PROMOTING MENTAL HEALTH

Enabling a Whole School Approach

Preeti Vivek Mishra

6

PROMOTING MENTAL HEALTH

Enabling a Whole *School* Approach

First Published – November 2022 (2T)

ISBN:- 978-81-953899-0-2

Published by the Registrar, National Institute of Educational Planning and Administration (NIEPA), 17-B, Sri Aurobindo Marg, New Delhi-110016, Designed and Printed at M/s Archna Printers, Okhla, New Delhi–110020.

Contents

Section I: Theoretical Underpinnings

Section II: Facilitator's Toolkit

SECTION I
Theoretical Underpinnings

6.0 A Word to the School Leaders...

The National Education Policy-2020 emphasizes the need to foreground Mental Health for teachers and learners, alike. This emphasis has been recurrent in global education discourse and emanates from a recognition of the inextricability of positive mental health and student learning. The interlinkage between the two is bolstered by research evidence linking subjective well-being and resilience of teachers and learners with improved instructional effectiveness, improved student learning outcomes, positive classroom environments, reduced rates of delinquency, and strengthening of socio-emotional and academic capabilities of students. Various related interventions like Life-skills education, psycho-education, Socio-emotional Learning and so forth mirror this emphasis. Even as this module nears completion, the current pandemic situation has added further impetus to the need of creating caring and positive educational cultures and emphasize emotional health of all.

The module is premised on the reasoned belief that as schools begin to embrace an openness and a language to discuss the mental health concerns of its members, they also begin to cognize and appreciate their role in nurturing resilience and promote subjective wellbeing among its members. It is against this research, policy and temporal context that the present module calls upon school leaders to lead the efforts to prioritize mental health and wellbeing of students, staff and themselves.

6.1 Objectives

1. To develop school leaders' Mental Health vocabulary.
2. To raise awareness among school leaders towards the relationship between positive Mental Health for all and student learning.
3. To aid school leaders in assessing their school's preparedness for addressing the specific mental health needs of their staff and learners.
4. To enable school leaders to lead the process of designing a customized school mental health plan for all stakeholder groups.

6.2 Concept Box

1. **Stressors:** External or internal events which are perceived by an individual as overwhelming or threatening their sense of well-being.
2. **Stress:** A process whereby an individual perceives and responds to stressors. It involves two things: firstly a subjective appraisal of a stressor with respect to the extent of threat it poses, and secondly a consideration of possible options for handling the situation as well as how effective each coping option may be.
3. **Mental Health:** Implies a complete state of physical, psychological and social wellbeing, and not just mere absence of illness. The parameters of wellbeing in each of the 3 domains remain open to cultural definitions. This holistic conception is also sometimes could positive Mental Health.
4. **Prevention:**Interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder.
5. **Mental Health Promotion:** Interventions that aim to enhance the ability to achieve developmentally appropriate tasks (developmental competencies) and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen the ability to cope with adversity.
6. **Treatment:** Interventions targeted to individuals who are identified as currently suffering from a diagnosable disorder that are intended to cure the disorder or reduce the symptoms or effects of the disorder, including the prevention of disability, relapse, and/or comorbidity.
7. **Resilience:** The relative capacity to cope with adversity and to avoid breakdown when confronted by stressors and psychosocial risk experiences. Resilience does not imply absence of stressors, it rather denotes better coping capacity and ability to jump back relatively psychologically unharmed.
8. **Mental Health Literacy:** An evolving concept, MHL includes knowledge, skills and attitudes which support mental health promotion for self and others.
9. **Whole School Approach:** An approach to promoting mental health which seeks to involve all actors (like staff, students, leadership), integrate mental health efforts across all domains (like curriculum, teaching learning, organizational structure and management, ethos and culture), and address a wide variety of mental health concerns (preventive, promotive and diagnostic)

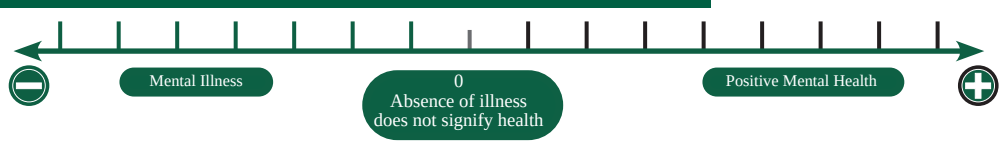
10. **School Mental Health Plan:** A comprehensive plan designed with a whole school approach to mental health promotion**.** It begins with laying down of a collective vision for a mentally healthy school. With preventive and promotive focus, the program involves need assessment, as well as identification of people, processes and interventions to address these needs. The program also has a well chalked out assessment and feedback system to gauge the efficacy of planned intervention and reflectively feed into future course of action.

6.3 What Exactly is Mental Health?

Reflecting on how we understand health can be a good starting point to understand Mental Health. WHO (2001) defines health as "… *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."* (WHO 2001, p.1).The definition points out to a key characteristic of health, i.e. health must be understood as comprising both absent and present states. To elaborate, health when referred to as an absent state indicates pathology or illness denoting absence of health. In present states it refers to positive states like fitness, endurance, ability and stamina. A comprehensive understanding of health incorporates a recognition of both absent and present states.

It would be worthwhile here to imaging health as a number line stretching from minus infinity to plus infinity, with the stretch to the left of zero indicating the absent state of health, and the stretch on the right denoting the present state. As individuals all of us may be located at different points on this number line at any given point in time. Also, as life unfolds, we may move either leftward or rightward from our given location. Whereas for all of us, zero may indicate an absence of disease, it does not portray a positive conception of health. Thus, zero is not the ideal state that one must consistently strive for. Rather any efforts towards health promotion must necessarily be guided by a constant striving for rightward movement for each and every individual on this number line. This dual conception of absent and present states will be of value as we move forward to understand Mental Health.

Mental Health : Absent and Present States



Put simply, Mental health pertains to the mind: our emotions, feelings, beliefs and our sense of psychological wellness. In its absent state, mental health denotes psychological distress and pathology in varying degrees. In its present state, it denotes a healthy, happy and harmonious mind.

Moving to a more formal definition of mental health, the WHO building on the conception of the present state of health has defined Mental Health as "*... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."* (WHO 2001a, p.1).

6.4 Three Takeaways for School Leaders

The foregoing discussion brings to the fore 3 key takeaways which must inform School Leaders' approach towards prioritizing Mental Health in schools. We discuss these in the paragraphs that follow:

Takeaway-1*: Overall health is incomplete without mental health*. A relook at the WHO definitions quoted earlier highlights that while mental health is the foundation for well-being and effective functioning for an individual, it is at the same time a key component of overall health too. Further, physical and mental health are closely related. Mental health is an important factor in the maintenance of good physical health and in recovery from physical illness. Similarly, physical ailments and fatigue are known to be a threat to the sense of well-being. Evidence suggests that mental health and/or its determinants can be improved in association with planned or unplanned changes in the physical environment. Therefore, any efforts to promote mental health must involve a focus on reducing physical stress as well as improving physical health. School leaders can do the needful by stressing the importance of an active school culture involving regular exercising, yoga and meditation etc. and making these an integral part of school-wide measures to promote mental health for all.

Takeaway-2: *Stress and stressors are a normal occurrence of life*. Closer perusal of the definitions of Mental health leads one to a *recognition of the universality of stress and stressors*.While recognizing that some circumstances may be particularly excruciating, it emphasizes the need to strive for Mental Health while experiencing the everyday ups and downs life has to offer. It is unrealistic to think of life as sanitized and free from any challenging or difficult circumstances. A useful trope in leading life is to define life itself as a process of mindful adaptation. Put simply, the quality of life is to be gauged not by the scarcity or absence of hardships but by an individual's mindful recognition of universality and ubiquity of

stressors and subsequently the approach an individual adopts towards these challenges. Thus, a fair barometer of Mental health lies in the constructive course of action or coping strategies she/he adopts to negotiate them. It is here that schools can rope in efforts around strengthening individual adaptive resources through interventions like life skills training, resilience building for all stakeholders.

Takeaway-3: *Mental health is everybody's business*: By stressing the community aspect , the WHO definition establishes that *Mental health is everybody's business*. Individuals are parts of various social institutions vis families, educational institutions, workplaces, faith-based organizations etc. In each of these contexts, individuals lead a relational existence, i.e. they relate to others. An individual's sense of wellbeing influences the quality of these relationships and interactions thereby impacting those who come in contact with such individual. In addition to the socio-emotional dimension of human to human interactions, mental health or the absence of it can also,in some though not all cases, adversely impact the quality of work-related contributions. This recognition is evident in the corporate world's emphasis on work life balance, employee satisfaction and so on.Human resource discourse has long recognized that an individual's mental health status tends to reverberate through her/his network of associations in various ways. Thus, investing in individual mental health is a worthwhile investment even from an organizational cohesion and productivity point of view. It is easy to imagine the import a mentally healthy school leader will have on her staff, and so on. While schools are organizations too and the above mentioned grounds fit well with them, there are several additional reasons which together build a robust case for the school leadership prioritizing mental health efforts. The next section aims to build a rationale for foregrounding mental health in the school context.

6.5 Prioritizing Mental Health in Schools

The role of schools as active agents of promoting or hindering mental health is well researched and documented. Several reasons are forwarded to support the case for schools adopting a prominent role in planning for and supporting mental health of all involved. Some often-discussed reasons include the research evidence that happy schools are also academically efficient schools i.e. schools which have an effective mental health promotion focus have been known to yield encouraging academic results too. Therefore, an investment in mental health is universally being acknowledged as a worthy investment on instrumental or performance grounds too.

Schools are also seen as a key socializing agency which along with the family have the crucial responsibility of engaging with individuals in their formative years. That schools do it for generation after generation, and for prolonged hours each day, only add to the magnitude of their potential impact on the young minds who pass through its gates every morning, noon or evening. If schools as sites are unwelcoming, strife-laden and emotionally thwarting, they may dent young minds and rock the foundations of their budding personalities for a life-time thus sowing seeds for crippling of sound mental health in near or distant future.

Then again, the normative role of schools as sites of cultural transmission necessitate that schools also transmit a culture of positivity, acceptance and sensitivity towards others and oneself. Thus, schools must look beyond their academic-instrumental role and focus on the facilitation of well-rounded development of their wards. Further, as social spaces where individuals interact with others from diverse socio-religious, ethnic, linguistic backgrounds, schools are mini-representations of the world that the young minds would go on to inhabit, at least with reference to diversity. Therefore, they are a near perfect breeding ground for socio-emotional skills which go a long way in ensuring both individual and organizational mental health, today and tomorrow.

Additionally, as school leaders, we are well-versed with the relational nature of schools as organizations with intricately woven webs of relationships and interactions, accordingly the need to stress Mental Health of all involved in schools cannot be overemphasized.

It is however noteworthy that as organizations, schools are typical. They are among the rare setups wherein children and adults are co-stakeholders. Other than families which are the primary socializing agency, schools are the only other socializing agency which is as consistently and continually invested in the foundational years of children. As a result, any beginnings made in the school years can be expected to be equally, if not more, fundamental to developing sustainable habits and dispositions. Clearly then, schools must focus their energies and initiatives on promoting mental health for all students, at all ages and at all grade levels.

Apart from the organizational productivity logic mentioned in the previous section, investing in mental health for all stakeholders in school is also advocated on grounds of its potential to significantly improve learning outcomes. Research evidence has repeatedly reinforced that while on one hand positive mental health contributes substantially to effective and joyful learning but on the other hand the experiences of prolonged mental distress mental problems and chronic mental illnesses can significantly hamper the process of learning too.

