RE

Beyond Clinical Contexts

FRAME

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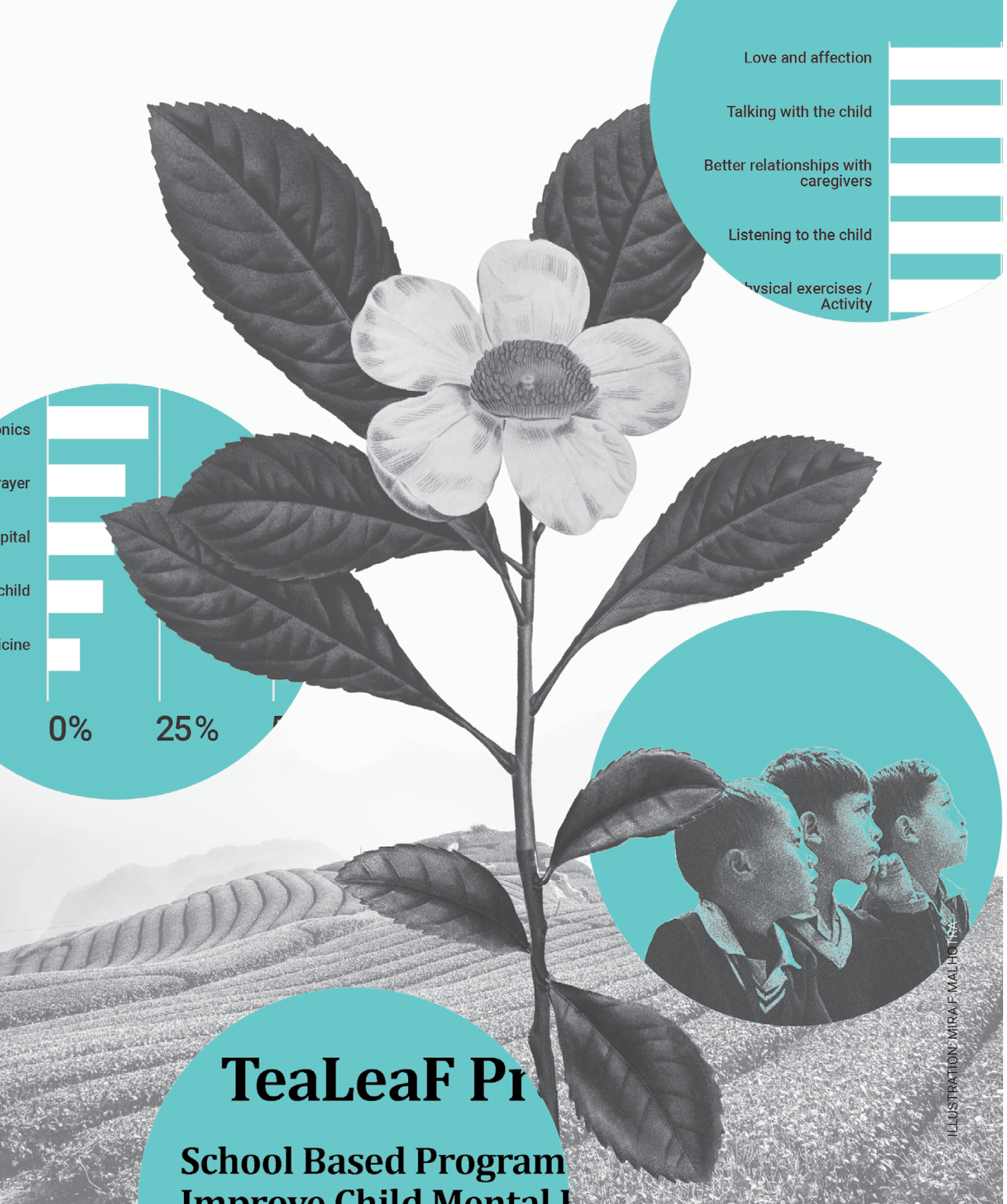


ILLUSTRATION: MIRA F MALHOTRA

CAPACITY BUILDING

Teachers as Agents of Change

Tealeaf: Mansik Swastha teachers renegotiate traditional roles and relationships as they become delivery agents of Mental Health (MH) care in a school setting

BY Emma O'Brien, Choden Dukpa, Juliana Vanderburg, The Tealeaf team

'What help can I give? We know how hard she is working...'

