL, and GBG are being carried out in lower and middle-income group countries such as Brazil and Chile. The majority of these programs have adopted "Tier 1" and "Tier 2" approaches with successful outcomes. The efficacy of these interventions was found to be moderate to strong [13].

A number of randomized controlled trials (RCT) have been conducted assessing the outcomes of the SMHS in the west. School-Wide Positive Behavioural Interventions and Supports (SWPBIS) is a successful “Tier 1” program being conducted in more than 16 000 schools in the United States of America [14]. It was found that schools in the SWPBIS program had performed significantly better in terms of lesser behavioural or disciplinary problems and better concentration, social and emotional functioning. It is further important to note that these results were more pronounced when the intervention was started as early as the kindergarten [14]. A meta-analysis of 43 RCTs involving elementary children reported that SMHS was found to result in small to medium effect size in reducing psychological problems [15]. Highest effect size was noted for indicated intervention (effect size = 0.76) followed by selective (effect size = 0.67) and universal intervention (effect size = 0.29) [15]. SMHS was associated with better utilization of mental health services for affective disorders, eating disorders, substance use disorders as well as behavioural issues [16].

School mental health in India: The journey so far

The SMHS in India is in the infantile phase, with services limited to few centres. National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru was the first centre to take up the initiative of “Teachers’ Orientation Program” in 1976, where teachers were taught the skills to identify psychological problems, counsel as well as refer the students to mental health professionals when required [17]. Further, NIMHANS had also introduced a “Student Enrichment Program” for students belonging to rural areas regarding mental health,

performance during exams, interpersonal relationships, and career guidance. Around 1979, a multidisciplinary team was constituted by Nair Children's Hospital, Mumbai, to sensitize and train parents and teachers about psychological problems in children and treat the referred patients [17].

Around the 2000s, the “Cascade Model of Life Skills Education” was developed by NIMHANS [18]. This was aimed at training secondary school teachers as “Life skill facilitators” for teaching life skills to students. This is a module-based, culturally sensitive program that requires active participation from the students. It is available in certain Indian languages, covering multiple aspects such as health, hygiene, substance use, academics, career, relationships, as well as gender and related social issues. The resource material for this program was prepared to incorporate input from all the stakeholders such as adolescents, teachers, parents, non-governmental organizations (NGOs), and policymakers. Since then, this model has been widely used in schools in Karnataka [18]. Promotive Mental Health and Well- Being (PMHWB) program is a relatively recent culturally sensitive universal mental health promotional program developed by NIMHANS. It is a module-based program delivered by teachers to students from 7^{th} to 10^{th} class, focusing on positive mental health, resilience, self-image, peers, parent, gender-related issues, and substance use [19].

"Life Skills Education and Mental Health Awareness Program" is another program that is run by an NGO called "Expressions" with separate modules for children and adolescents. The module targeted for children below ten years of age aims to sensitize parents and teachers to identify common developmental and learning difficulties in children. The other module focusses on training teachers about life skills. It also provides an opportunity for students to be involved as "Peer educators." [17] Zippy’s children is a program developed in the United Kingdom adapted for use in Goa. It aims to teach preschoolers problem solving, coping,

identifying emotions and integrating emotional and language development as well as train the teachers in carrying out this program in schools [20].

There is limited published literature about the conduct and outcomes of such SMHS. A clinical practice guidelines document about school mental health prepared by the Indian Psychiatric Society has lucidly summarized about the content of such SMHS as follows (table 1) [17]

Table-1: Components of school-based life skills programs in India [17]

Domain
Generic developmental needs
Specific developmental needs ▪ Sexuality ▪ Human Immunodeficiency Virus – Acquired Immunodeficiency Virus infection ▪ Time management ▪ Drug abuse
Mental health
Student wellness/ enrichment