Early emphasis on mental health promotion efforts are also known to inculcate resilience in the upcoming generation right at the outset. Resilience is defined as the relative capacity to cope with adversity and to avoid breakdown when confronted by stressors and psychosocial risk experiences. Resilience does not imply absence of stressors; it rather denotes better coping capacity and ability to jump back relatively psychologically unharmed. Resilience is indicative of positive mental health. High levels of resilience are found to be correlated with low vulnerability to mental illnesses, lower medical costs and higher degrees of subjective well-being and life satisfaction. Inculcation of the ability to cope and adapt better to stressors and challenges of life in the foundational stages of life are an effective means of ensuring healthy futures. Therefore, the roles of schools as enabling institutions in this regard too cannot be undermined.

In addition to the reasons mentioned above, the potential positioning of schools as centers of early referral and diagnosis too offers a compelling reason for looking in the direction of schools as key collaborators in the journey towards mental health for all. Given that of all mental health conditions that carry through the lifetime, over 50% begin manifesting by the time a child reaches fourteen years of age, schools can be game changers in the fight against potential mental illnesses by allowing opportunities for early interventions. The arguments for trusting school staff with the responsibility of identifying situations and cases for referral diagnosis is premised on the obvious fact that children spend over one-third of their time in schools, school staff are naturally positioned to notice any significant behavioral changes, engage in early recognition of mental health issues and deliver both need-based and generic interventions.

The plethora of reasons mentioned above together build a compelling case for treating schools as central sites in the journey towards mental health promotion for all children. While the aforementioned reasons focus chiefly on student mental health and may be termed lopsided, they are nonetheless compelling enough by themselves to invest in school mental health.

Yet, the foregoing discussion should not be taken to mean that children alone are to be the focus of school mental health plans. In fact, research evidence has been consistently showing that mentally healthy schools are one wherein the mental health of all stakeholders is prioritized. As a school leader, one only has to augment these reasons by also stressing the need for staff mental health and the indispensability of investing in mental health stares us in the face, wide and clear. Justifiably then any school mental health planning has to be comprehensive in that it should be cognizant of the mental health needs and challenges of all stakeholders concerned.

Quicktake: Why should Schools Prioritize Mental Health?

- ☑ Both teachers and children spend over one-third of their time in schools.
- ☑ Comprehensive school mental health efforts are essential to creating and sustaining safe schools.
- ☑ Researches consistently show that mentally healthy children are more successful in school and in later life.
- ☑ Research also shows that mentally healthy teachers create happy classrooms.
- ☑ Comprehensive school mental and behavioral health services support an acknowledged mission and purpose of schools: learning.
- ☑ Positive Mental health interventions in formative years lead to sustainable changes in behavior and thought patterns
- ☑ Over 50% of Mental Health Concerns begin manifesting by the time a child reaches fourteen years of age. Hence schools are an ideal place to provide timely and often early preventive and promotive mental health inputs to children and youth.
- ☑ With a growingly alienated world and rapidly disintegrating mechanisms of community support, there is a growing and unmet need for mental health services for people of all ages. Schools are peculiar as individuals from multiple age brackets function collectively towards its success.

6.6 Residential School Context: A Mental Health Appraisal

An investment in individual mental health becomes particularly significant in a residential set up like Navodaya Vidyalayas wherein interpersonal relationships within school double up to perform a role well beyond their formal professional scope. It is thus paramount then that school leadership sees mental health as a community concern and accordingly the efforts are informed by a whole school approach and focus as much on positive school culture and ethos as on individuals in need of mental health services.

Residential schools are typical establishments in terms of the emotional and adjustment related demands they place on all stakeholders.As a result a thorough appraisal of the mental heath challenges and needs of all concerned is a prerequisite for developing effective school mental health plans.

Before commencing such an exercise, it must be iterated that such a discussion must consider not just the needs of the students involved but of the teachers and principals too, for the residential setup is a context that all involved have to acclimatize with.

From the students' point of view the most predominant challenge arises from encountering stranger and separation anxiety when making the transition to a Navodaya Vidyalaya set up. Whereas these terms are usually used while discussing the emotional trauma faced by kindergarten children when entering the formal school system for the first time in life, recent researchers on boarding school syndrome or residential school syndrome have reinforced the truth of their existence for children well past their kindergarten age when they are sent to residential setups at much later ages too.

Simply put , boarding school syndrome refers to the emotional upheavals and trauma encountered by boarders on account of having to leave their families and be in a regime-driven custody of non-familial adults. This has multiple repercussions on a young child's psychological world. Firstly, the move to a residential set up results in a partial severing of the most fundamental emotional scaffold in any child's life i.e. the attachment with primary care givers. This temporary state of emotional bereavement is what is aptly referred to as separation anxiety. In addition, this move not only implies a reduction in frequency of everyday interactions with one's primary care givers but also implies that the children are left uncertain about whether or how their emotional and physical needs would be met. To be thrust in the hands of complete strangers for sustained periods so much so that the school replaces the home setup in near entirety can exacerbate stranger anxiety.

The residential setup can also imply a complete loss of privacy and never ending forms of surveillance. For students entering their adolescence years this may be an additional source of stress and can even jeopardize organic milestones of development. While it is understood that it usually is teachers' sense of feeling responsible for the students physical safety in toto that results in umpteen modes of surveillance , one must acknowledge the need to allow students some degrees of privacy for youthful explorations. A recommended way of balancing the two is by engaging in sustained capacity building which will enable conscious decision making around healthy life pursuits and life styles.

Residential setups can also in some case throw up challenges around bullying and peer exploitation in varied forms. In such cases the adage 'a problem child is a child in problem' must be the first line of response. In other words, wherein issues of bullying etc. are encountered, the bully and the bullied are to be both seen as children in need of emotional support and equally vulnerable to mental distress of different kinds.

Residential setups can be equally challenging for the adults be it teachers, support staff or the principal herself. Forced separation from family due to non-family station postings, cultural non-continuities, the mentorship and house master roles, exaggerated expectations around ensuring safety and security of students, lack of community engagement, lack of socializing and recreation opportunities due to the typical locations of NVS establishments, sub-par accommodation facilitates in some cases, a sense of loss of privacy and a sense of continual workplace existence at all times can be especially stress inducing for the adults involved too.

Keeping the above multitude of stakeholders and the respective challenges in cognizance, any metal health plan for the schools in question will have to view teachers and staff in dual positions i.e. as both beneficiaries of certain interventions and deployers of certain others.

Any efforts to plan for school mental health require a substantial understanding of certain key conceptualizations and terminologies usually deployed in the field of mental health. It is to this end that the ensuing section now turns.

6.7 Fostering School Mental Health: The Pre-concepts.

Whereas development of positive school culture with a whole school approach is the favored orientation within the Mental Health discourse, even the most cursory steps towards these mandate a prior understanding of several pre-concepts which are the staple language of field of Mental Health. We now move on to engage with these foundational concepts.

(i) Mental Health Literacy

Mental health literacy involves the nurturance of the following fourfold knowledge, skills and attitudinal competence: firstly it seeks to cultivate an understanding of how to obtain and maintain positive mental health; secondly it seeks to develop an understanding about mental disorders and their treatments; further mental health literacy seeks to decreasing stigma related to mental disorders; and, finally it aims to enhance help-seeking efficacy or knowing when and where to seek help and developing competencies designed to improve one's mental health care and self-management capabilities (Kutcher, Wei and Coniglio, 2016, p.155).

Schools must seek to focus on Mental health Literacy just as they focus on numeric or linguistic literacy. In addition to the reasons repeatedly mentioned in earlier section on schools' role in promoting mental health for all students, an added reason w.r.t mental health literacy is the expertise that teachers have in all matters of nurturing literacy. Teachers are by virtue of their training and experience well-versed in knowledge on developmental milestones and challenges faced by children. Further they also have a thorough understanding of the pedagogical aptness of methods and techniques for various ages and stages of a child's life in school. They are expected to be trained in sociological underpinnings of education and how it impacts children and childhood. Clearly then, in designing interventions that seek to nurture mental health literacy the pedagogical and sociological-psychological knowledge of teachers can be a huge advantage.

(ii) Illness-based and wellness-based approaches to Mental Health

At the outset, we must learn to differentiate between and balance the illness-based and wellness-based approaches to mental health. Depending on which approach one subscribes too, the nature of interventions we invest in is impacted too. This understanding and adoption of these approaches is thus the foremost step in the journey towards school mental health.

The *illness-based* approach derives from the conception of 'absence of health' view discussed at the outset. It is limited in scope and applicability, To elaborate it focuses on deviances from normal levels of mental health. It identifies instances of mental illnesses, whether mild, moderate or severe and adopts a remedial-medical approach to addressing these. The interventions are reserved for select population who may be symptomatic of specific mental health ailments. The treatment or curative approach derives from the illness perspective of Mental Health. The treatment approach requires the services of trained specialists with expansive knowledge and practitioner experience. The role of teachers and school leaders is rightfully limited in such scenarios. The school counsellor may facilitate early identification and referral.

On the other hand, it is with reference to *wellness-based* understanding of mental health that schools have a significant and sustainable role to play. Wellness perspective derives from the 'present' state of health discussed at the outset. Wellness perspective focuses on strengthening an individual's personal resource pool for adaptive living. It shifts the focus to the right-hand side of the health number line discussed above. Unlike the illness perspective wherein the mental health interventions are aimed at symptom alleviation and return to a before disease state or a state of *homeostasis*,

wellness perspective sees mental health promotion as an ongoing and eternal exercise. It does not presume an end point to how mentally healthy, happy, harmonious and resilient one can be. Rather it conceptualizes mental health as a continuous journey wherein an individual moves from strength to strength and becoming a more evolved version of oneself with every passing moment. In other words, the wellness model of mental health is guided by the principle of *heterostatsis*.

Schools have a key role to play in addressing the wellness aspect of mental health. As a result it merits a deeper discussion. As the name suggests wellness perspective focuses on positive mental health. When planned for, it goes over and above the diagnostic-curative orientation. Unlike illness perspective, wellness approach begins before any specific problem is experienced by an individual. Actually it focusses on creating conditions which disallow any problems to arise in the first place. To ensure that problems do not arise, two related strands are focused on: one is to *minimize all those factors which may pose a threat to mental health, second is to maximise those factors which nurture mental health.* The focus on minimization is called preventive focus and the focus on maximization is called promotive focus.

(iii) Preventive and Promotive Focus of Mental Health Interventions

Factors which require minimization and are the subject of preventive focus can be further divided into two types, firstly there are factors which are specific and which make some and not all individuals more vulnerable to breakdowns. Dysfunctional families, physical disabilities and a history of physical, verbal or sexual abuse etc. make an individual more prone to stress, anxiety, depression etc. A recognition of the heightened vulnerability of such individuals mandates that specific interventions with these target individuals are planned such that any adverse effects of these factors can be minimized.The second type of preventive focus is more universal in that it derives largely from the understanding of developmental psychology to predict some common age-related mental health concerns for example substance abuse, teenage sexuality,body image related issues or examination stress in adolescent years. Knowing well in advance that these issues typically may emerge during certain age and grade levels and are known to influence larger population albeit in varying degrees, pre-emptive universal interventions are planned for the larger group to ensure that all students are firstly aware of what to expect as they grow up and secondly, know how to face these pressures and challenges should they arise in their life. As both types of foci discussed above are governed by the principle of minimization of certain factors, they are examples of a preventive approach.