'The people who are helping the children are more learned than us.'

— PARENTS

Many primary school teachers already support students with MH difficulties and significant behavioural challenges. While the intervention discussed here shifts care to a community-based setting, it remains embedded within the school as an institution. Understanding how power operates within the school, and in the community, is key to our evaluation of this intervention.

the intervention

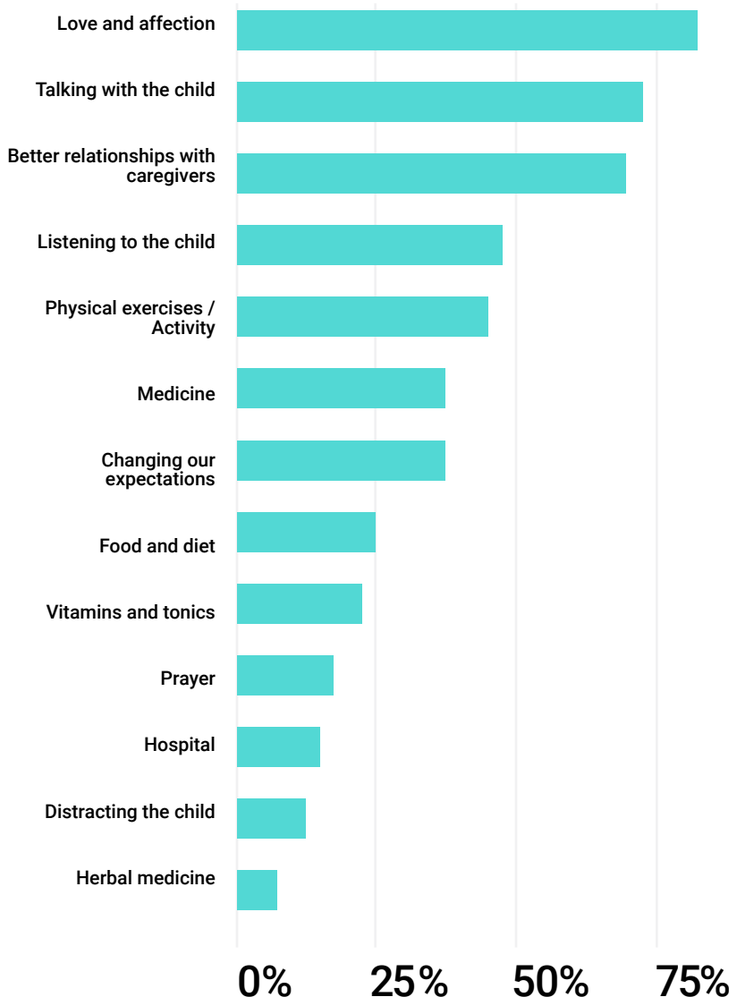
Tealeaf: Mansik Swastha (Tealeaf) reimagines MH care for primary school children by integrating it into teacher workflow. Appropriate MH care for younger children can help to build their social and emotional life skills, support future mental well-being, and may reduce the extent of future disability. Evidence-based therapy lies at the core of this intervention, guided by the WHO Mental Health Gap Action Program.[1] By incorporating targeted MH care for students throughout the day, the care becomes ongoing, situated and community-based, rather than being provided only in expert-led, clinical settings.

A randomized controlled trial to evaluate the efficacy of this intervention is under way, along with an embedded ethnographic study of process.

context

Darjeeling is a geographically and ethnically distinct part of West Bengal – its only hilly region. Most, but not all, aspects of state administration fall under the separate authority of the Gorkhaland Territorial Administration. Regional marginalization, the complex governance structure, and the absence of Panchayati Raj institutions bring challenges in the implementation of development schemes here.