There is no national program exclusively for the mental health of children and adolescents in schools. However, certain programs have components of mental health promotion in schools. Lifestyle Education and Awareness Program (LEAP), which is targeted towards lifestyle illnesses in adolescents have a provision for counselling for psychological issues [21]. The Adolescent Reproductive and Sexual Health (ARSH) program, which is a part of the Reproductive and Child Health program, has a component of imparting life skills with regard to emotional and sexual issues in adolescents [21]. DISHA (Direct Intervention System for Health Awareness) offers telephonic support to adolescents to alleviate exam distress [21]. Rashtriya Bal Swasthya Karyakram (RSSK) offers provision for screening and treatment for common childhood psychiatric illnesses in school children. "Help Desk Program" under Sarva Shiksha Abhiyan (SSA) also offers a dropbox facility (where children can get support for their problems confidentially), training to teachers for identification of psychological issues and counselling in addition to screening facilities [21]. It was found that following workshops

involving school principals and teachers (conducted as a part of SSA), the referral and follow up rate of students availing child guidance clinic services at a hospital in Pune improved consistently [22].

There are a few sustainable programs which have been scalable in resource deficit setting. Central Institute of Psychiatry (CIP), Ranchi has a multidisciplinary team comprising of psychiatrists, psychologist, and social worker who conduct workshops for teachers and principals of schools for sensitizing about psychological problems in the young. Later on, they have monthly visits to the schools where they evaluate and treat the children identified by the trained teachers. The team reported that this model had advantages in the form of better acceptance by parents, involvement of teachers and parents in the treatment process, better attendance at school, and lesser stigma [23].

Unarv is a district-level adolescent school mental health program with a three-tier approach, in Thiruvananthapuram, Kerala. In this program, two teachers from high school and higher secondary school are trained annually through workshops. The workshop covered training in a wide range of topics such as common psychiatric illnesses and psychological problems in children and adolescents such as relationships, masturbation, excessive use of mobile phones, social media etc. These trained teachers called the primary counselors assess the students referred from all the classes of government and government-aided schools of Thiruvananthapuram. Counseling sessions about modifying the learning atmosphere and the type of activity are discussed with the children in the presence of parents at the school. Those with no improvement are referred to the Unarv clinic in the district panchayath office where they are treated by the child mental health specialist. If there is no improvement, then the patient is referred for detailed evaluation and management at the tertiary care center, Thiruvananthapuram [24]. An audit of five-year data of the Unarv program from 2007-2012

found that about 2432 children utilized these services, and about 36% had conduct disorder. It is interesting to note that about 95% of these children went back to school [24].

SHAPE (School HeAlth Promotion and Empowerment) program based on the HPS approach was designed by Sangath, a NGO in Goa for 5th to 12th class students. There are three kinds of activities involving the students supervised by lay school health counsellors. Mapping of school for assessing the resources, conducting a needs assessment for the students, teachers, parents, "Speak-Out box" (for students to anonymously drop in about their problems) and screening camps for visual and nutritional problems are the activities at the school level. At the class level, life skills training was provided through interactive means, and at an individual level, face to face counselling was delivered. It was found that this intervention was feasible and acceptable in the school setting with positive outcomes in health-related behaviours [25].

Another program worth discussing is SEHER (Strengthening Evidence base on scHool-based intErventions for pRomoting adolescent health program). It is a low-cost intervention in Bihar utilizing the services of lay counselor called "SEHER Mitra" (SM) and a trained teacher "SEHER Mitra" (TSM). SEHER aims at improving "climate" in the schools by focusing on social skills, involving students, parents, and teachers in making decisions, improving factual knowledge, and problem-solving skills. It involves the whole school, group and individual activities [26].

At an individual level, SM and TSM assessed students referred for scholastic, behavioral, nutritional, and social problems and offered counseling and referred to a mental health professional when required. Group activities included peer group activities and workshops on effective study strategies supervised by SM or TSM. Teachers are taught about myths and practices about discipline. At the school level, a variety of activities such as meetings, competitions, magazines, speak outboxes are carried out throughout the year, discussing physical, psychological well-being, healthy sexual practices, bullying, social, and academic

skills [26]. A randomized trial assessing SEHER in class nine students at government schools in Bihar noted that interventions delivered by SM were associated with better outcomes in depression, bullying, violence, knowledge, and attitude about gender equality and sexuality [26].

Challenges of SMHS in India

Funding and workforce are the most significant challenges for SMHS [27]. About 0.06% of the national health budget is the share allocated to mental health in India [28] and mental health is neglected in the national health policy. Hence, the amount of money available to be spent on child and adolescent mental health services is meagre. In the existing health programs, the main focus is not on improving adolescent mental health. There is a need for a national program focussing exclusively on the mental health of children and adolescents. The important pillars of such program would be adequate funding, effective coordination among all stakeholders and successful implementation of the services.

