ESTD : 1880

AL-SHODHANA
A Multi -Disciplinary Double Blind Peer Reviewed Research Journal
https://sadupublications.com/journals/index.php/al-shodhana
Open Access
ISSN(P): 2320-6221
ISSN (Online): 3049-3870

BEYOND BOOKS: SCHOOL MENTAL HEALTH INITIATIVES FOR ADOLESCENTS, IN PATHANAMTHITTA, KERALA

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ARTICLE HISTORY

Received : 03-04-2025
Revised : 18-06-2025
Accepted : 11-07-2025
Published : 30-07-2025

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Keywords
Adolescents,
High schools,
Higher secondary schools,
School counsellors,
School mental health initiatives.

Abstract

This study investigates mental health initiatives, support systems, and challenges in schools across Pathanamthitta District, Kerala. Using a mixed-methods approach, 50 schools were surveyed using stratified random sampling, and in-depth interviews with ten school counsellors were also held. The results show that while private schools exhibit notable service gaps, frequently lacking trained staff and integrated support systems, government and aided schools consistently offer structured counselling, referral pathways, and wellness infrastructure, largely supported by state-led programs like ORC and Souhrida clubs. Social Emotional Learning (SEL) integration into school curricula, teacher orientation programs, and appointing qualified counsellors are other initiatives that could help integrate responsiveness, equality, and accountability into Kerala's school mental health ecosystem.

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DOI: https://doi.org/10.70644/as.v13.i2.4

Introduction

Adolescent mental health is increasingly recognised as a significant public health priority worldwide, particularly in low- and middle-income countries (LMICs) like India, where over 250 million individuals are aged between 10 and 19 years. This developmental phase is linked with increased emotional, cognitive, and social vulnerability, leading to a higher occurrence of mental health problems such as anxiety, depression, and emotional dysregulation (Li, 2025). Approximately 10–20% of children and adolescents experience mental health disorders globally; however, more than 80% of those affected live in LMICs, where access to quality care remains inadequate (Kassa et al., 2025).

School mental health encompasses the range of strategies, services, and day-to-day practices within schools that aim to support students' emotional well-being, prevent the onset of psychological difficulties, and ensure timely help when problems arise (Murugappan & Vanishree, 2019). It often involves trained counsellors, life skills programmes, teacher engagement, and strong links with families and community resources (Weare & Nind, 2011). When schools prioritise mental health, they can catch concerns early, improve learning outcomes, and nurture resilience, reducing the risk of long-term disorders (Durlak et al., 2011). In essence, a mentally healthy school fosters safety, inclusion, and balanced personal growth for every learner.

In India, despite efforts through the National Mental Health Programme and Rashtriya Kishor Swasthya Karyakram (RKSK), significant barriers persist. These include stigma, lack of mental health professionals in school settings, inadequate teacher training, and fragmented implementation of preventive interventions (Malik et al., 2025). Schools are recognised as fundamental environments for early intervention. Universal school-based mental health initiatives — particularly those promoting life skills, emotional regulation, and resilience — have demonstrated effectiveness in improving adolescent well-being (Hetrick & Sharma, 2025).

Kerala, the state well known for its educational and health indicators, has introduced innovative state-specific programmes like *Our Responsibility to Children (ORC)* and *Souhrida Clubs* aimed at nurturing adolescent mental health through school-based interventions. However, field evaluations reveal that these initiatives are inconsistently implemented, particularly in semi-urban and rural districts such as Pathanamthitta. Adolescents here experience acute academic pressures, familial expectations, and peer-related challenges. Inadequate staffing, outdated programmes, and low community

awareness hinder the effectiveness of available support systems. Recent alarming events, including the death of a veterinary student in Wayanad after being bullied and the sexual exploitation case involving minors in Pathanamthitta, have made it clear that we need to do more to protect the mental health of adolescents. Increasing cases of cyberbullying, group violence, and peer-induced emotional distress in Kerala schools reveal broader psychosocial vulnerabilities that demand systemic intervention.

Latest studies show that emotion regulation strategies, family dynamics, and societal factors play an important role in moulding an adolescent's mental health (Li, 2025). Also, initiatives driven by young people themselves, including co-designed emotional literacy programs, have shown potential in making schools more compassionate and resilient (Hetrick & Sharma, 2025). Nevertheless, successful integration of such models requires context-sensitive adaptation, ongoing monitoring, and multisectoral collaboration. Against this backdrop, the present study investigates the availability and challenges of mental health initiatives in high schools and higher secondary schools in Pathanamthitta District, Kerala. By employing a mixed-methods approach, the study seeks to offer actionable, evidence-based recommendations for strengthening adolescent mental health support systems within Kerala's educational framework, contributing to Sustainable Development Goal 3: Good Health and Well-being.