Another useful approach in promoting wellness is the adoption of a *promotive focus*. Promotive focus is governed by the principle of *maximization of factors which are conducive to positive mental health*. These interventions are more fundamental in that they do not begin by predicting problems, rather they begin by imaging what an ideal human existence must look like. Thus, the promotive focus attempts to create a physical, social, emotional ethos which is premised on principles of freedom, justice, equity, dignity and so on. It seeks to make people more sensitive, appreciative and accepting of self and others. The interventions are typically focused around life skills, mindfulness training, team building exercises, collective responsibility, self-discipline, strengthening the socio-emotional-spiritual quotients, cultivating gratefulness, forgiveness and selflessness etc. Each of these interventions make people more resilient by altering their life perspectives and philosophies. Schools can benefit by adopting a promotive focus as these interventions create an inclusive ethos where diversity is cherished and celebrated and heterogeneity is seen as asset. Given that the school populace is heterogenous by age, backgrounds and hierarchical positions such an ethos can go a long way in ensuring that all members of school feel valued and find school to be a welcoming place. Once again in a residential setup, such an ethos assumes even greater importance due to prolonged and more intimate degrees of interaction between different stakeholder groups.

Having acquainted ourselves with the concept of mental health and related terminologies in detail, we now advance to understanding concepts and terminologies needed to plan for mental health in schools.

6.8 Planning for School Mental Health

As the consensus on the need for schools to step up their mental health efforts have emerged, the discussions on how to do so have also become more focused and frequent.Globally, the concept of *health promoting schools* has been considered as most ethical, comprehensive and useful when looking to focus on mental health in schools. Whereas this term emerged in the domain of health promotion, it has been found to be worthy reference point in discussions on mental health too. Weare (2000, p.21) elaborates on health promoting schools by pointing that , 'The health promoting school approach attempts to shape the whole school context, including theschool's ethos, organization, management structures, relationships andphysical environment, as well as the taught curriculum, so that the totalexperience of school life is conducive to the health of all who learn andwork there."Applying the same

understanding to mental health implies the adoption of a whole school approach to ensure that all actors experience school life as emotionally and mentally harmonious.

(i) Whole School Approach

A whole school approach can be understood as involving all stakeholders, at all times, through all components of the school life experience and finally addressing all dimensions of the mental health continuum within the reasonable limits of staff expertise. In other words, a Whole school approach is an approach to promoting mental health which seeks to involve all actors (like staff, students, leadership), be continuous (longitudinal for each student cohort, running as thematic undergirding for all activities throughout the year), integrate mental health efforts across all domains (like curriculum, teaching learning, organizational structure and management, ethos and culture), and address a wide variety of mental health concerns (preventive, promotive and diagnostic).

Quick Take: 8 Principles of Whole School Approach (Govt.of Scotland (n.d.))

- A leadership and management that supports mental health and wellbeing across the school.
- An ethos and environment that promotes positive and respectful relationships and values diversity.
- Effective curriculum and learning and teaching to promote resilience and support mental, emotional, social & physical wellbeing & learning.
- Enabling children's and young people's voices and participation to influence decisions.
- Supporting staff professional learning and development in order to ensure their own and others' wellbeing.
- Identifying need and monitoring impact of interventions.
- Working with parents, carers and the wider community.
- Targeted support and appropriate pathways to the right support

(ii) School Mental Health Plan (SMHP):

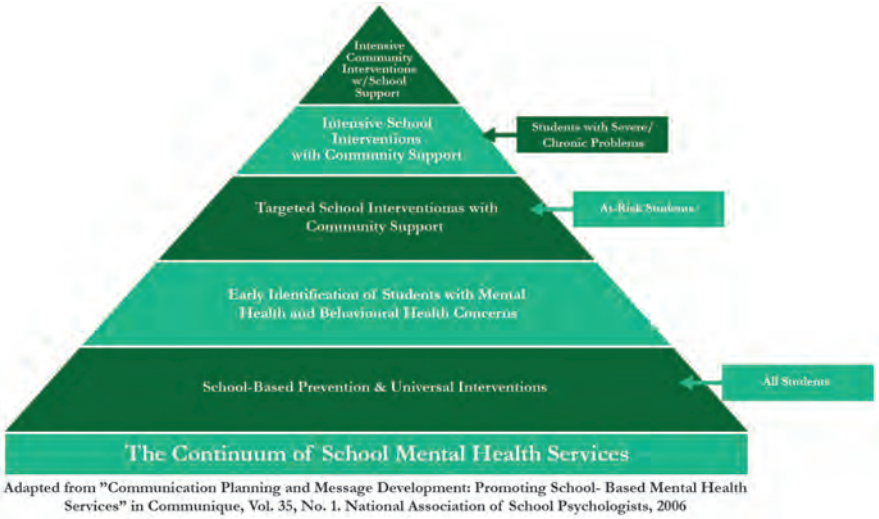
An SMHP is a comprehensive plan designed with the aforementioned whole school approach to mental health promotion**.** It begins with laying down of a

collective vision for a mentally healthy school. With preventive and promotive focus, the program involves need assessment, as well as identification of people, processes and interventions to address these needs. The program also has a well chalked out assessment and feedback system to gauge the efficacy of planned intervention and reflectively feed into future course of action.

Before setting forth to develop a school mental health plan, two pieces of knowledge can be found to be extremely beneficial.

Firstly, the school leadership must be well aware of the scope as well as limits of School mental health services. The following diagram reflects the unanimous understanding around the coverage and limits of school based mental health services. The diagram indicates for each level the coverage in terms of whether the intervention can be targeted universally (.i.e. at all members of a stakeholder category under consideration, say for e g. citizenship training for all students being considered) or for a really select targeted population (say students with diagnosed mental illnesses). The diagram also highlights the need to recognize when and where does the role of school teachers remain primary and in what instances should they pave way for professionals in the community vis. counsellors, psychologists, psychotherapists and so forth.

The Continuum of School Mental Health Services



Adapted from "Communication Planning and Message Development: Promoting School- Based Mental Health Services" in Communique, Vol. 35, No. 1. National Association of School Psychologists, 2006

As evidenced by the diagram, the school assumes a primary role for all universal interventions. As discussed elsewhere these universal interventions can be either preventive or promotive or both. It is in specifically identifying the areas to be addressed through these interventions that the second piece of knowledge becomes crucial. To elaborate, before proceeding forth with designing a School Mental Health Plan, it is worthwhile that an enlisting is done of the various areas around which preventive as well as promotive interventions can be designed for each stakeholder group. To illustrate, let us take the student community as a stakeholder group. Unlike other stakeholder groups the student community is by default very varied as the entire group can be further classified based on the ages and stages of life, with each stage throwing up a different set of mental health concerns and need areas. If one could roughly classify the entire student group into four broad categories say students in the foundational, preparatory, middle and secondary stages(with approximate age brackets defined in consonance with the NEP 2020 i.e. 3-8, 8-11, 11-14 and 14-18 respectively) then for each of the stages teachers, parents and where ever possible students too can together draw up such a list. Whereas mental health needs are universally accepted as being context specific, yet keeping in mind the general biological trajectory of development in mind an indicative list can look something like the following:

Stage	Universal Preventive Focus	Universal Promotive Focus
Foundational	Stranger Anxiety Separation Anxiety Training around Good touch bad touch	Developing Cooperation Nurturing Sharing Developing Healthy eating habits
Preparatory	Addressing Bullying Body image positivity for early bloomers Addressing Grade transition and academic stress	Practicing Gratitude Learning to be independent Assertiveness training
Middle	Stranger Anxiety (in case of residential setups) Separation Anxiety (in case of residential setups) Adapting to Pubertal changes Saying No to aggression and violence	Healthy Gender attitudes Developing self-study habits Practicing Hygiene Nurturing Secularism
Secondary	Body image positivity for late bloomers Examination Anxiety Substance abuse Sexual Experimentation	Developing Leadership Developing creativity and innovation Citizenship training Practicing Inclusion

Having understood the limits of school mental health services and having identified an indicative list of intervention areas, one can progress with working out a customized School mental health plan. The following flowchart showcases the steps to be taken and the questions to be asked at each step of developing a school mental health plan.

The Planning Flowchart

	As a leader, Create a MH Leadership Team with a clear rationale for its composition. Also share the steps taken by you to create this team. Justify which actors will be involved, in what numbers for how long etc.
	Create a Vision Statement for MHWB, it may reflect your commitments around *understanding of what MHWB means to your organisation *time investements and sustainability *the vision around decision making and participation, and so on...
	Identify an actor group and mental health issues pertaining to them which: • *require preventive action • *require promotive action • How are these issues related to improving teaching learning?
	Identify the kind of information/data you need to understand the issue. Identify and plan strategies to gain such information.
	Using the data gain above, what steps are required to address the issue? If so, tabulate the assests, levers and problems for this course of action.
	Plan interventions and timelines which: *Align with your vision *Involve all relevant actors *Draw upon your strength, and address your weaknesses
	Plan evaluation and review mechanism. *who evaluates? how often? *what are the predefined criteria?

6.9 Summary

Schools are a key agency of socialization in the formative years of a school going child's life and can both be effective allies in promotion of mental health and major deterrents to the same. A whole school approach to Mental Health looks to sustainably harness the role of schools as mental health promoting sites. A whole school approach seeks to involve all actors (like staff, students, leadership), address the mental health needs of all stakeholders, integrate mental health efforts across all domains (like curriculum, teaching learning, organizational structure and management, ethos and culture), and address a wide variety of mental health concerns (preventive, promotive and diagnostic). School leaders need to work towards mental health literacy in their establishments thus making all stakeholders cognize the potentials as well limits to school's capacitates to intervene in concerns of mental health thereby promoting as well as destigmatizing authentic instances of professional support seeking. Finally, schools must be proactive in planning mental health promoting interventions which can be targeted universally and must make the development, review and revisions of school mental health plans a way of life.

References

Cowan, K.C. (2006). *Communication Planning and Message Development:Promoting School-based Mentalhealth Services*, Communique, 35(1).

Government of Scotland (n.d.).Whole School Approach Framework for Schools to Support Children andYoung People's Mental Health and Wellbeing. Available from: https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2021/08/whole-school-approach-mental-health-wellbeing/documents/whole-school-approach-mental-health-wellbeing/whole-school-approach-mental-health-wellbeing/govscot%3Adocument/whole-school-approach-mental-health-wellbeing.pdf

Kutcher, S., Wei, Y., and Coniglio, C. (2016). Mental Health Literacy: Past, Present, and Future.The Canadian Journal of Psychiatry, Vol. 61(3): 154-158.

National Association of School Psychologists. (2021). *Comprehensive School-Based Mental and Behavioral Health Services and School Psychologists* [handout]. Author. Available from: https://www.nasponline.org/resources-and-publications/resources-and-podcasts/mental-health/school-psychology-and-mental-health/comprehensive-school-based-mental-and-behavioral-health-services-and-school-psychologists

O'Connell ME, Boat T, Warner KE, (2009) (ed.). *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities.* National Research Council (US) and Institute of Medicine (US) Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions; Washington (DC): National Academies Press (US); 2009. Glossary. Available from: https://www.ncbi.nlm.nih.gov/books/NBK32794/

Rossen, E. & Cowan, K.C. (2014). *Improving mental health in school*s. Phi Delta Kappan, 96 (4), 8-13.

World Health Organization. (2003). *Investing in mental health* [Report]. Geneva, Switzerland: Author. www.who.int/mental_health/en/investing_in_mnh_final.pdf

Recommended Resources:

Atkinson, M. and Hornby, G. (2002). Mental Health Handbook for Schools. Routledge Farmer.London.

