

MENTAL HEALTH PROVISIONS IN SCHOOLS OF KERALA: A NARRATIVE OVERVIEW OF PROGRAMS AND INTERVENTIONS

GS Ramkumar

Psychiatry Specialist, Caritas Hospital, Kottayam

Correspondence: House no 63, KMLRA, Mosque Lane, Kumarapuram, Medical College PO, Thiruvananthapuram 695011.

Email: ram3481@gmail.com

ABSTRACT

In recent years, many interventions that specifically focus on mental wellbeing of children are being made available in schools of Kerala. This paper is a narrative overview of the major school-based mental health interventions currently being implemented in the state. Fifteen programs, selected after applying certain screening procedures, are analyzed using the Institute of Medicine (IOM) frame work. These services are being provided by multiple agencies from different governmental sectors, nongovernmental sector and private sector, and overall developments in the state parallel the developments happening in mental health scenario in schools of high income countries. Nine programs had universal prevention as a component, and the components of selective and indicated prevention were present respectively in three and eight programs. The personnel delivering indicated interventions were minimally trained and had received little specialist guidance. Many programs allude to referral to specialist professionals, but without any clear delineation of the care pathway. There are indications of a lack of coordination between the various programs, precluding synergy of work and efficient fund utilization. The DMHP could fill the service gap by facilitating and coordinating selective and indicated prevention programs in our schools. Creation of a nodal agency within the Education Department itself, with mandate for intersectoral coordination, could be a way ahead in integrating the programs and in ensuring universal access and quality of the interventions.

Keywords: School mental health, Kerala, children

INTRODUCTION

Universal enrollment of children in schools is fast becoming the norm even in low and middle income countries (LAMIC). India has near-universal annual enrolment (96%) for age group 6-14 continuously in the last

six years.¹ Kerala has achieved commendable advances, not only in universal enrollment and retention of children in schools, but also in the health status and literacy rate of the general population.² Therefore, providing mental health interventions for children (4-18 years

Please cite this article as: Ramkumar GS. Mental health provisions in schools of Kerala: a narrative overview of programs and interventions. Kerala Journal of Psychiatry 2015; 28(1):82-93.

of age) in schools itself can ensure universal access to care. Timely provision of mental health interventions not only improves their present mental and physical health, but also improves educational outcomes in the long term.³ There is a widespread felt-need from various quarters like school principals, teachers and others for providing psychological support for school-going children in Kerala. This is raised more often in the context of exam-related stress and concerns about increasing substance abuse in children.

Approach to school based interventions:

School-based interventions vary based on the scope of the approach, the kind of personnel delivering the care, targets of the interventions, etc. The Institute of Medicine (IOM) framework from the United States, which has been used to analyze school based preventive interventions, has categorized preventive interventions into three:^{4,5}

1. **Universal prevention** interventions are provided for entire population of children irrespective of their risk for mental health problems. They include promotive interventions which focus on positive mental health aspects.
2. **Selective prevention** interventions are directed at sub-populations of children identified with known risk factors or are considered *at-risk* for developing mental health problems.
3. **Indicated prevention** interventions are directed at individual children with mental health problems, minimal symptoms or signs.

A public mental health based approach to school programs is conceived as a tiered approach, where school associated personnel, like school teachers and other natural supports, provide the primary level interventions, while skilled counselors and specialized mental-health professionals

provide the more intense interventions.⁴ The WHO framework of Health-Promoting-Schools, which has been endorsed by the Government of India, views schools as an enabling atmosphere for comprehensive wellbeing of the students and the larger community with participation from all stakeholders.⁶

ABOUT THIS REVIEW

This paper is a narrative overview of the major school-based interventions implemented in Kerala in recent years. It discusses salient features of the programs and ponders about certain operational realities of school-based interventions in the Kerala context.