With a wide mental health gap and a lesser number of trained teachers, being a part of SMHS could be considered as burdensome and as an "additional responsibility." Hence, adequate staffing of SMHS is warranted. So far, many of the SMHS is primarily being carried out in schools, especially in urban areas, in a short-term manner with no standardized measures to assess outcome. There is a lack of effective public, private partnerships which can strengthen SMHS [2].

The way forward

Increasing the rates of screening and treatment of psychiatric illness, widening the scope of SMHS, reduction of stigma, as well as suicide, are some of the important goals for SMHS [29]. There is a tremendous need for understanding the perspectives and needs of all the stakeholders during designing SMHS. Issues such as Stigma, confidentiality must be appropriately addressed for better outcomes [30]. A multi-layered approach is recommended with the active

participation of policymakers at both central and state levels at the top with intermediary teams supervising SMHS and providing feedback to the top and, finally, school teachers implementing the SMHS. Hence, both top-down as well as bottom-up approaches are needed [27]. School-based mental health screening programs need to be increased as many of the existing SMHS are aimed at mental health promotion [31].

Mental health screening camps for early detection of psychiatric illnesses can be integrated with physical health programs such as ophthalmic and dental camps for lowering the Stigma and better acceptance by children as well as parents. Digital aids can be used to attract the attention of the students and enhance participation. The training of the school personnel must be carried out from time to time in the form of booster sessions or continuing programs rather than a single session. Proper follow-up and monitoring need to be carried out to ensure the quality of SMHS [32].There is a need for measuring the cost-effectiveness of programs that can guide the policymakers in decision making. Most importantly, an active liaison between the teachers, parents, counsellors, mental health professionals, and the policymakers is warranted for the successful implementation of SMHS. Lastly, the sensitization of all the stakeholders is needed for the timely expansion of SMHS.

Acknowledgment: None declared

Conflict of interest: None declared

References

1. Nebhinani N, Jain S. Adolescent mental health: Issues, challenges, and solutions. Ann Indian Psychiatry 2019, 3:4-7.
2. Hossain MM, Purohit N. Improving child and adolescent mental health in India: Status, services, policies, and way forward. Indian J Psychiatry 2019, 61: 415.
3. Ministry of Health and Family Welfare, Government of India. National Mental Health Survey of India; 2016. Available from: http://www.indianmhs.nimhans.ac.in/Docs/Summary.pdf

4. Malhotra S, Patra BN. Prevalence of child and adolescent psychiatric disorders in India: a systematic review and meta-analysis. Child Adolesc Psychiatry Ment Health 2014, 8:22.
5. Doll B, Nastasi BK, Cornell L, Song SY. School-based mental health services: Definitions and models of effective practice. J Appl Sch Psychol 2017, 33:179-94.
6. Weist MD, Murray M. Advancing school mental health promotion globally. Adv Sch Ment Health Promot 2008, 1:2-12.
7. Fazel M, Kohrt BA. Prevention versus intervention in school mental health. Lancet Psychiatry 2019, 6: 969-71.
8. Manila: WHO Regional Office for the Western Pacific health promoting schools: 1996. Regional guidelines Development of health promoting schools–A framework for action, ser 5.
9. Langford R, Bonnell CP, Jones HE, Pouliou T, Murphy SM, Waters E, Komro KA, Gibbs LF, Magnus D, Campbell R. The WHO Health Promoting School framework for improving the health and well-being of students and their academic achievement. Cochrane Database of Systematic Reviews 2014, Issue 4.
10. Caldwell DM, Davies SR, Hetrick SE, Palmer JC, Caro P, López-López JA, Gunnell D, Kidger J, Thomas J, French C, Stockings E. School-based interventions to prevent anxiety and depression in children and young people: a systematic review and network meta-analysis. Lancet Psychiatry 2019, 6: 1011-20.
11. García-Carrión R, Villarejo-Carballido B, Villardón-Gallego L. Children and Adolescents Mental Health: A Systematic Review of Interaction-Based Interventions in Schools and Communities. Front Psychol 2019, 10: 918.
12. Hoover SA, Mayworm AM. The Benefits of School Mental Health 2017. In: Michael K., Jameson J. (eds) Handbook of Rural School Mental Health. Springer, Cham
13. Murphy JM, Abel MR, Hoover S, Jellinek M, Fazel M. Scope, scale, and dose of the world's largest school-based mental health programs. Harv Rev Psychiatry 2017, 25:218-28.
14. Bradshaw CP, Waasdorp TE, Leaf PJ. Effects of school-wide positive behavioral interventions and supports on child behavior problems. Pediatrics 2012,130: e1136-45.
15. Sanchez AL, Cornacchio D, Poznanski B, Golik AM, Chou T, Comer JS. The effectiveness of school-based mental health services for elementary-aged children: A meta-analysis. J Am Acad Child Adolesc Psychiatry 2018, 57: 153.