(Read the book for information on childhood and adolescent mental health problems commonly encountered in schools, and practical suggestions for identifying and supporting pupils with specific mental health difficulties as well as identifying the circumstances which can lead to these difficulties.)

CBSE (n.d). Mental Health and Wellbeing: A Perspective. Available from: http://manodarpan.mhrd.gov.in/assets/img/pdf/CBSE_MH_Manual.pdf.

(An easy to navigate resource the manual catalogues some common mental health concerns of adolescents in chapter 10. The annexure section also offers over half a dozen activities that teachers can use with adolescent students.)

Hornby, G. and Atkinson, M. (2003). A Framework for Promoting Mental Health in School. Pastoral Care in Education. 21. 3-9. 10.1111/1468-0122.00256. Available from: https://www.researchgate.net/publication/249396679_A_Framework_for_Promoting_Mental_Health_in_School.

(Another resource from the experts in field, the article provides a bird's eye view of the whole school framework for MH promotion. It discusses the 4 levels of involvement which together make the whole school approach,beginning from the broadest level of school ethosto school organization, to pastoral provisions and classroompractices.)

Kumar, D. (2021). School mental health program in India: Need to shift from a piecemeal approach to a long-term comprehensive approach with strong intersectoral coordination. Indian J Psychiatry [serial online] 2021 [cited 2021 Jul 4];63:91-6. Available from: https://www.indianjpsychiatry.org/text.asp?2021/63/1/91/309478

Weare, K. (1950). Promoting Mental, Emotional, and Social Health: A Whole School Approach. Routledge: London. Read the 'Introduction: Why promoting mental, emotional and social health is becoming a fundamental issue in schools.'

https://www.cfchildren.org/resources/bullying-prevention-resources/

https://www.cfchildren.org/what-is-social-emotional-learning/schools/

https://www.pursuit-of-happiness.org/

SECTION II

Facilitator's Toolkit

A. Blueprint

B. Session Manual and Resources

A. Blueprint

S. No.	Session Focus	Focal Points	Group Size	Session/ Activity Title	Materials Required	Time
Day-1						
S1.	Setting the tone	Identifying one's reactions to daily stressors. Building a language around common coping methods.	Individual	S1A1-The Mental Health Bingo.	D1/S1A1- Bingo Sheets Colored Pens Reward Poster	30 min
		Preliminary Identification of the strengths and weaknesses of one's school with regards to experiencing mental health for key stakeholders.	Individual	S1A2-Thriving, Striving, Struggling!	D1/S1A2- School Wellbeing Emoji Grid Chart Papers Markers	30 min
S2.	Everyday MH	Bringing to fore the commonly held perceptions around mental healthIdentifying terms that commonly get associated with mental health.	R1-Entire Group R2- Randomly divided into Two teams	S2A1-The MH Dumb Charades. (2 Rounds: R1: Facilitator driven, R2- done with 2 teams)	Easel Board Post-its Markers	R1-10 min + R2-20 min

SECTION II

S. No.	Session Focus	Focal Points	Group Size	Session/ Activity Title	Materials Required	Time
S3.	Decoding MH.	Developing a cursory awareness of myths pertaining to mental health problems. Develop a sensitivity towards the need to cultivate Mental Health Literacy.	Team of 4-5 members each.	S3A1-Myths & Facts Worksheet	D1/S3A1-Myth/Fact Worksheet.	60 min
		Presenting a Bird's eye-view of the field of Mental Health Developing a conceptual understanding of Positive Mental Health briefly covering the definition, principles and debates.	The entire Group	S3A2- The MH Lecture covering Mental Illness vs. Mental Health Positive Mental Health The Mental Health Continuum Resilience etc.	PPT **Video Resource:** Early Treatment of Mental Disorders https://www.youtube.com/watch?v=1IzmyruT_w	60 min
S4.	MH in Schools	Awareness of MH approaches a) Preventive and Promotive. b) Universal, Selective/targeted and indicated To identify school based, grade appropriate preventive and promotive interventions	Groups of 6 members each. Total no. of groups are then equally divided to work with 3 age ranges	S4A1-Making a Start: From Theory to Schools…	Chart Papers Pens 2 readings, i.e., D1/S4R1: WHO Reading D1/S4R2: Youth.Gov reading Diagram	60 min + 60 min

S. No.	Session Focus	Focal Points	Group Size	Session/ Activity Title	Materials Required	Time
			Day 2			
S5.	Planning for MH	Introducing the linguistic and conceptual toolkit required to plan for Mental health in schools.	Group of 4-6 members.	S5A1-Create your Worksheet Topics: Positive Mental Health Resilience Whole school Approach School Mental Health Plan MH Literacy	PPT A4 sheets. Chart Marker pens **Video Resource:** How to escape education's death valley https://www.youtube.com/watch?v=wX78iKhInsc	60 min

S. No.	Session Focus	Focal Points	Group Size	Session/ Activity Title	Materials Required	Time
S6.	SWOT Analysis of One's School w.r.t mental health promotion	To facilitate an appraisal of school specific challenges to, and preparedness for Promoting and sustaining a Whole School Approach to MH.	Phased … Initially individually, then in groups of 4-6 members	S6A1 Of MH Death Valley, Rain and Seeds of Possibilities… (Discussion and Poster Presentation)	Baseline Audit Worksheet D2/S6A1 School Wellbeing Emoji Grid from Day 1 Death Valley Worksheet (Assets, Levers and Problems) D2/S6A2 A4 Sheets Markers	90 min
S7.	Planning for School Mental Health-I	To identify Actors and domains crucial to the process of planning for MH from a whole school approach	Groups of even number members (either 4 or 6 each)	S7A1 The Actors and the Domains	The Actors Worksheet- D2-S7 The Domains Worksheet- D2-S8 Markers	90 Min

S. No.	Session Focus	Focal Points	Group Size	Session/ Activity Title	Materials Required	Time
S8.	Planning for School Mental Health-II	To Chart the Steps to design a School Mental Health Plan (SMHP)	Group of 8 Any members over and above will play MH Review Committee Members along with the facilitators	S8A1MH Think Tank, and Presentation Pitch	The Planning Flow Chart D2-S9 Charts Pens Markers	2 Hours
S9.	The Road Ahead… 30 minutes					

B. Session Manual and Resources

Day and Session	Session Title	Session Resources	
		Type	Title
D1. S1. A1	The Mental Health Bingo	Worksheet	D1. S1. A1 Bingo Sheet
D1. S1. A2	Thriving, Striving, Struggling!	Worksheet	D1. S1. A2 School Wellbeing Emoji Grid Worksheet
D1. S2. A1	The Mental Health Dumb Charades	NA	D1. S2. A1
D1. S3. A1	Mental health Problems: Myths and Facts	Worksheet	D1. S3. A1 MHP Myths/Facts Worksheet
D1. S3. A2	The MH Lecture	NA	–
D1. S4. A1	Making a Start: From Theroy to schools	Reading	D1. S4. R1 WHO Reading on Promotion and Prevention
		Reading	D1-S4.R2 YouthGov Document on reading on Prevention and Promotion
		Handout	D1. S4. A1 Diagram of SMH Services from Section 6.8
D2. S5. A1	Create Your Worksheet Challenge…	Video	How to escape Education's Death Valley
D2. S6. A1	Of MH Death Valley, Rain and Seeds of Possibilities	Worksheet Worksheet	D2. S6. A1-I-Baseline Audit D2. S6. A1-II- Death Valley Worksheet

Day and Session	Session Title	Session Resources	
		Type	Title
D2. S7. A1	Planning for Mental Health: The Actors and the Domains	Worksheet Worksheet	D2. S7. A1-I-The Actors of Whole School Approach Worksheet D2. S7. A1-II-The Domains of Whole School Approach Worksheet
D2. S8. A1	Planning for Mental Health II: MH Think Tank, and Presentation Pitch	Handout	D2. S8. A1 The Planning Flow Chart
D2.S9	Last Session: The Road Ahead		

D1.S1.A1

Activity: The Mental Health Bingo

Time Required: 30 minutes

Objectives:

- Identifying one's reactions to daily stressors.
- Building a language around common coping methods.

Group Size: Individual

Materials Required: Bingo Sheets, Colored Pens and Reward Poster.

Steps for Facilitation:

1. Distribute the sheets, one to each participant.
2. Share the rules of the activity as follows:
    a. The participants will get 5 minutes to complete the task.
    b. When the timer starts, participants need to leave their seats and start meeting each other.
    c. The activity sheet consists of 24 reaction boxes which list 18 common reactions and behaviors that people engage in when they are stressed, the grid also consists of 6 blanks.
    d. As they meet other participants they need to ask if they use any of the reactions listed in the sheet. If yes, they must write the name of that participant in the box which lists the reaction deployed by them.
    e. Depending on the group size, the facilitators can choose how many times a name can appear in the sheet. For example, if the group is over 30, then no repetition is to be allowed. If it is less than 30 then the facilitator must reason out the maximum number of repetitions that can be allowed tand share it beforehand.
    f. Other than the listed reactions, the 6 blanks have to be filled with any other reactions that the participant encounters.

g. The name of the respondent must be written for each of the 24 reaction boxes.

h. The activity stops as soon as any participant claims to have finished the entire grid.

i. The facilitator checks the grid for names and allowed repetitions and declares the task winner, who gets a poster on positive Mental Health.

j. If the participant claiming to be winner fails to meet the rules laid down above regarding filling the grid, then whoever has the next greatest number of completed box is invited to get their sheet evaluated.

k. If no participant is able to complete the sheet in 5 minutes, then too, the participant with greatest number of completed boxes is to be declared winner after checking of sheets.

3. Conduct the activity as per time and rule protocols laid above.

4. Evaluate Completed Sheets and Announce the winner as per procedure laid above.

5. Settle the group and debrief as follows.

Points for Debriefing:

- What commonalities, if any, did we notice in the 24 reactions in the coping grid?
- Could the listed activities be categorized into groups? If so, what bases could be used for such categorization?
- What might have happened if repetition of names was allowed? What does it imply?
- Are there any strategies that you would not want your students to engage in? Why?
- Which factors may be contributing to individual variations in our coping strategies?

Key Takeaways:

- Coping strategies and skills are the reactions and behaviors one adopts to deal with difficult situations.
- One way of categorizing coping Strategies is to focus on the dominant domain vis. Physical, cognitive or socio-emotional.
- Coping strategies can also be categorized as helpful/positive or hurtful/negative
- Individuals use several coping strategies and not just one. Some are helpful and others are hurtful.
- As coping strategies are learnt over life course, healthy coping strategies can be modeled and hence the role of schools and teachers!

D1.S1.A1: Resource

Worksheet: Bingo Sheet

_____	Exercise or play sports	Spend time with a pet	Hit someone or something
Oversleep	_____	Prayto god for help	Panic and feel helpless
View the problem as an opportunity to grow and better yourself.	Indulge in self-blaming	_____	Indulge in Smoking, drinking etc.
_____	Overeat	Sing or hear songs you like	_____
Watch television or a movie	_____	Distance yourself from the source of stress.	Play an instrument, dance, act
Google to find any solutions	Use humor to laugh off the situation.	Talk to someone you trust	Take a walk, or go for a drive

D1.S1.A2

Activity: Thriving, Striving, Struggling!

Time Required: 30 minutes

Objectives:

- Preliminary identification of the strengths and weaknesses of one's school with regards to experiencing mental health for key stakeholders.

Group Size: Individual

Materials Required: 3*4 The Wellbeing Grid, Chart papers and Markers.

