School Mental Health In India: An Emerging Paradigm On School Counseling Services

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Abstract: *We have entered the new millennium and as we introspect issues that matter to us as part of a rapidly changing society, it is imperative that an appraisal be made of the psychosocial needs of the children and adolescents who are leading the baton of human chain into the 21st Century.*

CHILDHOOD AND ADOLESCENCE..... A time in life span when children realize who they are? What they would like to be? It's time to forge an identity. Career choices to be made, meaningful relationships to be formed and sustained technological advances tackled, attitudes and roles chiseled. Isn't this process of transition fraught with trials and tribulations? Information overload, mixed messages from media, press, teachers, and family and from society at large add to the confusing scenario of the assimilating young mind.

INTRODUCTION

MENTAL HEALTH OF OUR CHILDREN- A CHILD RIGHTS PERSPECTIVE

Children are the most important assets of any country and the most important human resource for overall development. Schools are one of the settings outside the home where children can acquire new knowledge and skills to grow into productive and capable citizens, who can involve, support and help their communities to grow and prosper. A Health Promoting School is a setting where education and health programmers create a "Joyful and Happy" environment that promotes diversity in learning and evolving. Don't the children have the right for this?

Majority of the public schools have no counselors or a social workers, yet schools are being asked to deal with more of the mental health needs of their students. In addition, reports of increased bullying and school violence account the importance of recognizing and responding to the psychic agony of the school campus.

In the last decade, School mental health has expanded to address school violence, sexual harassment, bullying, substance abuse, discrimination and healthy discipline. Psychiatrists and other mental health professionals continue to refine their role in schools, incorporating the corporate and education principles in effecting change and improving system functioning. Modern school consultation focuses more on early identification and intervention at the individual and systems level to help attain immediate educational and behavioral goals and to prevent long term negative outcomes in the overall personality of children.

Also a few of these youngsters seem to be in vague kind of disturbances, of having lost something, of a sense of betrayal, a gnawing frustration that often blazes into aggression, insecurity, loneliness, boredom, defiance and a feeling of being on the brink of crisis-symptoms that are spreading through the nervous system of the entire generation. It's time for a closer mind watch at the school.

IT IS WORTH REMEMBERING.....

- India - Children and adolescents constitute 40% - 44% of over 1000 million populations.
- ICMR (2001) study found 12.8% of the children and adolescents suffering from Mental & Behavioral Disorders.

Child mental health care has received scant attention in service, research and training aspects in the national context, despite has sound policy guidelines.

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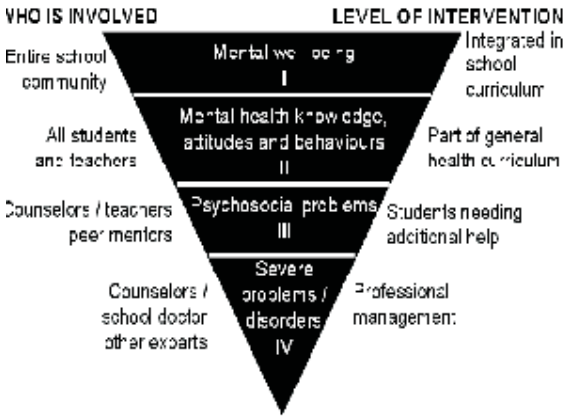
TYPES OF MENTAL HEALTH INTERVENTIONS IN SCHOOLS

1. **MENTAL HEALTH PROMOTION -**to build awareness and resilience
2. **UNIVERSAL AND SELECTIVE PREVENTION-**to reduce risk and vulnerability factors and build protective factors
3. **PREVENTION AND EARLY INTERVENTION STRATEGIES-**for those with early signs of disorder

A FRAMEWORK FOR SCHOOL MENTAL HEALTH PROGRAMMES

The following diagram illustrates the psychosocial and mental health concerns of the schools and indicates who is likely to be affected:



Children who are not doing well in school may be suffering depression, anxiety, aggression or\psychosomatic disorders. Their families may come to the attention of schools due to disruptive and disturbing psychosocial problems. Children with poor mental health skills and / or environmental stress such as family or emotional problems or the feeling that nobody cares – are unlikely to perform well in school or later in life.