Tealeaf is being implemented in 20 rural low-cost private schools, expanding to 60 schools by 2022. We have chosen to work in private schools, given their increasing role in the education sector. These schools fulfill education needs and aspirations in rural areas where government schools are distant, or not functioning well. Official data on Darjeeling is sparse, but our



experience suggests that private school enrolment is at the high end of the nationally estimated range of 30% to 50%.[2,3] Additionally, private schools are excluded from existing school health interventions, with teachers having little access to ongoing training and support. Thus, their students are at risk of being left behind.

teacher knowledge and attitudes about mental health

The majority of teachers who attended our one-week training in 2020 believed that both school and community had a role to play in managing MH challenges. They were clear that such care should not be confined to far-off "experts", and that families should not have to manage without support. The teachers' top four ranked responses about what helps children with MH health care needs were all relation- and interaction-based, rather than deriving from a medical understanding, as in the graph seen to the left.

Only a small minority of training participants (7%) felt that the role of certified professionals was crucial. The larger recognition of the importance of community support, on the other hand, has been extremely encouraging.

"In becoming delivery agents of MH care, teachers must renegotiate existing dynamics while gaining a better understanding of their multiple, intersecting positionalities and roles.

Training participants saw their teaching role as one of community service or social work. These teachers are poorly paid, most earning Rs 1,500 to Rs 3,000 monthly.

school as a site of mental health care

While the Tealeaf intervention shifts care delivery to a community-based setting, it remains embedded within institutions that have their own power dynamics: between teachers and children; teachers and parents; teachers and school principals. Care plans depend on teachers and parents co-operating to achieve the best outcome possible for children in the program. Yet the traditional perception of teacher as "expert" does not necessarily align with a collaborative approach to MH care. Teachers, too, may have their own biases and assumptions, which need to be challenged if they are to effectively support children and deliver this type of care.

power structures and class dynamics

Despite their willingness to support children and families, and their view of themselves as "social workers", teachers inevitably have a culturally situated position of authority.[4] When sharing their experiences, they described a clear social distance between themselves and their students' families. Even the language that teachers use is typical of the ways in which the Darjeeling middle class distinguishes itself from the less educated, or those seen as less sophisticated.[5]

Teachers often had the impression that parents did not care or were not interested in their child's education. 'Parents feel that sending their child to the school is their only responsibility, and after that the teacher is supposed to take care of everything.'

What teachers perceived as a lack of care, or disinterest, was in many instances an expression of trust in the teacher's abilities. Parents who were not highly educated felt themselves ill-equipped, and were handing all responsibility for their child's development over to the school. By encouraging relationships based on shared goals of supporting and caring for the child, such gaps between teachers and parents may be minimized.

While parents might view teachers as the ultimate authorities regarding their child's education, teachers are often disempowered within the school environment, subject to the strict control of school owners and principals. Some teachers were actively discouraged from communicating with parents. In becoming delivery agents of MH care, teachers must renegotiate existing dynamics while gaining a better understanding of their multiple, intersecting positionalities and roles.

unlocking change: improved relationships

Changing language used, establishing new relationships and challenging bias cannot all be accomplished in a one-week training. Ongoing mentorship and support is, then, a core component of Tealeaf. Workshops with principals and parents also help to bridge gaps. By modelling supportive behaviour and good communication skills, and providing suggestions for parent interactions, Tealeaf initiates a larger shift in relationships in the wider community.

Following the intervention, a teacher explained how her perspective about a child's challenging behaviour changed:

'. . . we realized that we need to

observe and find out the root cause for the (child's) behavior. . . we got to know that the child couldn't do the homework or study at home because there was no electricity at home. This way we became aware.'