Steps for Facilitation:

1. Distribute the sheets, one to each participant.
2. Facilitator will explain the term wellbeing in very brief before proceeding to share the rules of the activity as follows:
    a. The participants will get 10 minutes to complete the task.
    b. The Wellbeing Grid is to capture three emotional states: happiness, sadness and a neutral state of different stakeholder groups of participant's school.
    c. The participants have to respond first as themselves, then as teachers of their school, and finally imaging themselves to be the students of their school.
    d. For each stakeholder group they must list 4 school related aspects/factors which induce each emotional state. So for example, they will list 4 school based aspects/factors (such as processes, policies, practices etc.) which make teachers happy.
    e. Repetition of factors is allowed across stakeholder groups as well as across emotional states.
    f. The task is considered completed for a participant when all rows and columns of the grid are filled.
    g. There are no winners in this task.
    h. The worksheet is to be kept with the participants for use on Day-2.

3. Once all participants have finished the activity sheet, the facilitator will debrief as follows.

4. During debriefing, the facilitator will simultaneously make a summary of the recurrent areas which induce happiness or sadness across stakeholder groups. The intent is to identify some common areas of strength and weakness of schools as organizations w.r.t mental health promotion.

Points for Debriefing:

- Why should we be discussing emotional states when discussing wellbeing in an academic space?
- Why do we need to focus on sadness or neutrality? Is focusing on happiness not enough?
- Were there any factors which occurred more than once in individual sheets?
- What does repetition of factors across stakeholders group tell us?
- What may repetition of factors across emotional states tell us?
- Is there a way to categorize these factors?
- Are there factors which reported by several factors? What are these? How do we understand the prevalence?

Key Takeaways:

- Wellbeing is a subjective assessment made by individuals about the quality of their life. It has both a cognitive and an emotional component.
- Metal Health and Wellbeing must be prioritized and promoted for all stakeholders including the school leader herself.
- In order to promote wellbeing, schools must,at the outset, be invested in developing an understanding of how various stakeholders feel in and about school.
- The network of interactions and relationships in school means the emotional states of one stakeholder may impact their emotional engagement with other stakeholders, thus creating shared positive or negative emotional states.
- Same factors may be varyingly perceived as source of happiness as well as sadness. An openness to the complexity of emotions must be exercised.

D1.S1.A2: Resource

Worksheet: School Wellbeing Emoji Grid

	Myself	My Teachers	My Students
	1. 2. 3. 4.	1. 2. 3. 4.	1. 2. 3. 4.
	5. 6. 7. 8.	5. 6. 7. 8.	5. 6. 7. 8.
	9. 10. 11. 12.	9. 10. 11. 12.	9. 10. 11. 12.

D1.S2.A1

Activity: The Mental Health Dumb Charades

Time Required: 30 minutes (10 + 20 minutes)

Objectives:

- Bringing to fore the commonly held perceptions around Mental Health
- Identifying the terms that commonly get associated with Mental Health

Group Size: Individual

Materials Required: Easel Board, Post its and Markers

Steps for Facilitation:

1. The Resource Person discusses the rules of the game of dumbcharades.
2. For round 1 the facilitator invites 3 volunteers to play act the words given by the facilitator one by one.
3. The facilitator can take a call on the time allotted to each participant within which the remaining participants must try to guess the word.
4. For round 1, the words are:
   i. Psychiatrist,
   ii. Mental Health
   iii Abnormal
5. As the volunteers playact the given word, the facilitator keenly notes any gestures made by the volunteers or any remarks made in the course of guessing the words. These words must be such as are deemed helpful in highlighting the misconceptions, myths, fears or stigma around mental health conditions to be discussed in debriefing later.
6. Once the 3 words of round 1 are guessed, the group is divided into two teams.
7. Each team is asked to come up with a list of 10 words related to mental health that they would want the other team to playact and guess.

8. 4 to 5 rounds of dumb charades are played depending on availability of time. The facilitator is to take a call in this regard. Importantly, she must continue to make notes as instructed in point 5 above.

9. Once the time is up, the facilitator writes the list of each team on easel board chart for debriefing session.

10. Debriefing exercise weaves in concrete instances noted by the facilitator and touches upon following points.

Points for Debriefing:

- What in your estimation is a lay person's understanding of mental illness and mental health?
- Based on what we saw and heard throughout the game (for example the gestures, the word lists prepared by two teams etc.), what do you infer about our understanding as a group around mental health?
- What according to you may be the sources of our dominant understanding about Mental health and illness?
- Can you think of the reasons behind, and the adverse effects of stigma, fear or apprehension around mental health challenges?
- What specific role can all of us present here play in our respective organizations in this regard?

Key Takeaways:

- The stigma around mental health challenge is an outcome of lack of Mental Health Literacy.
- This stigma is a major impediment in individuals reaching out for help.
- Systemic efforts must incorporate mental health literacy to redress the situation.

D1.S3.A1

Activity: Mental Health Problems: Myths and Facts

Time Required: 60 minutes

Objectives:

- Developing a cursory awareness of myths pertaining to Mental Health Problems (MHPs).
- To develop a sensitivity towards the need to cultivate Mental health Literacy.

Group Size: Team of 4-5 members each.

Materials Required: Myth or fact worksheet.

Steps for Facilitation:

1. The participants are divided into groups of 4-5 members.
2. Each group is provided with the Myth/Fact Worksheet and a couple of plain A4 sheets.
3. The group is instructed to complete the worksheet with 2 specific instructions, namely:
    a. Keep a track of any items for which a consensus was missing and the sheet was completed as per majority's view.
    b. For each item that was considered false, the group must construct the alternative statement which according to them is true.
4. Once the worksheet is completed along with the details sought in point 3 above, the items are discussed one by one.
5. The facilitator focuses on making the discussion interactive by inviting group responses, while also making it informative by adding relevant addition information on each item.

Points for Debriefing:

While the debriefing for this activity was weaved within the discussion round, some additional pointers must be addressed before closure, namely

- Why is the area of mental health plagued with so many myths, what according to you may be some contributing factors?
- Mental Health literacy efforts mandate that exercises like the Myth/Fact worksheet be done in schools regularly. What does it help us know about MHL
- What in your estimation are some benefits of focusing on Mental health literacy in schools?

Key Takeaways:

- Mental Health myths are rooted in several sources like, the debates within the theoretical discourse and the conflicting information available to us, the populist media portrayals around mental problems, the shame and stigma surrounding MHPs, the resultant lack of transparency in discussing it as a health issue, lack of Mental Health Literacy in our growing up years, the prioritization of the body over mind in populist fitness literature and so on.
- Mental health literacy refers to the understanding of how to obtain as well as maintain positive mental health; it also includes the understanding of mental health problems and their possible treatments.
- Mental Health Literacy is empowering in that it helps decreasing stigma related to mental health problems; and, enhancing help-seeking efficacy. Accordingly, it leads one towards a better acceptance and handling of Mental health issues at personal and social level.

D1.S3.A1: Resource

Worksheet: Myths and Facts

The Myth/Fact Sheet has 15 items focusing on 3 thematic areas, namely, the self, children, and general population having MHPs. For each item indicate by ticking the appropriate box, if the statement is true or false according to you.

S. No	Focus	Statement	True	False
1.	Self	I can never get Mental Health Problem.	☐	☐
2.		I may not be the first one to know if I ever have MHP.	☐	☐
3.		I may already have had an MHP without knowing it.	☐	☐
4.		I can't do anything for a person with a mental health problem.	☐	☐
5.		If I had MHP, I would not be able to come to office	☐	☐
6.	Children	Children are too small to experience mental health problems	☐	☐
7.		Children of happy parents will never have MHP	☐	☐
8.		Troubled making teenagers just need more discipline.	☐	☐
9.		**MH problems are a result of bad parenting**	☐	☐
10.		Students who use drugs are not spoilt, they may have MHPs	☐	☐
11.	Others	Mental illness is a personal problem not an organization's concern.	☐	☐
12.		People with Strong personality and character will not face MHPs	☐	☐
13.		People with mental health problems are violent and unpredictable.	☐	☐
14.		MHP will go way on their own with time.	☐	☐
15.		**Having MHP does not mean you are damaged for life.**	☐	☐

D1.S3.A2

Activity: The MH Lecture

Time Required: 60 minutes

Objectives:

- Presenting a Bird's eye view of the field of Mental Health.
- Introducing the concept of Mental health, briefly covering the definition, principles and debates.

Group Size: Whole Group

Materials Required: PowerPoints Presentation Worksheet to be completed as lecture proceeds.

Steps for Facilitation:

1. The session proceeds through an interactive pedagogy. The facilitator makes a presentation on key concepts while making a continued attempt at stimulating participation through questioning, inviting opinions, illustrative examples and so on.
2. At the outset, the facilitator distributes a self-made worksheet. The worksheet comprises of concepts that the facilitator seeks to present during the session in incomplete form(vis. Fill up the missing phrase, match the following, complete the flowchart and so on).
3. The participants are asked to go through the worksheet before the presentation, to create a cognitive focus and ensure attention on key concepts.
4. The power point presentation can touch upon the following conceptual areas:
    a. Normality vs. Abnormality
    b. Mental Illness vs. Mental Health
    c. Positive Mental Health
    d. Universal vs. Cultural relativism
    e. The Mental Health Continuum, and
    f. Other Newer conceptualizations like Subjective Well Being, and Resilience.
5. Doubt clarification and debriefing is taken up.

Points for Debriefing:

- Can you think of some school-related protocols/expectation which may be sources of stress for either students, staff or yourself because of the inherent cultural discontinuity between school as a formal organization and their respective background.
- We have come across different views on what constitutes mental health throughout history? Which of these ideas would you like to become cornerstone of your school's mental health policy?
- Which ones would you endeavor to avoid?

Key Takeaways:

- The norms around normality, abnormality have varied over history, yet the common denominator has been their mutually referential nature wherein abnormality was judged against what was considered normal; biologically, culturally and socially.
- Any understanding of mental health and well-being must be equally mindful of theoretical discourse as well as cultural-contextual specificities of the target population.
- To establish minimum universal understanding of mental health, it can be seen as the optimal level of individual and social functioning. Similarly, mental illness can be understood as internalized conditioning and resultant behavior which obstructs optimal social,emotional and productive capacities.
- Schools must prioritize positive conception of Mental Health, and yet be aware and mindful of instances of mental illnesses or challenges.

D1.S4.A1

Activity: Making a Start: From Theory to Schools

Time Required: 120 Minutes

Objectives:

- To develop an awareness of the primary approaches guiding MH interventions in schools i.e. Preventive and Promotive
- To develop an awareness of the various levels addressed by MH interventions i.e. Universal, selective, indicated and treatment oriented.
- To identify grade appropriate interventions that can be subsumed under preventive and /or promotive approach.

Group Size:

For phase-I: Groups of 6 members each

For phase-II: Total no of groups to be equally divided to work with 3 different grade ranges (classes 6 and 7, or classes 8 and 9, or classes 10 to 12.)

Materials Required:

Reading: D1-S4R1 WHO Document on reading on Prevention and Promotion,

Reading: D1-S4R2 YouthGov Document on reading on Prevention and Promotion,

D1-S4.A1 Diagram on 'The Continuum of School Mental Health Services' given in theoretical underpinning section 6.8, chart papers, pens.