Methodology: Information about the programs was gathered from the field during the author's work as Field Psychiatrist at District Mental Health Program (DMHP), Kottayam. Additional data were sourced from primary and secondary online sources, draft proposals of programs, government orders, and minutes and proceedings of meetings of governmental agencies. Any intervention, program, or part of a larger program, which has been packaged for provision in the school context, and has direct or indirect influence on the mental well-being of children, was deemed suitable for inclusion in this review. A broadly inclusive approach was adopted so as to be illustrative of the different types of existing interventions. Programs that did not have an explicit mental health angle, like the School Health Program of the National Rural Health Mission (NRHM) and programs which did not have a school focus, like the Integrated Child Protection Scheme (ICPS) for 'vulnerable children', were excluded. The nature of the programs was then mapped into a matrix based on the typology in the IOM framework.

FINDINGS

Overview of the sectors involved: The primary role in school-based mental health interventions in the state is played, not unexpectedly, by the Education Department (ED). Government departments like Social Justice Department (SJD) and Department of Health (DoH) too are significant players, while other government sectors like Kerala Police, Home department and District Panchayats too have their own involvement. In some of the interventions NGOs and the private sector too are involved. Programs like Our Responsibility to Children (ORC) (by SJD and ED) and Gurukulam project (by District Panchayat and Kerala Police) are joint ventures of different sectors. Public health programs which have an add-on mental health component are enumerated in Table 1 and all the major programs (n=15) are enumerated, based on a sectoral differentiation, in Table 2.

Focus of the interventions: The areas of focus of the major prevention programs, based on the IOM framework, are provided in Tables 3A and 3B.

Nine programs used a clear **universal prevention** strategy. Clean Campus Safe Campus program focuses on reducing access to drugs in and around schools, Souhrida clubs arrange talks by mental health professionals on stress management and life skills, Thangu project orients teachers in providing psychological support, and Santhvanam project focused on empowerment of parents, teachers and students. Six programs were identified to have a focus on mental health promotive activities — volunteer camps for leadership training (Souhrida clubs), curricular life skills lessons by teachers (Ullasaparavakal), mental health/ill-health sensitization classes

for parents, teachers and children by mental health professionals (Thalir program), publishing model student-led activities with social message in newspaper (Nallapadam), and health promotive classes (Lifestyle Education and Awareness Program [LEAP], Adolescent Reproductive and Sexual Health [ARSH]).

Three programs used **selective prevention** strategy (Gurukulam project, Clean Campus Safe Campus, ORC). The interventions were focused on early identification and treatment of at-risk children with substance misuse and truancy.

Eight programs had a component of **indicated prevention**. The personnel who delivered the interventions were mentors or counselors (ORC), lady counselors (PSP), telephonic support by counselors (Childline, Dial-a-Doctor), teacher counselor (Help Desk program, Souhrida Club) and homeopathic doctors (Jyothirgamaya project).

Though many of the programs had a commitment to refer children to mental health professionals for treatment interventions, the care pathways were not delineated. Some programs (PSP, ORC) are in the process of establishing such linkages. The DMHP, as part of the comprehensive mental health program 2014-15,⁷ and the SJD, as part of the Social Security Mission, are setting up 'counseling rooms' in schools. Similarly, 'resource rooms' are also being set up in schools as part of the inclusive education programs for children with special needs.

Characteristics of major programs: Directorate of Higher Secondary Education has a 'Career guidance and adolescent counseling cell'. It has two arms – the career guidance units and the *Souhrida clubs*. The

Public health program	Focus of the add-on mental health intervention
Lifestyle Education and Awareness Program (LEAP) which focuses on lifestyle issues like obesity of school going adolescents.	Counseling for mental health issues.
The Adolescent Reproductive and Sexual Health (ARSH) arm of the Reproductive and Child Health program (RCH- II)	School-based outreach with life-skills education for dealing with emotional issues of adolescence, sexual harassment, and abuse.
Dial-a-Doctor program of DISHA (Direct Intervention System for Health Awareness)	Telephonic counseling for students during exam time.
Childline – a Government supported NGO which focuses on rehabilitating ‘vulnerable children’.	School based and telephonic support for children in distress.
District Early Intervention Centers (DEIC) of the Rashtriya Bal Swasthya Karyakram (RSSK)	Screening in schools for treatable childhood conditions including Autism and ADHD, and provision of treatment outside school settings.