METHODOLOGY

The study adopted a descriptive research design, combining both quantitative and qualitative methods to examine the mental health initiatives of high schools and higher secondary schools of Pathanamthitta district, Kerala. The study site was selected due to the diverse mix of government, aided, and private institutions, along with reported adolescent mental health concerns in the recent years. The sample involved 50 schools ensuring proportional representations from ICSE, CBSE and Kerala State Boards, which were administered a structured questionnaire. These schools were selected using stratified random sampling method, after considering the total number of schools in each board of education. In addition, 10 school counsellors were interviewed for in-depth qualitative insights, who were purposively selected to ensure representation across different boards and experience level.

SPSS and Microsoft Excel were used to analyse the surveyed data, while the interview responses were thematically analysed to identify common patterns. Ethical considerations were upheld by obtaining institutional permissions and verbal consent. The study aimed to assess school profiles, identify existing mental health support

systems, and understand the perspectives of the school counsellor on the current mental health initiatives. Limitations include possible response bias and a restricted qualitative sample that may not fully represent counsellors from all educational boards, as well as the absence of perspectives from other stakeholders such as students and parents, which could have enriched the findings through data triangulation.

Results And Discussions

Table 1: Demographic Profile of Schools

Sl. No	Variable	Categories	Percentage (%)
1	**Type of Board**	Kerala State Board	80
		CBSE	16
		ICSE	4
2	**Respondent Designation**	Senior Teacher	42
		Principal/Headmaster	34
		School Counsellor	24
3	**School Management**	Government	42
		Aided	42
		Private	16
4	**Year of Establishment**	1–50 Years	50
		51–100 Years	30
		101-150 Years	14
		151-200 Years	6
5	**Student Population**	<300 Students	76
		>300 Students	24
6	Student-Teacher Ratio	1:1 to 10:1	22
		11:1 to 20:1	58
		20:1 to 30:1	16
		31:1 to 40:1	2

Table 1 clearly shows that, most of the respondents were senior teachers, while the participation of the school counsellors was very low, which can be due to a shortage of appointed school counsellors. Government and aided schools (84%) are the major respondents, showcasing the significant role of public sector institutions in the district's educational sector. Half of the schools were established within the last 50 years, suggesting the significant growth of educational institutions in recent decades. While 58% of schools maintain a good student-teacher ratio, there are many schools (22%) with small student populations, whereas a few exhibited higher student enrolments, which may challenge the quality and effectiveness of mental health services. Larger student numbers are often associated with reduced individual attention and lower access to mental health support (Weare & Nind, 2011).

Table 2: The availability of Mental Health support systems in Schools

SI. No	Facility/Service	Available (%)	Mean count
1	Counselling Services Present	62	31
2	Referral Services Available	78.4	39
3	Online Counselling Access	7.8	04
4	General Internet Access	100	50
5	Playground Available	89.6	45
6	Sick/ Wellness room	70.8	35
7	Recreational Room Present	31.3	16
8	No Relaxation Space	4.2	02
		Overall mean count = 27.75, SD = 17.15	

The data in table 2 reveals a mixed picture regarding the availability of mental health support systems in schools. While a majority of schools (62%) report having counselling services, a significant 38% still lack this basic mental health provision. Of the total respondents, only 29% reported having an appointed school counsellor (psychologist or social worker), while the rest provide mental health support through external visiting resource persons, trained teachers, or religious heads. This finding aligns with Venkatesan and Shyam (2015), who in their survey of 101 national and international schools in Karnataka reported that only 19% had formally appointed school counsellors, while the rest depended on ad-hoc arrangements. Together, these findings indicate that despite growing recognition of the need for school-based mental health support, the majority of Indian schools still operate without dedicated, professionally trained counsellors, limiting the quality and continuity of care provided to students. On a more positive note, referral services are available in 78.4% of schools, indicating that many institutions are at least able to direct students to external mental health resources when needed.

However, access to online counselling services is notably low, with only 7.8% of schools offering this option, despite 100% of schools reporting general internet access. This suggests a significant underutilization of digital infrastructure that could potentially bridge the gap in in-person mental health support, particularly in resource-constrained or rural settings. Physical infrastructure that supports overall wellbeing is unevenly distributed. While most schools (89.6%) have a playground, and 70.8% offer a sick/ wellness room, only 31.3% have a dedicated recreational room, which could be vital for stress relief and promoting emotional wellbeing. Alarmingly, 4.2% of schools report having no relaxation space at all, underscoring a lack of attention to students' need for informal, safe environments to decompress.