INTERVENTION MODEL -AN EXPLANATION

Levels I through IV can be likened to primary, secondary, and tertiary prevention efforts. Primary prevention and health promotion (**Levels I and II**) target the causes of healthy and unhealthy conditions with interventions which to promote healthy behaviors and prevent a disorder from developing. Secondary prevention (**Level III**) targets a more selected population of high-risk people to protect against the onset of the disorder. Tertiary prevention (**Level IV**) targets people who already have developed the disorder with the intent of treating the disorder, reducing the impairment from the disorder, and / or preventing relapse.

FUNDAMENTAL GUIDELINES FOR IMPLEMENTATION

School-based mental health programmes can be **Environment-Centered** or **Child-Centered**.

1. ENVIRONMENT-CENTRED APPROACHES

In this approach the aim is to improve the educational climate of the school and to provide opportunities for the child to utilize the healthy school programme. The positive mental health atmosphere includes the amount of time spent in school, the structuring of playground activities, the physical structure of the school and the classroom decoration.

Programmes the school can conduct are as follows:-

(a) Programmes/workshops can be organized to enhance the ability of administrators, teachers and support staff to deal with the specific areas of emotional or behavioral disturbance that they encounter.

(b) Programme for improving teachers capacity to understand how to make use of other agencies providing mental health services for children.

(c) National campaigns to reduce the incidence of certain mental health damaging behaviors e.g., bullying, raging, corporal punishment etc.

(d) Improvement in the school's social environment can be brought about by encouraging parent participation through parent programme in support of school activities.

(e) A multidisciplinary mental health team can be established in the school to provide consultation in the management of student behavior problems.

(f) The mental health team can include representatives from the governing body, teachers, support staff, and parents. The governing body can identify and rate problems and opportunities within the school.

(g) The school mental health team can monitor and evaluate the outcome and provide feedback so that appropriate modifications can be made to the programme.

(h) Schools can be the centre for community enhancement projects including programmes to improve health and mental health. They can serve as

training centers for parenting skills where parents learn more about child development and parent effectiveness skills and receive support to enhance feelings of self worth and competence.

Such a programme provides a coordinated, collaborative effort to improve communication, understanding, and respect between staff, students and parents. This provides a sense of direction and ownership of the programme.

2. CHILD-CENTRED APPROACH

Child-centre approach includes individual mental health consultations and specific problem-focused interventions as well as more general classroom programmes to improve coping skills, social support, and self-esteem.

Programmes the school can conduct are as follows:-

(a) Particular child and family having difficulty can be referred to the school counselor or mental health professionals

(b) The counselor is involved in giving recommendations to the parents, the teachers and in some cases referral for treatment outside the classroom.

(c) Maladjustment can be prevented by locating at-risk children and involving them in an intensive goal-directed intervention that should include close contact with non-professional child-aides such as special educator, resource room teachers and peer mentors.

(d) The use of parents as teacher's aides can be a helpful learning experience for the parents, the teacher and the child. Working in the classroom provides parents with a new perspective of their child as they observe other children and talk with other parents and the teacher.

(e) Early intervention programmes with high risk behaviors such as aggressiveness, smoking, precocious sexuality, excessive shyness, poor worsening of interpersonal relationship, poor school attendance, declining academic performances, irritable and fluctuating moods, and changes in peer groups can prevent serious consequences.

(f) Schools can also use screening tools for identification of psychosocial problems and mental disorder. This can help the schools in determining if children have (or are at risk of having) significant mental health problems. Although, there is a danger of "labeling" and stigma nevertheless, the instruments can be very useful in planning management strategies.

(g) **School based health centers- or clubs** located within the school have an important role in supporting better health care for children and adolescents. The mental health services in these school-based health clinics can provide screening, counseling for common child and adolescent concerns, information about substance abuse, sexuality, HIV / AIDS, reproductive health, depression, stress, anxiety, etc. Because these clinics are located within the daily environment of the children most youth, they offer particular benefit to young people who might not otherwise receive assistance, by decreasing the economic and psychological barriers. Clinics can facilitate and support positive relationships among students, their families, the schools, and other community services.

KEY STEPS IN SETTING UP SCHOOL MENTAL HEALTH SERVICES

STEP I: ESTABLISHMENT OF A TEAM

Planning for a comprehensive school mental health programme begins with the collaboration of school personnel, family members, community members, predations mental health professionals and students who work together to create an environment that is productive, positive and supportive.