Table 1: Public health programs with add-on mental health component

Education sector	<ul style="list-style-type: none"> • Souhrida club project of Higher Secondary Education Dept. • Ullasaparavakal-Life skills education module by SCERT. • Help desks in schools and ‘Thangu’ Project of SSA
Health sector	<ul style="list-style-type: none"> • Thalir program from DMHP, Thiruvananthapuram. • Jyothirgamaya- Dept. of Homeopathy. • LEAP- Lifestyle Education and Awareness Program. • Dial a doctor-Telephonic counseling by Direct Intervention System for Health Awareness (DISHA). • ARSH-Adolescent Reproductive and Sexual Health.
Social sector	<ul style="list-style-type: none"> • PSP -Psycho Social Service Program for adolescent girls. • ORC –Our Responsibility to children (with education sector) + ICPS (Integrated Child Protection Scheme)
Other sectors	<ul style="list-style-type: none"> • Clean Campus, Safe Campus (Home Department, Education Dept.), • Gurukulam Project (Kottayam District Panchayat, Police, Excise Dept.) • Santhwanam (Pathanamthitta District Panchayat) • Nalla-Padom by Malayala Manorama • School interventions by Childline (NGO)

Table 2: Sectoral breakup of school-based programs. SCERT- State Council for Educational Research and Training, SSA –Sarva Shiksha Abihiyan, DMHP- District Mental Health Program

Program	Implementing agency	Target population	Interventions
Ullasaparavakal	State Council Educational Research and Training	1 st to 12 th standard.	Curricular life skills modules for children taken by teachers.
Nallapadom	Malayala Manorama group	All schools.	Encourage student-led activities with social message. Publish model works in the newspaper.
LEAP (Life style Education and Awareness Program)	Health Dept. via NRHM.	School-going adolescents.	Mental health promotion included as part of lifestyle education.
ARSH (Adolescent Reproductive and Sexual Health)	Ministry of health and family welfare.	School outreach.	Life-skills for dealing with emotional issues of adolescence. Prevention of sexual harassment and abuse.
Thalir*	District Mental Health Program of Health Dept.	Age 10-19 years.	Sensitization / awareness for parents, teachers, children.
Santhvanam**	District Panchayat, Pathanamthitta.	Children up to 18 years.	Empowerment program for parents, teachers and students. Guidance for students.
Souhrida clubs***	Dept. of Higher Secondary Education	Higher Secondary students	Talks by psychologists (stress management, life skills), volunteer camps for leadership training, 'Amma-Ariyan' program (parental education).

Table 3A: Programs which focus on universal prevention approach

* Also undertakes selective prevention interventions like 'Counseling camps' by multidisciplinary community mental team for at-risk/ in-need children, and indicated interventions like referrals to DMHP outpatient clinics and 'Supervision' of rehabilitation at Buds schools.

** Also undertakes indicated interventions like clinical support and academic and vocational counseling for children with special needs.

*** Also undertakes indicated interventions like counseling for children in distress by Souhrida coordinators in their capacity as teachers and referral to mental health professionals.