Steps for Facilitation:

1. The session proceeds in two phases, with phase-I addressing objectives 1 and 2, and phase-II addressing objective 3.
2. For phase I, the following facilitation is to be required:
   a. The facilitator divides the cohort into groups of 6 members each.
   b. Each group is given both the readings.
   c. The groups are also given the diagram on Continuum of school mental health services.

d. Each group is asked to use the given resources to develop understanding around the following key terms : preventive, promotive, universal, selected, indicated and treatment.

e. Such understanding is to be documented on the chart paper provided and displayed.

f. The facilitator then weaves such understanding in a summing- up lecture on these key terms.

3. For Phase-II, the facilitator the earlier formed groups are asked to choose one school grade range from among classes 6 and 7, or classes 8 and 9, or classes 10 to 12.

4. The groups use the understanding developed in phase I to identify grade appropriate interventions that can be subsumed under preventive and /or promotive approach.

5. The facilitator steers the discussion and clarifies any confusions as and when it arises.

Points for Debriefing:

- What is the interlinkage between approaches (preventive-promotive) and type of intervention vis. (universal, selected, targeted and treatment)?
- Can an intervention be both preventive and promotive?
- What insight did you get about your school's focus vis a vis approach adopted?
- What insight did you get about your school's focus vis a vis type of interventions planned generally?

Key Takeaways:

- Treatment and Indicated interventions are beyond the realm of teachers and requires professional training.
- Promotive approach largely focusses on universal interventions.
- Preventive approach foresees impending issues and thus is largely focused on selective interventions.
- An intervention can be both preventive and/or promotive depending on the intent behind it.
- Different ages and grades have different concerns and issues.

Reading: WHO reading on Prevention and Promotion of Mental Health

What is prevention and promotion in mental health?

About 450 million people alive today suffer from mental disorders, according to estimates given in WHO's World Health Report 2001. One person in every four will be affected by a mental disorder at some stage of his or her life. Neuropsychiatric disorders account for 12.3% of the Disability-Adjusted LifeYears (DALYs) out of the total DALYs for all disorders. Unipolar depression, self-inflicted injuries and alcohol use disorders are among the top 20 leading causes for disease burden among all ages. Six neuropsychiatric conditions rank among the top 20 causes for disease burden in the 15-44- years age group. It is estimated that by the year 2020, depression will become the second lead- ing cause for disease burden (Murray & Lopez, 1996). Given this grim scenario, it is not hard to understand why preventing mental disorders and promoting mental health is of immense inter- est not only among researchers, but also among policy-makers.

Mental disorders affect the functioning of the individual, resulting in not only enormous emotional suffering and a diminished quality of life, but also alienation, stigma and discrimination. This bur- den extends further into the community and society as a whole, having far-reaching economic and social consequences. Mental disorders are often associated with extended treatment periods, absence due to sickness, unemployment (for long or short periods), increased labour turnover, and loss of productivity leading to overall increased costs. In addition, because mental disorders are disabling and last for many years, they can take a tremendous toll on the emotional and socio- economic well being of family members caring for the people suffering from mental disorders.

This burden is especially heavy for parents of chronically ill young persons.To reduce the burden of mental disorders, it is essential that greater attention be given to prevention and promotion in mental health at the level of policy formulation, legislation, decision-making, resource allocation and the overall health care system.

Concepts of prevention and promotion in the field of mental health

One of the initial dilemmas facing researchers and policy-makers in this field is conceptualising the definitions and boundaries within which the individual strategies can

be developed. Often prevention of mental disorders is considered one of the aims and outcomes of a broader mental health promotion strategy. Prevention and promotion, though distinct entities, have overlap- ping boundaries.

Prevention of mental disorders

"To prevent" literally means"to keep something from happening". However, there are different notions about that "something" and they have been identified as the incidence of a disorder, its relapses, the disability associated with it, or the risks for a disorder – and this has led to confusion in the field of mental health regarding the term prevention (Mrazek & Haggerty, 1994). Historically, the public health concept of disease prevention has viewed prevention as primary, secondary or tertiary depending on whether the strategy prevents the disease itself, the severity of the disease or the associated disability.This system works well for medical disorders with a known etiology. Mental disorders, on the other hand, often occurs due to the interaction of environmental and genetic factors at specific periods of life. It becomes difficult even to agree on the exact time of onset of a mental disorder, as the progression from the asymptomatic to symptomatic state may be insidious. Also, a person may suffer from the signs and symptoms of a mental illness and be dysfunctional, without fulfilling the required criteria to be diagnosed within a diagnostic system. Preventive strategies are usually directed against risk factors, hence need to be implemented at specific periods before the onset of the disorder in order to be maximally effective. However, once the disorder has developed, it is still possible to reduce its severity, course, duration, and associated disability by taking preventive measures throughout the course of the disorder.

Another way of conceptualising prevention strategies is based on a risk-benefit point of view, i.e. the risk to an individual of get- ting a disease against the cost, risk, and discomfort of the preven- tive strategy (Gordon, 1987).The following three categories of primary prevention have been identified:

Universal prevention: targeting the general public or a whole population group.

Selective prevention: targeting individuals or subgroups of the population whose risk of developing a mental disorder is significantly higher than that of the rest of the population.

Indicated prevention: targeting persons at high-risk for mental disorders.

Secondary prevention: refers to interventions undertaken to reduce the prevalence, i.e. all specific treatment-related strategies, and tertiary prevention would include interventions that reduce dis- ability and all forms of rehabilitation as well as prevention of relapses of the illness.

Promotion of mental health

WHO defines health promotion as "the process of enabling people to increase control over, and to improve their health" (WHO, 1986).

Mental health promotion often refers to positive mental health, rather than mental ill health. Positive mental health is the desired outcome of health promotion interventions. However, this is not an universally accepted concept and there is debate about mental health promotion – its definition, its place within the overall concept of health promotion, and its boundaries with pre- vention of mental disorders. Mental health has been defined from the perspective of absence of mental illness, but so that this definition will conform to the definition of health, mental health needs to be redefined from the point of view of positive mental health in different contexts and cultures.Strategies for mental health promotion are related to improving the quality of life and potential for health rather than amelioration of symptoms and deficits.These should be recog- nized, not as strategies for tertiary prevention but as mental health promotion in its most posi- tive sense (Secker, 1998).

A number of definitions or frameworks have been put forward to distinguish between mental ill health and positive mental health. Mental health promotion is any action taken to maximize men- tal health and well being among populations and individuals (Commonwealth Department of Health and Aged Care, 2000). Another definition is that the promotion of mental health is the operation by which we improve the place which mental health occupies on the scale of values of individuals, families or societies.This definition is based on the idea that when mental health is valued more, people tend to be more motivated to improve it (Sartorius, 1998). Hodgson et al. (1996) defined mental health promotion as the enhancement of the capacity of individuals, families, groups or communities to strengthen or support positive emotional, cognitive and related experiences. Other definitions have viewed mental health promotion as a reduction of morbidity from mental illness and the enhance- ment of the coping capacities of a member of a community.

Interface between prevention and promotion in the field of mental health

Prevention is concerned with avoiding disease while promotion is about improving health and well being. By identifying the positive aspects of mental health, one can highlight or target the areas to promote and the goals to be attained. It is important to target the positive aspects of mental health, together with targeting the illness. Preventive and promotional elements can be present within the same programme and hold different meanings for two groups of the targeted population.Thus, the two approaches may sometimes involve

similar activities but produce differ- ent outcomes. For example, a mental health promotion intervention that is aimed at increasing well being in a community may have the effect of decreasing the incidence of mental disorders. Mental health promotion efforts have sometimes been advocated, because they are believed to reduce vulnerability to a disorder and sometimes as an end in itself without the potential to pre- vent a disorder.

The determinants of mental health include not only factors related to actions by individuals, such as behaviours and lifestyles, coping skills, and good interpersonal relationships, but also social and environmental factors like income, social status, education, employment, housing and working conditions, access to appro- priate health services, and good physical health. Fostering of these individual, social and environmental qualities and the avoidance of the converse are the objectives of mental health promotion and prevention of mental disorders (Herrman, 2001).

There are a number of advantages for integrating promotion and prevention in the field of mental health. Preventing mental disorders not only involves targeting risk factors and early symptoms of the disease, but can also involve promoting associated activities that improve the overall qual- ity of life of people and their society. For example, child abuse, sexual abuse and substance use have been found to be associated with a number of mental disorders. Promotional and preventive activities aimed at teaching parenting in secondary schools and supporting families can reduce child abuse and neglect and prevent future mental health problems. Joint work produces and stimulates more intersectoral collaboration and such strategies may result in multiple outcomes, reduced stigma and more cost-effective impact. Integrating prevention and promotion may help mobilize collective resources to influence health policy and increase public investment.

Conceptually too, the characteristics of strategies and actions for prevention and promotion in mental health often overlap.The main characteristics of mental health promotional strategies are: drawing on health promotion theory to re-conceptualise mental health and illness; making a commitment to explore and value lay understandings of mental health; developing intersectoral alliances aiming to address social and economic inequalities; and validating the participatory methods through evaluation research and development of strategies which are themselves consistent with health promotion principles (Secker, 1998). Some of the characteristics of mental disorder prevention strategies are: interventions done primarily to help individuals to have posi- tive effects on the family and society; it often becomes difficult to demarcate primary from sec- ondary prevention since the borderline between disease and disability is not clear; preventive measures can reduce the severity of the disorder and remove disability even if impairment is not wholly avoidable (Sartorius & Henderson, 1992).

Possible reasons for keeping promotion and prevention programmes in the field of mental health conceptually separate are: as the target population for prevention is often smaller and more sharply defined, keeping the two separate facilitates giving adequate attention to both; fund-raising for smaller preventive or promotional strategies is easier than for larger strategies that combine the two; and it is also easier for policy-makers to assess the outcomes.

Prevention and promotion in the field of mental health within overall public health

Preventive and promotional strategies can be used by clinicians targeting individual patients and also public health programme planners targeting large population groups.The health, social and economic impact of public health programmes related to promotion and prevention has been documented (IUHPE, 1999; Marmot, 1999;Rootman et al., 2001). However, within the health sector, there is still an imbalance between the amount of resources devoted to curative interventions and resources devoted to public health related preventive and promotional activities. In view of the evidence supporting implementation of programmes related to prevention and promotion in health, it is essential that more funds be made available for such programmes at the public health level.

Support for a population approach to mental health emerged with the WHO document on Global Strategy for Health for All by the Year 2000 (WHO, 1981), which linked health improvements to overall social and economic development.The emphasis was expanded with the Ottawa Charter (WHO, 1986) and the Jakarta Declaration (WHO, 1997). Although health promotion and prevention of ill- ness have strong acceptance within public health, they have often failed to incorporate mental health components within their framework. This lack of emphasis on mental health is surprising, considering the evidence of strong linkages between mental and physical health. Policy-makers and practitioners need a greater understanding of the links between mental well being and physical health in order to implement programmes effectively.

The relationship of depression with cardiovascular illnesses and vice versa is well documented. Mental disorders like depression, anxiety, and substance use disorders can also complicate exist- ing physical disorders, as patients suffering from mental disorders may have poor compliance rates and may fail to adhere to their treatment schedules. Head injury can affect the personality and cause mood disorders. Moreover, patients with these mental disorders are at increased risk of psychosomatic conditions.Education, employment, social well-being, availability of food, hous- ing and other public health-related factors play an important role in preventing mental disorders and promoting mental health.These

factors are also responsible for better physical health. Again, a number of behaviours like smoking and sexual activities can be linked to development of phys- ical disorders like carcinoma and HIV, which in turn can lead to mental health problems.Thus a number of strategies for prevention and promotion in mental health deal with human behaviours and physical disorders and are discussed in the published literature and also in this document.