16. Tegethoff M, Stalujanis E, Belardi A, Meinlschmidt G. School mental health services: Signpost for out-of-school service utilization in adolescents with mental disorders? A nationally representative United States cohort. PloS one 2014, 9: e99675.
17. Bharath S, Kumar KV, Mukesh YP. Clinical practice guidelines for school mental health program. Indian J Psychiatry 2008, 307-21.
18. Bharath S, Kumar KV. Health Promotion Using Life Skills Education Approach for Adolescents in Schools--Development of a Model. J Indian Assoc Child Adoles Ment Health 2008, 4:5-11.
19. Vranda MN. Promotion of mental health and well-being of adolescents in schools—A NIMHANS model. J Psychiatry 2015, 18:1-5.
20. Patel V, Flisher AJ, Nikapota A, Malhotra S. Promoting child and adolescent mental health in low and middle income countries. J Child Psychol Psychiatry 2008, 49:313-34.
21. Ramkumar GS. Mental health provisions in schools of Kerala: a narrative overview of programs and interventions. Kerala J Psychiatry 2015, 28: 82-93.
22. Gujar K, Pingale V. School mental health programme in Maharashtra-Today and way ahead. Ann Indian Psychiatry 2017, 1:4
23. Sinha VK, Kishore MT, Thakur A. A school mental health program in India. J Am Acad Child Adolesc Psychiatry 2003, 6:624.
24. Jayaprakash R, Sharija S. UNARV: A district model for adolescent school mental health programme in Kerala, India. Indian J Soc Psychiatry 2017;33: 233-9.
25. Rajaraman D, Travasso S, Chatterjee A, Bhat B, Andrew G, Parab S, Patel V. The acceptability, feasibility and impact of a lay health counsellor delivered health promoting schools programme in India: a case study evaluation. BMC health services research 2012, 12: 127.
26. Shinde S, Weiss HA, Varghese B, Khandeparkar P, Pereira B, Sharma A, Gupta R, Ross DA, Patton G, Patel V. Promoting school climate and health outcomes with the SEHER multi-component secondary school intervention in Bihar, India: a cluster-randomised controlled trial. Lancet 2018, 392(10163):2465-77.
27. Kutcher S, Wei Y, Weist MD. Global school mental health. School mental health: Global challenges and opportunities 2015, 299.
28. World Health Organization. India: Mental Health Atlas. World Health Organization; 2011. p. 1-4. Available from http://www.who.int/mental_health/evidence/atlas/profiles/ind_mh_profile.pdf.

29. Stephan SH, Weist M, Kataoka S, Adelsheim S, Mills C. Transformation of children's mental health services: The role of school mental health. Psychiatr Serv 2007, 58:1330-8.
30. Parikh R, Michelson D, Sapru M, Sahu R, Singh A, Cuijpers P, Patel V. Priorities and preferences for school-based mental health services in India: a multi-stakeholder study with adolescents, parents, school staff, and mental health providers. Global Ment Health 2019, 6.
31. Dowdy E, Ritchey K, Kamphaus RW. School-based screening: A population-based approach to inform and monitor children's mental health needs. School Ment Health 2010, 2:166-76.
32. Fazel M, Hoagwood K, Stephan S, Ford T. Mental health interventions in schools in high-income countries. Lancet Psychiatry 2014, 1:377-87.

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