Program, Implementing agency, Target population	Preventive interventions		
	Universal	Selective	Indicated
Clean Campus, Safe Campus: Dept. of Home. Higher Secondary Schools.	Reduce access to drugs around schools, via raids and vigilance by police.	Ensure attendance, feedback to parents, scrutiny of high risk children by the 'shadow police'.	No
Gurukulam Project: Kottayam District Panchayat, Police, and Excise Dept. Targeted at truancy and substance use in School children.		SMS alerts to parents. Early intervention to prevent drug use.	Online counseling by psychologist for children in need via website of police.
Our Responsibility to Children: Dept. of education, Social Justice Dept. and District Panchayat. Children of 10-17 years with 'behavioral problems'	? Sensitization / awareness classes for parents and teachers	Interventions for high-risk children	Interventions by mentors for ADHD, substance use and conduct disorder. Mentors will act as link agents with specialists.
Childline: NGO. 'Vulnerable children'			Telephonic support and counseling.
Dial A Doctor: Health Dept, Exam-going children.			Telephonic support and counseling.
Jyothirgamaya: Dept. of Homeopathy. Two schools in a district each year.	Awareness classes for parents, teachers and students.		Screening. Suitable interventions for needy students.
PSP (Psycho Social Program): Social Justice Dept. Adolescent girls.	?	.	Counseling for children with exam anxiety, drug use problems, suicidal tendencies etc. Link with professionals.
Help Desk Program: Sarva Shiksha Abhiyan, Ministry of Human Resource Development. Girls up to 8th standard.	Orientation for teachers (Thangu Project)		Early identification of children with problems, Drop box activities ('Santhwanapetti'), Counseling by teachers.

Table 3B: Programs focusing on Selective and Indicated Prevention Approach. Highlighted areas indicate area of major focus for the programs. ADHD- Attention Deficit Hyperactivity Disorder

latter are conceived as platforms for students to freely express their problems. Its student-centric activities are coordinated by students as class-conveners, who in turn are guided by teacher coordinators. The goals of the program are to improve physical, academic, social and interpersonal skills and self-development of adolescents, and their overall empowerment. In addition to health awareness and life-skills classes, counseling services to students by the Souhrida coordinator / career guide (trained teachers) are provisioned. The coordinating teachers are required to do counseling in their capacity, and if more in-depth psychological support is needed, the child shall be referred to professionals in the government health system.⁸

The Help Desk program under Sarva Shiksha Abhiyan (SSA) is also a teacher-led program, with components of teacher orientation in counseling skills ('Thangu Project') and student-centric activity of a *Drop Box* ('Santhwanapetti') wherein children can submit their problems with confidentiality and seek support.

Ullasparavakal is a modular life skills based mental health promotive intervention delivered for children which will be introduced into the school curriculum by the state school education board (SCERT). Curricular approach for life skills education is being followed by central boards of education like the CBSE. (Such integrated curricular programs were pioneered from the state itself, wherein equipping teachers as "diagnosticians" and "therapists" has been suggested as a way to go to cater to "children with poor school performance".⁹)

In the *Clean Campus, Safe Campus* program, the Home department collaborates with ED and DoH. Its

methodologies include using the Kerala Police ('shadow police') to crackdown on drugs and tobacco products near schools, involving students through the 'Student Police Cadets', and strengthening the 'School Jagratha Samitis'.

The *Psychosocial Service Program* (PSP) by the SJD focuses on providing psychological support for adolescent school girls by trained lady counselors "to help reduce school dropout, exam fear, suicide among students, sexual abuse from parents and relatives, alcohol and drug addictions etc."

The *Gurukulam project*, a joint venture of the Kottayam District Panchayat, Police, and the Excise department, is targeted at children with truancy and drug abuse through selective and indicated interventions. It tracks truancy in children by computer software that monitors class attendance and sends SMS messages to parents. Early identification and addressing of emotional problems are intended to prevent children taking recourse to drugs. The project plans to provide online counseling to needy children by psychologist via website of the Police Department, and expects to overcome the stigma associated with mental health interventions by using such an approach. *Santhwanam* is a similar project of District Panchayat of Pathanamthitta which coordinates all student related programs at school level for facilitating counseling and guidance.

The *Thalir* program, from DMHP of Thiruvananthapuram, has the primary objective of enhancing awareness about common adolescent issues among teachers, parents and students, and helps them manage such issues.⁷ The program has enumerated the topics for awareness classes,

and modularized them for presentation by trainers.

Nallapadom is a venture supported by the Malayala Manorama group. It encourages and acknowledges school-based co-curricular activities that inculcate social consciousness in children, and publishes them as model activities in the newspaper.