There are advantages of combining preventive and promotional programs in mental health with those in overall public health, and some of them have been outlined in the Institute of Medicine Report (Mrazek & Haggerty, 1994).Such combinations help in tackling physical disorders with co- morbid mental disorders more effectively. Again, effective social and public health programs and policies that tackle general health problems also act on mental health conditions, thus combining the two makes it more efficient. Issues like poverty, crime, and teenage pregnancy have implica- tions not only for physical health but also for mental health. It also reduces the stigma attached with mental health. Finally, such combinations benefit the resource-poor countries in streamlin- ing their budgets for prevention and promotional activities.

One of the concerns about combining preventive and promo- tional programmes in mental health with those in public health is that the relevance of mental health might get lost within the larger area of health. Integrating the two may lead to diversion of allotted mental health funds to other health conditions. However, the strategy of integrating mental health within the larger public health interventions generally serves well and should always be explored.The shift towards public health should be dependent on each country's economic and political situation, as well as on the availability of resources. A stepwise process towards integrat- ing physical and mental health is required. Current advocacy on the increasing burden of mental disorders and on the availability of effective interventions together with intersectoral collaborations is to include mental health as a central part of public health.The optimal strategy should combine specific interventions for various mental health problems with horizontal action crosscutting physical and mental health issues where co-morbid risk and pro- tective factors need to be tackled. Good evidence-based effective strategies suitable for a specific country and culture need to be adopted and adapted and mental health experts should be involved in advocacy, monitoring and surveillance.

D1.S4.R2: Resource

Reading: YouthGov Reading on Prevention and Promotion of Mental Health

Promotion & Prevention

The terms mental health promotion and prevention have often been confused. Promotion is defined as intervening to optimize positive mental health by addressing determinants of positive mental health before a specific mental health problem has been identified, with the ultimate goal of improving the positive mental health of the population. Mental health prevention is defined as intervening to minimize mental health problems by addressing determinants of mental health problems before a specific mental health problem has been identified in the individual, group, or population of focus with the ultimate goal of reducing the number of future mental health problems in the population.1 Mental health promotion and prevention are at the core of a public health approach to children and youth mental health which addresses the mental health of all children, focusing on the balance of optimizing positive mental health as well as preventing and treating mental health problems.

Promotion

Mental health promotion attempts to encourage and increase protective factors and healthy behaviors that can help prevent the onset of a diagnosable mental disorder and reduce risk factors that can lead to the development of a mental disorder.2 It also involves creating living conditions and environments that support mental health and allow people to adopt and maintain healthy lifestyles or a "a climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom provided by these rights, it is very difficult to maintain a high level of mental health."3

Specifically, mental health can be promoted through

- early childhood interventions (e.g., home visits for pregnant women, pre-school psychosocial activities);
- providing support for children (e.g., skills building programs, child and youth development programs);

- programs targeted at vulnerable groups, including minorities, indigenous people, migrants, and people affected by conflicts and disasters (e.g., psychosocial interventions after disasters);
- incorporating mental health promotional activities in schools (e.g., programs supporting ecological changes in schools and child-friendly schools);
- violence prevention programs; and, among others,
- community development programs.[4]

Positive youth development is defined by the Interagency Working Group on Youth Programs as an intentional, pro-social approach that

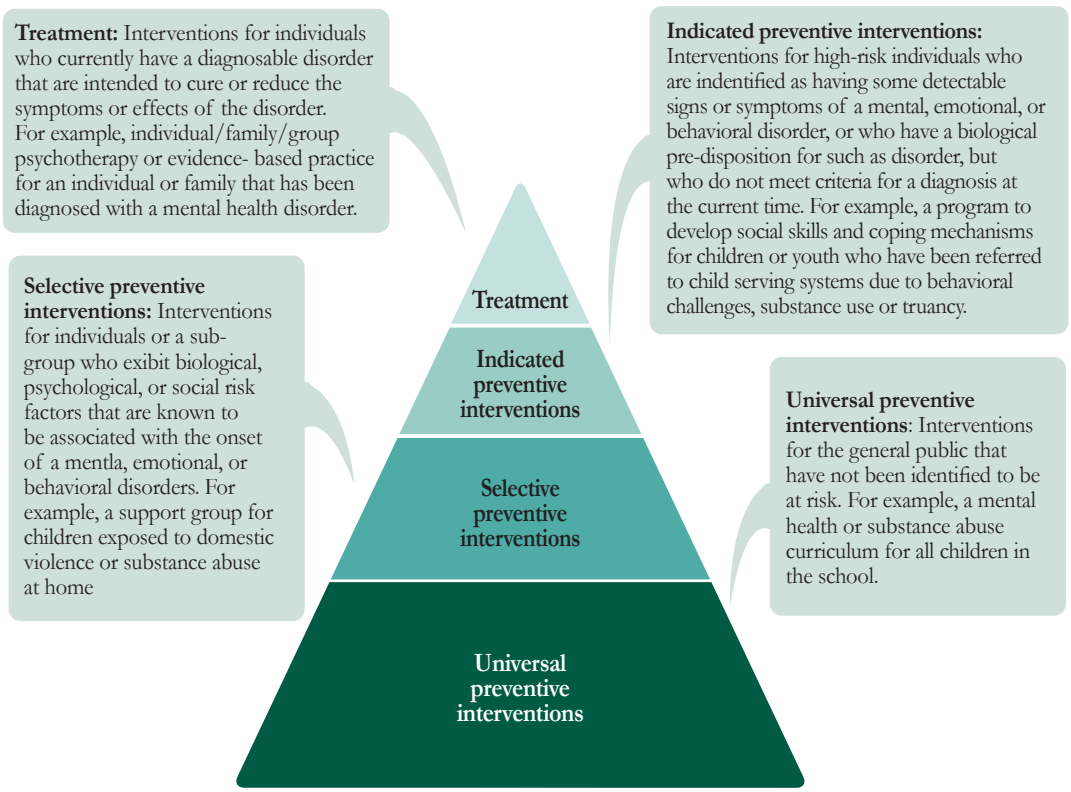
- engages youth within their communities, schools, organizations, peer groups, and families in a manner that is productive and constructive;
- recognizes, utilizes, and enhances youths' strengths; and
- promotes positive outcomes for young people by providing opportunities, fostering positive relationships, and furnishing the support needed to build on their leadership strengths.

It provides a lens for promoting the mental health of youth by focusing on protective factors in a young person's environment, and on how these factors could influence one's ability to overcome adversity. Learn more about positive youth development.

Prevention

Prevention efforts can vary based on the, audience they are addressing, level of intensity they are providing, and the development phase they target. Figure 1 depicts the different types of prevention as defined by the Institute of Medicine. As prevention efforts move from universal prevention interventions to treatment they increase in intensity and become more individualized.

Figure 1: Levels of Intervention[5]



Interventions may vary not only based on level of intensity, as seen in Figure 1, but also on the development phase of the youth. Figure 2 provides examples of preventive interventions for each of the developmental stages through young adulthood.

Figure 2: Preventive Interventions by Developmental Phase

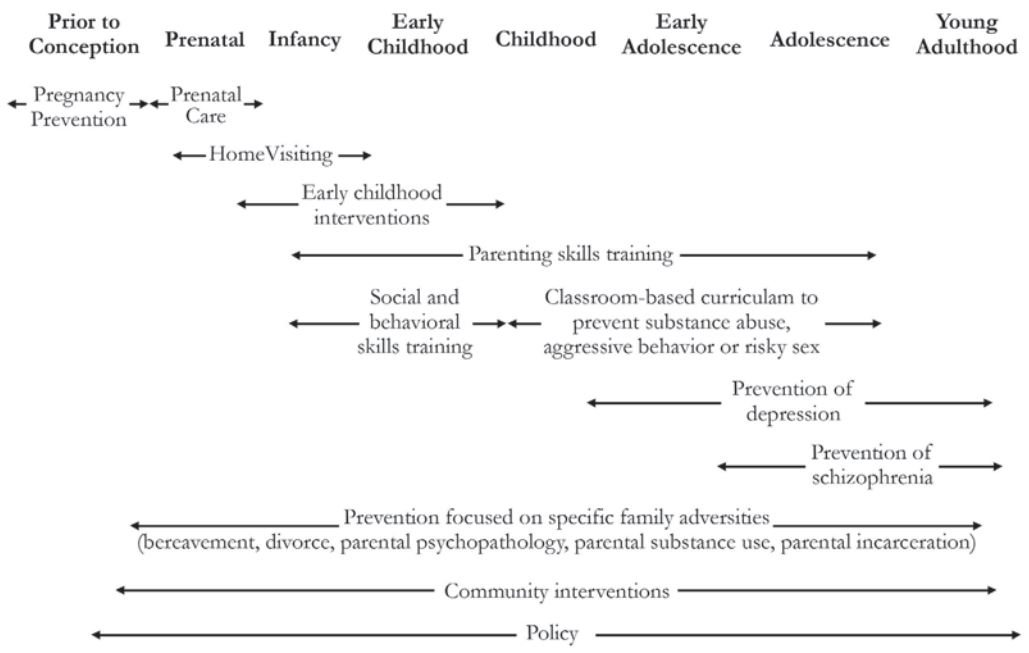


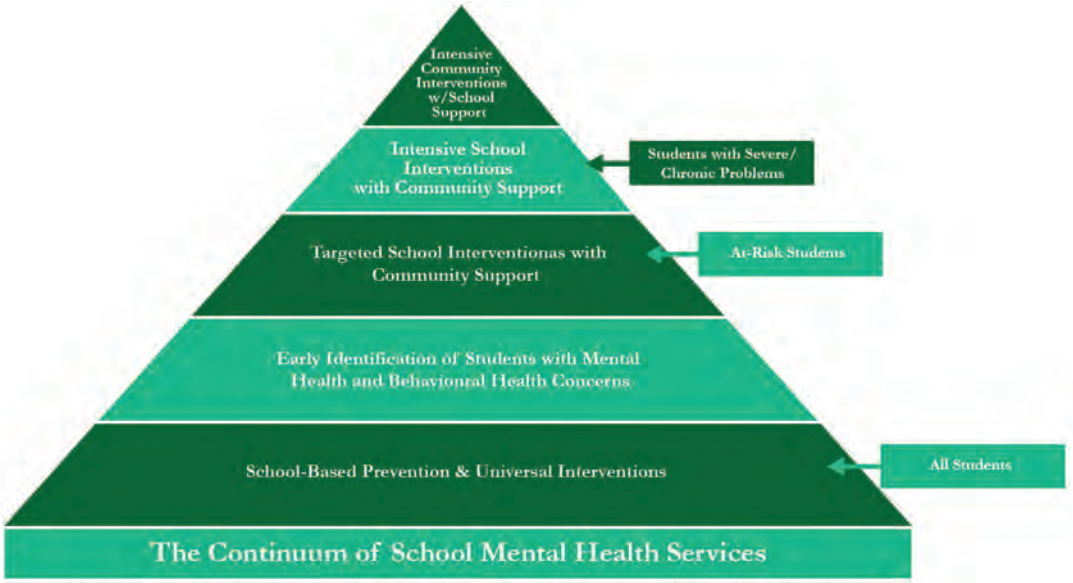
Figure II-I Intervention and thier targeted developmental stages

1. Miles, Espiritu, Horen, Sebian, & Waetzig, 2010
2. WHO, 2010
3. WHO, 2010
4. Substance Abuse and Mental Health Services Administration, National Registry of Evidence-based Programs and Practices, 2012
5. O'Connell, Boat, & Warner, 2009, p. 66
6. O'Connell, Boat, & Warner, 2009, p. 155

D1.S4.A1: Resource

Handout: The Continuum of SMH Services

The Continuum of School Mental Health Services



Adapted from "Communication Planning and Message Development: Promoting School- Based Mental Health Services" in Communique, Vol. 35, No. 1. National Association of School Psychologists, 2006

D2.S5.A1

Activity: Create Your Worksheet

Time Required: 60 Minutes

Objectives:

- Introducing the linguistic and conceptual toolkit required to plan for Mental health in schools.