With improved communication, parents feel more empowered to engage with the school, and teachers to empathize with the complex challenges faced by the children and their families – thus being better placed to understand the links between child behaviour and mental health.

conclusion

Task-shifting MH care to classroom teachers is a potentially powerful approach to embedding such care in the school and community, and closing the care gap by providing children with the much-needed MH support they may not otherwise receive. While teachers are trained to identify, and provide targeted support to, children showing signs or at risk of mental distress, it is evident that these skills are already being used more widely – increased community engagement and relationship-building have already extended far beyond those children receiving targeted support. Over the next three years, our documentation and analysis of this intervention will further explore how differences in power, including those related to class, status, age and gender, impact its effectiveness. ¤

Emma O'Brien is a Research Communications Coordinator at DLR Prerna. She did her Masters in Social Policy Research from University College Cork, 2015, after graduating with Law and French. Her varied experience includes program and policy work in maternal health, abortion rights, environmental protection, migration, and children and young people.

Choden Dukpa is a Research Associate at DLR Prerna. She has a Masters from Tata Institute of Social Sciences, Mumbai. A former Young Professional at BRLPS, JEEViKA (Govt. of Bihar), she worked on women empowerment through rural entrepreneurship development. In her current role she leads qualitative and quantitative research activities in child mental health.

Juliana Vanderburg is a third-year doctoral student in the School Psychology program at the University of North Carolina at Chapel Hill. She has a BSc in Psychology and Spanish and MSc in Psychology from Tulane University, and currently serves as a research assistant for several projects focused on evaluating school-based interventions designed to promote student mental health.

The Tealeaf team is a group of doctors, non-profit professionals, public health professionals, researchers, social workers and teachers. We come from NGOs, universities, health systems, and school systems. The intervention and research are co-funded by Mariwala Health Initiative and the University of North Carolina.

SERVICE DELIVERY

A Home Away from Home

Creating a space of care to provide mental health support for children, adolescents and their families in Sri Lanka.

BY Giselle Dass, Rini Sinha

'No, I'm not going in there!' screamed a young child diagnosed with Asperger's, who was scheduled for an appointment at a MH clinic where psychologist Giselle Dass was practicing at the time. The outburst was triggered by the board outside the clinic that read 'Psychological Services'. This incident helped Giselle realize how simple details such as the text on a signboard hold the potential to make service users feel comfortable – or uncomfortable– in a space.

'Was that a relative who just spotted me?' 'What will people say?' The odour of disinfectants clogs the nostrils, there's the stark white of claustrophobic corridors, paperwork, questions, and more questions… doubts might well crowd the mind of anyone who visits a hospital in Sri Lanka to seek MH support.

When the team at Child, Adolescent and Family Services (CAFS), led by psychologists Giselle Dass and Suhaila Shafeek-Irshard, began to track the landscape of care in Sri Lanka, it realized that for children, adolescents, and their families, MH care was available only at overstretched and under-resourced hospitals or private clinics. The services were primarily psychiatric, focused on prescribing psychotropic medication. While fear, shame, cost, and the pervasive stigma associated with MH issues were barriers for many people, the biomedical emphasis suggested that the social dimension of mental distress was being ignored.

Such an approach may prove particularly problematic when it comes to children and adolescents. 10-20% of adolescents experience MH challenges, and half of all mental disorders begin before the age of 14.[1] However, the clinical health system's responses to adolescent needs in low-resource settings are often ineffective in dealing with these challenges holistically.[2] Getting adolescents to open up about their issues and seek help requires the use of creative methods, and an interdisciplinary approach that includes ways of supporting the families.

building a home

The CAFS team realized that children and adolescents needing psychosocial support did not respond well to typical clinical spaces in overburdened hospitals. What could a doctor do about the complex stressors embedded in their family life, their experience of schooling, or their uncertain futures? A shift was indicated – from the clinic to a space that felt more inclusive and secure – which led CAFS to develop a space based on the concept of "home".

The CAFS-run "home" is a child- and youth-friendly community hub

ReFrame, a journal by the Mariwala Health Initiative is a platform to challenge existing norms and explore diverse voices within the mental health space — expanding horizons for who gets to participate in such conversations in an effort to firmly ground mental health in a contextual, intersectional, right-based, intersectoral framework. It is envisioned as a tool for mental health practitioners, advocates, activists, scholars, students, experts, funders, government officials and non-profit organizations — and those from closely allied sectors.

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