STEP 2: ASSESSMENT OF SCHOOL & COMMUNITY ENVIRONMENT

Basic information regarding regional demographics, health risks, and resources should be available for the team to consider. When possible, an assessment focusing on community strengths and available resources, as well as needs should be done to provide the planning team with the information they require to develop objectives.

STEP 3: DEVELOPMENT OF A PLAN

Once the needs and potentials for school mental health programmes are assessed and most suitable elements of the model framework are chosen after discussions with parents, educators, students, community members, and mental health professionals, the next task is to develop a specific plan of action including clearly stated objectives, assignment of responsibilities, a time-line and a coordinating mechanisms with outside agency.

STEP 4: MONITORING AND EVALUATION

Obtaining baseline data on the mental health of the children, the quality of school health services, the

environment of the school and the health knowledge, skills and practices of students, are all essential for evaluating the effectiveness of a planned intervention involving standouts and their participation is a continuous process at all steps for the progress to the program.

MENTAL HEALTH ORIENTATION & COUNSELING SKILLS

Before we formulate an interventional programmed the need of the hour is to recognize the mental health related disorders in the school children.

IDENTIFICATON OF PSYCHIATRIC DISORDERS IN SCHOOL CHILDREN

Like adults, children may experience disturbance in emotions, behavior and relationships, which impairs their functioning. It is distressing to the child as well as parents and community. *Judicious early identification would curtail needless suffering and avoid spiraling of problems.*

There is no one cause for these disturbances. Reasons are often multiple: genetic, environmental, chromosomal and socio-cultural. Factors like child's temperament, parental health, family relationships and parenting styles are important. Despite these environmental influences and stressors certain children are more vulnerable while some are less. Children differ in their personality character or temperament. A "difficult child" is much more likely to show emotional problems during the pre-school period than an "easy child".

Comprehensive evaluation of the child should include:

- Clinical Interviews
- School Report
- Intellectual Functioning
- Development Tests
- Neurological Assessment

Therefore school forms an integral part of the child's assessment regarding his/her mental and development related issues. Some of the **most common problems** seen in school children are as follows:

1. THE HYPERACTIVE CHILD (Attention Deficit Hyperactivity Disorder)

All children are active, but a few are extraordinarily so and are considered hyperactive. They are constantly in motion, darting from one activity to another. Often failing to sustain attention in simple tasks or play activities. Complaints regarding these children by parents and teachers are that the children do not seem to listen, cannot concentrate, are easily distracted, fail to finish assignments, daydream and change activities as compared to other children. Attention Deficit Hyperactivity Disorder (ADHD) affects between 3 and 10 percent of all school-age children. ADHD is four to eight times more common in boys than it is in girls.

Core Symptoms		
Inattention	**Hyperactivity**	**Impulsivity**
• Failing to give close attention to details • Difficulty sustaining attention • Not listening • Easily become distracted • Forgetfulness	• Fidgeting • Inability to sit at one place • Difficulty playing quietly • Always 'on the go' or 'driven by motor' • Excessive talking	• Blurting • Difficulty awaiting a turn • Interrupting or intruding on others

ROLE OF TEACHERS

If you are sensitized to the common symptoms of this condition, your observations about the intensity, frequency and associated problems would be very helpful in thorough evaluation of the child. As the first step, a **Behavior Checklist** for ADHD should be filled out by parents and teachers to provide information on types and severity of ADHD symptoms at home and at school, as well as other emotional and behavior problems.

2. CONDUCT AND RELATED DISORDERS

A conduct disorder child is repeatedly aggressive and his behavior violates the rights of others. They show excessive levels of fighting, hostility, verbal abuse, defiance, and cruelty to animals, destruction of property, lying, stealing and truancy. It appears to be more prevalent in urban than rural settings. It is about 3 times more common in boys than in girls. The prevalence rates for boys under the age of 18 are 6-16%; for girls, rates range from 2-9%.