Programs for children with disabilities: Provisioning of mental health care for children with disabilities is not uniformly available even in high income countries, and community mental health outreach teams are being touted to have a potential role in filling this service gap.⁴ The DMHP of Thiruvananthapuram is supervising rehabilitation of children in ‘Buds’ schools — schools for mentally and physically challenged children. However, no specific provisions focusing on mental health issues of children in special schools could be found in an article on the topic by Soman and Kiran.⁷

In Kerala, children with mild to moderate level of intellectual disability (ID) attend regular schools. But, as regular schools do not have specialized teachers or educators, it is being recommended that the DMHP could be extended to the Taluk level to ensure training of nurses to fill the service gap and give better focus on mental health needs of children with ID.¹⁰

Three programs focus on the educational needs of children with disabilities — Integrated Education for Disabled Children (IEDC) by ED, Integrated Child Development Scheme (ICDS) by Dept. of Women and Child Welfare (Govt. of India), and District Early Intervention Centers (DIECs) from MoH. DIECs screen children in schools for conditions like ID, Autism etc. and provides interventions in district centers.

Children with special needs receive services in 49 Autism Centers in the state where they get three hours of specialized tuition and spend the rest of the time in regular classrooms. However, other disabilities like Learning Disability (LD) do not get similar attention.¹¹ Association of Learning Disabilities India (ALDI), an NGO, has developed ARMS (ALDI Remedial and Rehabilitation Measures) which helps children cope with learning problems. Their programs include measures to bring dropouts back to school, devising classroom strategies and training manuals for children with LD for integrated education, training master trainers of SSA and IEDC, training of teachers, and the ‘school adoption program’ wherein academically and economically backward schools are selected for focused action.

School dropouts is another group that might require focused mental health interventions. Kishore and Shaji reported that Kerala has an annual school dropout rate of around 1% and that a combination of factors like poverty, developmental factors (ID, LD, ADHD), school pedagogical factors, etc. are mediating the dropout. They emphasized the need to address this as a public health issue and the need to use a multipronged strategy to address the needs of such children.¹²

SOME CRITICAL COMMENTS

Use of teachers: Many programs utilize teachers as counselors, coordinators etc., especially because of non-availability of qualified counselors. Indeed, Indian studies have considered teachers as a reliable resource who can be equipped to fill the service gap by training them in the requisite skills, and this approach is being considered as the best strategy in the Indian context of resource constraints as it ensures “coverage, continuity and cost-effectiveness”.¹³

However, one should not forget that some views are critical of the capacity of teachers to deliver mental health interventions. For example, Fazel et al (2014) report that, if left unsupported; teachers in LAMICs may not be able to shoulder the additional burden of add-on programs and effectively participate in them due to the generally inadequate prospects for their professional advancement in such contexts.⁵

There is a dearth of quality research to guide decisions in this area. In one of the available Indian studies that addressed the issue, during an evaluation of their life-skills (LS) module after one year of its implementation, the authors commented on the need of the teachers for “support in the form of syllabus, resource materials, and training to be able to promote LS among the adolescents”.¹⁴ However, the motivational and other hardship aspects were not commented upon. The authors used survey method to collect the teachers’ responses, and this may have prevented teachers from sharing not-so-positive information like hardships and implementation difficulties they faced. (The authors also haven’t mentioned the non-responder rate).

However, it is good to notice that some short courses suitable for graduates of any stream (including teachers) have come up in recent times — these include Diploma in Guidance and Counselling by Regional Institute of Education, Mysore, under NCERT, and PG Diploma in Child Adolescent and Family Counseling by Child Development Centre (CDC) Thiruvananthapuram.