In summary, although foundational support systems like referral services and internet connectivity are widely available, there remains a pressing need to enhance in-school counselling provisions and leverage digital platforms for mental health support. Additionally, expanding access to recreational and relaxation spaces could further promote a holistic, student-centred approach to mental wellbeing in schools. The overall mean score for mental health support facilities across schools is M=27.75. and the standard deviation score is SD=17.5. A high standard deviation scores of 17.5 suggests wide variation in the availability of these facilities across schools. Facilities such as internet access (100%) and playgrounds (89.6%) are widely available. Core mental health services like Counselling (62%) and referral services (78.4%) show a moderate presence. Online counselling (7.8%) and recreational/relaxational spaces (4.2%) are very limited, indicating a significant gap in tech-enabled &informal mental wellness resources. This disparity suggests a need to standardise Mental health infrastructure across schools, especially to promote accessible and student-friendly environments.

Table 3a: Mode of delivering/ implementing various mental health initiatives in schools.

Initiatives	Mode of Delivery / Implementation	Percentage of participation
Peer Support Programs	Training selected students	58%
	No Peer support programs conducted	48%
Anti-Bullying Programs	Strict School Policies	32%
	Through awareness classes	46%
	Through Campaigns	8%
	Integrated into the curriculum	4%
	No Anti-Bullying Programs conducted	50%
Social-Emotional Learning Programs	Through awareness classes	92%
	Through Training	72%
	Integrated into the curriculum	60%
	Through Co-curricular Activities	96%
	No SEL Programs are provided	0%
Collaboration and Partnership	With Mental Health Professionals	80%
	With NGOs	22%
	With Government	78%
	No such Collaborations	8%

Staff Training on Mental Health Issues	Cluster Training	6%
	Biannual Training	4%
	Annual Training	72%
	No Training Provided	18%
Yoga & Mindfulness Training	Integrated into the curriculum	18%
	Through Co-curricular Activities	18%
	As an awareness session	92%
	Short-term training/ Course	54%
	No Yoga & Mindfulness Training given	6%
Sexuality Education	Integrated into the curriculum	32%
	As an Awareness Session	88%
	No Sexuality Education Provided	6%

The data in table 3a indicates varied levels of implementation and delivery strategies for mental health initiatives across schools, reflecting both encouraging practices and significant gaps.

Regarding Peer Support Programs 58% of schools report training selected students for peer support, a promising sign of empowering students to support one another. However, 48% of schools do not conduct any peer support programs, highlighting a missed opportunity for student-led mental health support, especially in schools with limited counselling resources. Despite the recognised importance of anti-bullying interventions, 50% of schools report not conducting any such programs. Among the schools that do, 46% use awareness classes, while only 32% have strict school policies. Campaigns (8%) and curriculum integration (4%) are rare. This indicates a reliance on short-term awareness rather than sustained, policy-driven or integrated approaches to tackle bullying effectively.

96% of schools implement Social Emotional Learning Programs (SEL) through co-curricular activities, 92% through awareness classes, 72% through training, and 60% have integrated SEL into the curriculum; hence, Social-Emotional Learning (SEL) Programs appear to be widely adopted. Notably, 0% reported no SEL programs, suggesting near-universal acknowledgement of the importance of emotional and social skills in education.

The study shows that 80% of schools collaborate with mental health professionals, and 78% with government agencies, reflecting strong institutional partnerships. Since

the collaboration with NGOs is less common (22%), and 8% of schools report no such collaborations, there is a need to strengthen community-based connections and expand support systems. It is encouraging that 72% of schools provide annual staff training. However, 6% offer cluster training and 4% biannual training, which may limit the depth and continuity of capacity building. Alarmingly, 18% of schools provide no mental health training for staff, weakening frontline response mechanisms in school settings.

Yoga and Mindfulness Training are mostly offered as awareness sessions (92%), with 54% offering short-term training or courses. Integration into the curriculum (18%) and co-curricular activities (18%) is relatively limited, suggesting these practices are more sporadic than embedded. Still, only 6% of schools report no such training, which reflects a broad interest in incorporating mindfulness into school life. When regularly practised in schools, yoga can notably decrease issues like hyperactivity and difficulties with peers. It also boosts academic success, strengthens teenagers' ability to bounce back from adversity, improves their control over emotions, and actively supports their mental health (Pandey et al., 2024; Giridharan & Pandiyan, 2024). Sexuality Education is primarily delivered through awareness sessions (88%), while 32% have integrated it into the curriculum. Encouragingly, only 6% of schools provide no sexuality education, indicating increasing openness and responsiveness to adolescent developmental needs. Nag et al. (2025) highlighted the importance of school-based gender equity interventions in shaping adolescent attitudes and improving sexual health literacy in Indian schools.