Core Symptoms	
• Stealing without confronting a victim • Running from home • Lying • Setting Fires • Truancy • Breaking into someone's house, building or car	• Use of a weapon • Initiating physical fights • Stealing when confronting a victim • Physical cruelty to people • Physical cruelty to animals • Forcing someone into sexual activity • Deliberate destruction of another's property

Conduct disorder is associated with family instability, including victimization by physical or sexual abuse. Propensity for violence correlates with child abuse, family violence, alcoholism, and signs of severe psychopathology, e.g., paranoia and cognitive or subtle neurological deficits. It is crucial to explore for these signs; findings can guide treatment.

3. ANXIETY AS A SYMPTOM AND A DISORDER

The feeling of anxiety is generally characterized as diffuse and unpleasant. There is a sense of apprehension or worry, along with physical symptoms that may include headache, muscle tension, sweating, restlessness, tension in the chest and mild stomach discomfort. Anxiety becomes a disorder when the symptoms are severe, pervasive, lasting and interfere with normal life. Anxiety disorders can develop gradually over long periods of time or very quickly. These disorders can become disabling and interfere with school, relationships, social activities and work.

GROWING UP: DIFFERENT TYPES OF ANXIETY

Fears and phobias

Very young children often develop fears and phobias. These usually happen in particular situations, such as going to nursery or settling down at night, and can result from the fear of separation from parents or familiar adults. Sometimes, particular things such as dogs, spiders or snakes set off the anxieties. Fears like this are very common in early childhood, but with some encouragement and support, most children learn to overcome their anxiety.

General anxiety

Some youngsters feel anxious most of the time for no apparent reason. It may be part of their temperament, or it may be part of a pattern of behavior that is shared with other members of the family. If the anxiety becomes very severe, it can interfere with the child's ability to go to school, to concentrate and learn, and to be confident with others.

School-related anxiety or school refusal

Refusing to go to school can also be caused by anxiety. However, worries about going to school can be caused by a number of things. Children may refuse to go to school due to a physical illness. Some may be truants and choose not to go to school as a form of a rebellion. Another group stays away from school because they are anxious or miserable when there.

Core Symptoms		
• Experience of fear • Restlessness • Irritability • Avoidance • Rapid labored breathing • Sweating or perspiring • Trembling or "shaking" • Weakness • Poor memory	• Rapid heart beat • Chest pain or tension • Muscle tension • Indigestion or diarrhea • Dizziness or feeling "light-headed" • Racing thoughts • Neglecting responsibilities • Impatience	• Dwelling on fearful possibilities • Problems performing tasks • Frightening images • Thoughts of danger • Increased energy • Frustration • Problems concentrating

4. DEPRESSIVE DISORDERS IN CHILDREN

Feeling sad and upset occasionally is a phenomenon that everyone goes through. But there is reason to be concerned when symptoms of depression are severe, prolonged, unexpected, seem unusual or have no apparent cause.

CORE SYMPTOMS FOUND IN YOUNGER CHILDREN

- Emotionally brittle, temperamental, irritable or easily annoyed
- Loosing friends
- Repeated rejection by other children
- Inability to sit still, fidgeting or pacing
- Stays in room and isolates himself
- Repeated emotional outbursts, shouting or complaining
- Avoids and doesn't talk to other children
- Irregular sleep habits (up at night and sleep during the day)
- Recent emergence of bed wetting

CORE SYMPTOMS FOUND IN OLDER CHILDREN

- Loss of interest or pleasure in others or most activities
- Feeling discouraged or worthless
- A significant drop in performance in school
- Fatigue or loss of energy most of the time
- Restlessness, fidgeting or pacing
- Crying, feeling sad, helpless or hopeless
- Episodes of fear, tension or anxiety
- Frustration, irritability, emotional outbursts
- Excessive guilt or inappropriate self-blame
- Repeated medical complaints without a known medical cause (headaches, stomach aches, pain in arms or legs)
- Too much or too little sleep
- Significant increase or decrease in appetite

5. MENTAL RETARDATION AND RELATED ISSUES

In mental retardation the child operates at a level significantly below the intellectual functioning of the general population, resulting in difficulties of problem solving the adaptation in several areas of functioning. It is separated into mild, moderate, severe, and profound subgroups based on the degree of intellectual impairment defined by the IQ and the level of adaptive functioning.