Use of minimally trained personnel for indicated interventions: Indicated interventions for children with mental health problems would involve therapy in individual basis or in small groups, and this

will require trained personnel with certain skill sets. However, currently such interventions are being delivered by minimally trained personnel, with inadequate specialist support. According to a report, the counselors were very young and were appointed just after their studies for low remuneration. Many of them left the job after a short stint due to lack of job prospects, and just used the job as ‘a stop-gap arrangement in finding a prospective career’.¹⁵

Comments on specific programs: The Thalir program has promotive interventions as its primary objective. Currently it is only its secondary objective to provide counseling and treatment by conducting ‘counseling camps’ (selective/indicated prevention) in schools. It would be optimal for the program, given the specialist mental health team it has at its disposal, to prioritize selective and indicated preventive approaches as its primary objective. This is especially important as most of the other programs do not provide indicated interventions under specialist guidance and do not even have clearly delineated care pathways for specialist treatment. There is also a need for standardization of topics for educative lectures — there are emerging recommendations to include mental health literacy elements in awareness classes, as this will be able to influence student attitudes towards mental illness in their formative years itself and thus prevent stigma against mental illnesses.¹⁶

The approach of informing parents about student’s behavioral problems by SMS, as practiced in the Gurukulam project, may not be very helpful in some cases. It was noted during field work that, when the teachers called parents to come to school to discuss their children’s issues, some did not turn up, reportedly because they were daily wage

workers who stood to lose their day's wages if they obliged. There is a need for outreach programs from schools that can do psychosocial assessments at homes of the children and thus ensure better supervision of children in the community context.

The scalability of Jyothirgamaya project, if it has to be extended to more schools, is limited because of manpower requirements, as the program requires doctors to screen all children and provide round the year interventions.

Lack of empirical evaluation: There is a call now for greater attention to evaluation of programs. This would include measuring fidelity to the declared interventions of the particular program, process evaluation, and assessment of cost effectiveness of the interventions. However, it has been identified that these remain as research gaps.⁴

Overall, in the programs reviewed here, there is a lack of rigor in the stated objectives and lack of clarity on the mechanisms for their delivery. This author was able to find an evaluation report for only one of these programs — the Psychosocial Service Program.¹⁵ The key recommendation was to modify the program into a community based and beneficiary oriented one. Issues like non-cooperation from teachers towards counselors posted from a different department, counselor-related issues like poor job prospects, lack of experience and lack of systematic training, and lack of formal process for referral to psychiatrists were reported, and suitable remedial strategies were suggested.

Other limitations in the current scenario: According to a report on strengthening of counseling in schools, the presence of multiple agencies from different funding streams doing the same and overlapping

work, without any cross talk, is the norm now.¹⁷ The report also calls for monitoring and evaluation, and emphasizes the need for professionalism in counseling. The lack of coordination was also starkly evident in the media reports on the inability of inter-governmental agencies to effectively cater to the certification of LD for exam-related benefits in the state in recent years. Lacunae in training programs for Resource Teachers (SSA) were also identified — their needs for skills to deal with autistic children and LD are currently not being addressed.¹¹ Even when collaboration is proclaimed in certain programs, rarely does it translate into shared ownership of programs by pooling of funds by the collaborating partners. One example of shared ownership may be the Clean Campus Safe Campus program, where the management and PTA of schools are expected to meet the program expenses. Creation of a nodal agency within the Education Department, specifically for school-based mental health interventions, may help better intersectoral coordination, prevent fund wastage, and ensure universal access and quality assurance.

TRENDS AND FUTURE DIRECTIONS

Despite the limitations, the scenario of mental health interventions in schools of Kerala - a low resource setting - seems to closely follow the situation in high income countries than that in LAMICs.^{4,5} Though minimally trained personnel are currently delivering the interventions in most of the programs, attention is being currently given to aspects of quality of the counseling services and accreditation of service personnel.¹⁷ This is in contrast to the approach of 'task shifting' to trained nonprofessionals recommended for low resource settings.⁵ This can be seen in a 2013 action plan by the Government of Kerala

(developed with UNICEF support) which calls to provide effective counseling in schools for prevention of suicides and forms of abuse.¹⁸ It also has plans to accredit existing counselors, train them systematically, provide them with decent remuneration (not just honorarium), equip schools with counseling centers, and reinstate “protected teachers” as counselors (guidance teachers/mentors) after providing them with training in student counseling through a certificate course.