Group Size: Groups of 4-6 members each.

Materials Required: PPT , Blank A4 sheets, Chart, Marker pens and later on Death Valley Worksheet S6.A1-II as pre-activity for next day.

Steps for Facilitation:

1. The session begins with the facilitator making groups of 4-6 members each as per her discretion such that the total number of groups made are even.
2. Also each group is paired with another group such that these two groups are termed as each other's 'rival group'.
3. Each group is then given blank sheets to work with.
4. The task is to listen to the presentation carefully and come up with a worksheet based on the session presentation.
5. This worksheet is to be prepared as each concept is discussed. Accordingly the facilitator can choose to give discussion time after every two concepts discussed.
6. At the end of the lecture which should take around 50 minutes, the worksheets of the rival groups are exchanged.
7. The rival groups have to fill the worksheets and return to their creators.
8. Each group then checks the worksheet created by them and filled up by their rivals and share the score with the facilitator.
9. All worksheets are displayed on bulletin /pin up boards for all to see.
10. Any confusion or misconceptualization arising from either the questions or answers of these worksheets are clarified.

11. The session ends with the facilitator sharing the link for Sir Ken Robinson's ' How to Escape the Death Valley of Education' video.Participants are asked to view it while focussing on 3 terms, namely a) problems, b) levers and c) assests. The same will be discussed in next session on the following day.

D2.S6.A1

Activity: Of MH Death Valley, Rain and Seeds of Possibilities…

Time Required: 90 Minutes

Objectives:

To facilitate an appraisal of school specific challenges to, and preparedness for Promoting and sustaining a Whole School Approach to MH.

Group Size: Initially individually and then in groups of 4-6 members sorted on stakeholder and grade level choices made by participants.

Materials Required: Death Valley Worksheet (Assets, Levers and Problems) D2-S6. A1-II, The School Wellbeing Emoji Grid from Day 1, and Baseline Audit Worksheet D2-S6.A1-I Sheets, Markers

Steps for Facilitation:

1. The facilitator begins the session by asking participants to work individually.
2. Each participant is given a Baseline Audit worksheet which they have to fill as per the situations prevalent in their school.
3. The time allocated for this exercise is 15 minutes.
4. The participants are then asked to have a look at the School Wellbeing Emoji Grid filled up by them during session 2 on day 1.
5. Reflecting on these two together all participants are asked to choose which stakeholder group will they want to work with i.e. school leaders, teachers or students.
6. Having chosen a stakeholder group they need to fill in the Death Valley worksheet individually. The time allocation for this is again 15 minutes.
7. Once done, participants are paired into groups based on which stakeholders they have chosen, so for eg. those working with students are grouped together in group size of 4-5 participants each.
8. Each group is then asked to engage in extensive discussion and create a poster on some common Problems, Levers and Assets their schools possess in dealing with MH concerns of their chosen stakeholders group.

9. These posters are displayed for all to view and learn from. 15 minutes are allocated for this.

10. Discussion and debriefing is taken up based on the entire exercise.

Points for Debriefing:

- What inter-group similarity and dissimilarities if any did you observe when looking at posters made by other groups who chose same stakeholders as you?
- Were there any common elements which resurfaced across all stakeholder groups?
- What insight did you get about your school from the entire exercise?

Key Takeaways:

- Every school has a SWOT profile which when drawn can help focus efforts towards MH and help find hope.
- Working for different stakeholder groups require navigating different set of challenges.
- Yet, some elements of schools provide an undergirding to all mental health efforts across stakeholder groups

D2.S6.A1-I: Resource

Worksheet: Baseline Audit

S. No	School Practices and Processes	We are doing it reasonably well.	Tried but there are unaddressed challenges	Not yet, but would like to
1.	All stakeholders at all levels recognize that they have a part to play.			
2.	Students are consulted and have a voice about the type of support they value.			
3.	There is coherent and integrated planning that facilitates a whole school long term approach ensuring that wellbeing runs as a golden thread through everything the school does.			

S. No	School Practices and Processes	We are doing it reasonably well.	Tried but there are unaddressed challenges	Not yet, but would like to
4.	Wellbeing initiatives are regular and frequently monitored and evaluated against agreed and known criteria.			
5.	School leaders have introduced and implemented measures to assess early intervention & student supports.			
6.	Evidence about intervention/program efficacy is drawn from a range of sources including; pupils, teachers and parents wherever possible.			

S. No	School Practices and Processes	We are doing it reasonably well.	Tried but there are unaddressed challenges	Not yet, but would like to
7.	The school recognizes that wellbeing is as important for the staff as for the pupilsand as a result appropriate professional development has been put in place to support this.			
8.	Professional development ensures staff have the relevant knowledge and understanding to (teach) provide planned opportunities to explicitly promote wellbeing and create a positive classroom culture.			
9.	The school actively seeks out relevant and recent research, facts and evidence to support the school's actions.			

D2.S6.A1-II: Resource

Worksheet: Death Valley

S. No	What I wish to achieve vis a vis Mental Health in My school	Problems	Assets	Levers
1.				
2.				
3.				
4.				
5.				
6.				

D2.S7.A1

Activity: Planning for Mental Health: The Actors and the Domains

Time Required: 90 Minutes

Objectives:

- To identify actors and domains crucial to the process of planning for MH from a whole school approach

Group Size: Groups of even number of members (4 or 6)

Materials Required: D2-S7A1-IThe Actors Worksheet , D2-S7A1-I the Domains Worksheet and Markers

Steps for Facilitation:

1. The facilitator divides participants into groups such that each group has an even number of participants.
2. Each group is given the two worksheets i.e. the actor and domain worksheet and the group members are asked to have a look at the worksheet and further split up such that an equal number of people end up working on each worksheet to begin with.
3. Each sub group works returns to the amin group after 15 minutes.
4. The worksheets are shared, discussed and exchanged within the two sub groups of each group.
5. The swapped worksheets can be further enriched by the sub-group receiving it second. 10 minutes are given for this.
6. Each group presents its discussions to the house.
7. The facilitator develops a summary of findings actor-wise and domain-wise as each presentation progresses.
8. The house members are allowed to raise questions seeking further clarification or providing constructive feedback and input.
9. Common discussion and debriefing is done.

Points for Debriefing:

- Based on the summary developed during the presentations, what common patterns can you identify?
- What points took you by most surprise and why?
- What points emerging from the actor's worksheet came across as most inspirational to you?
- What points emerging from the domain's worksheet came across as most inspirational to you?

Key Takeaways:

- A Whole School approach to MH requires involvement of a multitude of stakeholder actors.
- Each of these actors may be having MH Related concerns of their own which required addressing.
- A Whole school approach also cuts across different domains of school processes and activities.
- Enabling the actor stakeholders can help ensure an exhaustive coverage of all domains of MH.

D2.S7.A1-I: Resource

Worksheet: The Actors of Whole School Approach

S. No	Actor Group	Why do you see them as crucial to MHWB Efforts	Any Sources of Resistance to their involvement	How will you address resistance and encourage participation	Do these actors have MH challenges of their own, List Most Common Challenges
1.					
2.					

S. No	Actor Group	Why do you see them as crucial to MHWB Efforts	Any Sources of Resistance to their involvement	How will you address resistance and encourage participation	Do they have MH challenges of their own, List Most Common Challenge
3.					
4.					

D2.S7.A1-II: Resource

Worksheet: The Domains of Whole School Approach

S. No	Domain	Any one specific challenge within this domain that may be threatening MH of one/ more actors	Which actors can you involve in your efforts to address this challenge/ gap?	List specific roles that you can foresee at this point for each of these actors, start with yourself.	Any other innovative idea/ process/practice how you can use this domain to promote MH.
1.	Prescribed Curriculum (Scholastic and Co-scholastic)				
2.	Teaching-Learning				

S. No	Domain	Any one specific challenge within this domain that may be threatening MHWB of one/ more actors	Which actors can you involve in your efforts to address this challenge/gap.	List specific roles that you can forsee at this point for each of these actors, start with yourself.	Any other innovative idea/ process/practice how you can use this domain to promote MHWB.
3.					
4.					

D2.S8.A1

Activity: Planning for Mental Health II: MH Think Tank, and Presentation Pitch

Time Required: 120 Minutes

Objectives:

- To Chart the Steps to design a School Mental Health Plan (SMHP)

Group Size: Groups of 8 members each

Materials Required: The Planning Flow Chart D2-S8A1, Charts, Pens, Markers

Steps for Facilitation:

1. The facilitator divides the entire group into groups of 8 members each.
2. The Groups are given the MH Planning flow chart and are asked to come up with a complete MH Plan in accordance with this Flowchart.
3. The planning stage is timed for 30 minutes.
4. The groups are supposed to present their Mental Health Plan to a panel comprising the Facilitator who along with invited experts from school context or any members left after groups of 8 were made.
5. The Panel is entrusted with the role to asking for clarifications, providing feedbacks and inviting inputs for other groups too.
6. All plans are presented and appraised.

Points for Debriefing:

- Which concepts introduced over the last sessions did you find most useful in charting your plan?
- What part of the exercise did you find most challenging? Where in your estimation did the challenge arise from? Knowledge, attitudes, ideologies?
- Which parts led to most disagreements?Reflect on any agreements or disagreements in terms of the terminologies and concepts we have internalized over last 2 days?

Key Takeaways:

- Designing a Mental Health Plan requires intensive planning with stakeholders.
- It involves envisioning, need assessment, execution and follow up.
- Different School contexts may throw up different challenges that require prioritising.
- SMHP work best when stakeholder involvement is consistently ensured.

D2.S8.A1: Resource

Handout: MH Planning Flow Chart

The Planning Flowchart

	As a leader, Create a MH Leadership Team with a clear rationale for its composition. Also share the steps taken by you to create this team. Justify which actors will be involved, in what numbers for how long etc.
	Create a Vision Statement for MHWB, it may reflect your commitments around • understanding of what MHWB means to your organisation • time investements and sustainability • the vision around decision making and participation, and so on...
	Identify an actor group and mental health issues pertaining to them which: • require preventive action • require promotive action • How are these issues related to improving teaching learning?
	Identify the kind of information/data you need to understand the issue. Identify and plan strategies to gain such information.
	Using the data gain above, what steps are required to address the issue? If so, tabulate the assests, levers and problems for this course of action.
	Plan interventions and timelines which: • Align with your vision • Involve all relevant actors • Draw upon your strength, and address your weaknesses
	Plan evaluation and review mechanism. • who evaluates? how often? • what are the predefined criteria?

Last Session: The Road Ahead

Time: 30 Minutes

Objective:

- Intended to be an informal session aimed at tying loose ends, seeking feedback and bidding farewells.

Group Size: Entire Group

Materials Required: None

Steps for Facilitation:

The facilitator is free to steer the discussion in directions they deem fit based on their previous interactions with the group.

National Centre for School Leadership
National Institute of Educational Planning and Administration
17- B, Sri Aurobindo Marg, New Delhi-110016 (INDIA)
EPABX Nos: 26565600, 26544800
Fax : 91-011-26853041, 26865180