DEGREES OF MENTAL RETARDATION

- Mild Mental Retardation - IQ: 50-55 to approximately 70
- Moderate Mental Retardation - IQ: 35-40 to 50-55
- Severe Mental Retardation - IQ: 20-25 to 35-40
- Profound Mental Retardation - IQ: Below 20 or 25

ROLE OF TEACHERS

- Collect information from the parents about early history e.g., did the mother have significant difficulties during pregnancy (diabetes, infections, thyroids etc.).
- Check if the mother had problems at the time of the child's birth e.g., premature baby, delayed birth cry, blue baby, severe jaundice and respiratory problems in the child.
- Suggest to the parent to meet a general physician, pediatrician or visit a Child Development Centre if available.

6. LEARNING DISABILITY

It is not a medical, neurological or psychological problem. Learning disability manifests itself in the school as:

DYSLEXIA may be defined as organizing or learning difficulties affecting language, line co-ordination skills & working memory skills. It is independent of overall ability and conventional teaching.

DYSCALCULIA - The child's performance in arithmetic is significantly below the level expected on the basis of his age, intelligence, and schooling. It has been seen that children with this disorder have problems in visuo-spatial and visual perceptual skills.

DYSGRAPHIA – refers to difficulty in hand writing. Children are unable to execute the motor movements to write or copy a written letter or form. They may be unable to transfer visual information into output of fine motor movements. They may be weak in visual motor function and in activities requiring visual and spatial judgment.

Writing requires

- Muscular control
- Eye hand coordination
- Visual Discrimination
- Smooth control of arms, hands and finger muscles
- Adequate perceptions of the letter and word formation

7. AUTISM

Autism is developmental disability in which there is significant impairment in social relatedness, communication, and the quality, variety, and frequency of various activities and behaviors. The onset of autism generally is before age 3 and impairment persists throughout the lifespan.

Primary symptoms include the following:

- ***Abnormal social relatedness:*** This is always impaired in autism. The degree of impairment however may range from oddness in social interaction, to an almost complete detachment and lack of responsiveness to other's social initiations. Social abnormalities may include poor use of eye contact, emotional cues, and social smile; lack of social initiation and disorganized patterns of reactions to strangers and separations. Children with autism demonstrate a particular inability to imitate others. They may disregard the other or, sometimes, inappropriately mirror the other's behavior.
- ***Abnormal communicative development:*** Much of the literature on autism has focused on deviance in the development of spoken language. However, the communication deficit is much more profound than impaired language alone.
- ***Abnormal capacity for symbolic play:*** Children with autism are particularly lacking in the pretend play typical of preschool-aged children, including doll pay, role play, and dramatic play. They rarely seek out play partners.
- ***Restricted and odd behavioral repertoire:*** Typical play, involving curiosity, exploration, interest in novelty, and goal directedness is lacking in children with autism. Much time is spent in a very limited range of activities, which may consist of a few highly ritualized or repetitive ways of handling a few object (e.g. sucking, shaking arranging, carrying around). Age-appropriate play skills may be present, but are often inappropriately repetitive.

GUIDELINES FOR SCHOOL COUNSELORS

- The school counselor/teacher counselor is informed, who assess the gravity of the situation.
- Empathetically tries to initiate a dialogue with the needy and tries to understand the situation from child's perspective.
- Collects basic information from the teacher and peer group of the student.
- Initiates a dialogue with the parents and formulates individualized management plan for the student.
- Family environment parenting practices are identified if any, and positive parenting strategies are suggested.
- Also, behavior strategies like CBT techniques etc could be utilized. Suggestions are given to peer group as well.
- Regular follow ups are carried out by the counselor afterwards.
- Administrative decisions to de-escalate the tension are worked upon with the school health committee.

Inputs for identification, intervention if possible at the school level along with the liaison of the physician/pediatrician 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.

CONCLUSION

The school plays a crucial role in the development of cognitive, linguistic, social, emotional and moral functions and competencies in a child. Schools have profound influence on children, their families and the community. Schools can act as a safety net, protecting children from hazards that affect their learning, development and psychosocial well-being. In addition to the family, schools are crucial in building or undermining self-esteem and a sense of competence. School mental health programmers are effective in improving learning, mental well-being, and channelizing management of mental disorders. When teachers are actively involved in mental health programmers, the interventions can reach generations of children. Make further recommendations to encourage mental health professionals to establish good practices in schools. School counselors and their profile need a revisit for enhancing their role and responsibility.

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