Table 3b: Mode of delivery of various Mental health initiatives in Schools

Mode of delivery of MH program	Mean Count	SD
Peer Support Programs	26.5	3.54
Anti-Bullying Programs	14	9.49
Social-Emotional Learning Programs	32	19.49
Collaboration and Partnership	23.5	15.75
Staff Training on Mental Health Issues	12.5	15.18
Yoga & Mindfulness Training	18.8	15.61
Sexuality Education	21	17.44

In table 3b, the mean of schools implementing various M H strategies ranges widely across domains from 12.5(staff training) to 32 (SEL program). In terms of program implementation, SEL was marked the highest (M=32; SD=19.49) with high participation in awareness & co-curricular activities. Followed by Sexuality education through awareness sessions (mean=21.Sd=17.44). Staff training and Peer support programs had

lower participation rates, indicating the need for strengthening such areas. The Standard deviation is high in most domains (Sd>15), indicating uneven implementation across different methods within each domain. There is considerable variation in how mental health initiatives are delivered across schools. While some practices like SEL and awareness sessions are widely adopted, others like online counselling, staff training, and NGO partnerships are less consistent. A more standardised, holistic and inclusive approach is needed to ensure that all schools provide comprehensive Mental health support to students.

Qualitative Analysis of In-Depth Interviews with School Counsellors

This qualitative analysis is drawn from interviews with female school counsellors aged 25–35 years, each holding a master's degree in counselling and possessing 2 to 15 years of professional experience. The responses were thematically categorised and reveal key insights into student mental health concerns and the perceived effectiveness of current support systems.

Prevalent Mental Health Issues

Counsellors consistently reported anxiety, stress, behavioural challenges, and relationship issues as the most common mental health problems among students. Another growing concern was smartphone addiction, often linked to reduced emotional well-being and academic decline. Counsellors also identified substance abuse, depression, ADHD, learning disabilities, psychosomatic complaints, suicidal ideation, and trauma from sexual abuse, but less frequently. The increasing number of POCSO cases was a major concern, pointing to the need for trauma-informed care.

Contributing Factors

The counsellors attributed the rise in mental health issues to societal and environmental stressors, such as, unfiltered social media exposure, family instability and parental conflicts and social isolation during the COVID-19 pandemic. These factors were seen as drivers of emotional instability, low self-esteem, reduced attention span, and unrealistic expectations in students.

Gaps in Support Systems

A majority of the respondents highlighted inadequate resources, including, Lack of full-time school counsellors, Absence of dedicated counselling spaces and Insufficient time for mental health programs within the school timetable. They also cited low

student engagement, negative parental attitudes, and overburdened academic schedules as major barriers.

Effectiveness of Existing Initiatives

The counsellors had mixed opinions on the effectiveness of current mental health initiatives. While some acknowledged positive outcomes, many viewed them as superficial or poorly implemented. Concerns were particularly directed at government-funded programs, which were seen as under-resourced and lacking qualified staff. Initiatives like "Makkale Ariyaan" were viewed as promising but were hindered by poor parental participation.

Recommendations from school counsellors

Counsellors strongly advocated for a comprehensive and systemic approach, such as Dedicated mental health curriculum time, Teacher training to identify early warning signs, Parental awareness programs on POCSO, cybercrime, and life skills, Individual counselling and recreational activities, improved infrastructure and increased funding. Holistic interventions to reduce student stress, such as updated teaching methods, reduced workloads, and enhanced support systems

Based on the study the following recommendations are proposed:

1. A School Mental Health Evaluation Authority should be established under the Ministry of Education and develop an **Annual Mental Health Action Plan.**
2. Adequate funding is crucial for improving **mental health infrastructure** in schools, including **playgrounds, recreational areas, and counselling rooms**.
3. Schools demonstrating exemplary mental health practices should be recognised and rewarded to encourage best practices.
4. Teacher training programs should be expanded to help educators identify and support students with mental health concerns, addressing the gap in the early detection of psychological distress among students.
5. Mental health education should be integrated into the curriculum through **Social Emotional Learning (SEL)** to develop **self-awareness, self-regulation, and decision-making skills.**
6. **Digital detox initiatives and awareness programs** should be implemented to address **excessive screen time and social media addiction**, with **parental guidance sessions** ensuring healthy technology use at home and school.

Conclusion

Student mental health is vital to overall well-being and academic achievement, yet often overlooked in educational planning. This study explores the availability and effectiveness of mental health initiatives in high schools and higher secondary schools across Pathanamthitta District. Key findings indicate significant infrastructure gaps, including playgrounds and counselling rooms. Although many schools provide counselling, these services are often irregular or understaffed, with teachers frequently serving as first responders to student distress. This highlights the requirement for systematic teacher training and increased incorporation of mental health learning within school curricula. Challenges persist in the form of stigma, limited funding, and poor stakeholder coordination. Moving forward, a more integrated, student-centred approach is essential. This involves committed counselling infrastructure, flexible scheduling, specialised teacher training, and engaged parental participation. Expanding awareness programs and embedding life skills and digital wellness into the curriculum can foster resilience. By grounding future interventions in real voices and lived experiences, schools can create a culture where emotional well-being is not just addressed, but truly prioritised.

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