CONCLUSION

This narrative enumeration of school-based mental health interventions in Kerala reveals many programs from multiple agencies from different governmental and nongovernmental sectors. Prevention programs span universal, selective and indicated interventions. Overall developments in the state parallel those in school settings of high income countries. Still, there are various lacunae, like lack of rigor in stated objectives of the existing programs, manpower-related issues, lack of evaluation of program processes and outcome, etc. The existing lack of coordination between programs, which leads to limitations in their efficiency, may be addressed by creation of a nodal agency with mandate for coordination and quality assurance. The DMHP could focus more on facilitating and coordinating selective and indicated prevention programs in schools.

REFERENCES

1. Annual Status of Education Report. ASER Center; 2014.
2. National Family Health Survey-3. Ministry of Health and Family Welfare Government of India; 2006.
3. The Lancet Psychiatry. The right place at the right time. *The Lancet Psychiatry*. 2014;1(5):319.
4. Fazel M, Hoagwood K, Stephan S, Ford T. Mental health interventions in schools in high-income countries. *The Lancet Psychiatry*. 2014; 1(5):377–387.
5. Fazel M, Patel V, Thomas S, Tol W. Mental health interventions in schools in low-income and middle-income countries. *The Lancet Psychiatry*. 2014; 1(5):388–398.
6. Report of the National Meeting of the Directors of State Council for Education Research and Training (SCERT) on School Health Promotion. Ministry of Health and Family Welfare. 19–21 June 2007. Government of India, New Delhi; 2007.
7. Soman SG, Kiran PS. “Thalir is Budding”: DMHP Thiruvananthapuram guidelines on School mental health implemented in comprehensive mental health scheme 2014-15. *Kerala J. psychiatry*. 2014; 27(2):36–9.
8. Manual for Career Guidance and Adolescent counseling programs in higher secondary education department. Government of Kerala 2014.
9. John P, George SK, Rajiv KJS, Kurian LG. A Manual for School Teachers and Counselors. Cochin, S. India; 2006. Available at: http://www.peejays.in/downloads/mental_health_&_substance_abuse_school_mental_health.pdf. Accessed December 8, 2014.
10. Minutes of the meeting on the problems of mentally challenged children; 2013. Available at: http://www.kescpcr.kerala.gov.in/files/Meeting_on_the_problems_of_mentally_challenged_children.pdf. Accessed January 6, 2015.
11. 19th Joint Review Mission, State Report. Kerala. Sarva Shiksha Abhiyan (SAA); 2014
12. Kishore ANR, Shaji KS. School dropouts: examining the space of reasons. *Indian J. Psychol. Med.* 2012;34(4):318–23.
13. Health Promotion using Life Skills Education Approach for Adolescents in Schools – Development of a Model. Available at: <http://www.jiacam.org/0401/LSE.pdf>. Accessed December 7, 2014.
14. Srikala B, Kishore KK V. Empowering adolescents with life skills education in schools - School mental health program: Does it work? *Indian J. Psychiatry*. 2010;52(4):344–9.
15. Concept note on redesigned psychosocial service program, 2013; G.O. Rt No.29/13/SJD; 01/02/2013.
16. Loganathan S. Targeting adolescents for mental health literacy via NIMHANS life skill education model. *Indian J. Psychiatry*. 2012; 54(3):292–3.

17. Strengthening of counselling in schools, child care homes including institutions for differently abled children. 2014. Available at: http://www.kescpcr.kerala.gov.in/files/Report_on_Strengthening_of_Counselling_in_Schools.pdf. Accessed January 6, 2015.

18. Plan for effective student counselling ready to roll out. The Times of India. Available at: <http://timesofindia.indiatimes.com/city/thiruvananthapuram/Plan-for-effective-student-counselling-ready-to-roll-out/articleshow/11040704.cms> Accessed March 20, 2015.

Source of support: None *Conflict of interest:* None declared