CHAPTER - V

CONCLUSION

The study was conducted with the objective of investigating the rate of prevalence of Mental Health problems of adolescent school going children aged 12-16 years of the state of West Bengal among a sample drawn from the school located in and around Kolkata. The study sample comprises of both male and female students; studying in English and Bengali medium schools located in rural and urban areas; belonging to nuclear and joint families; and single child of the parents and children having sibling(s). The study also wanted to find out the rate of prevalence of different dimensions of Mental Health problems, viz – emotional problem, conduct problem, hyperactive problem, peer problem and pro-social problem and further tried to find out the predictor of overall Mental Health problem. The present chapter discusses the major findings of the study, comparison of findings with other studies, its significance and implication for further research.

5.1 Findings of the Study

The study was conducted on a total number of 1361 students. The following are the major findings of the study:

**Prevalence of overall Mental Health Problem:** Out of the total students, 9.3% students had Very High or abnormal SDQ score, which means the prevalence rate of overall Mental Health problem of adolescent school going children was found to be 9.3%. These children have definite and severe Mental Health problem and require immediate interventions. Another 7.3% children under study were rated High and they were on the borderline. They may suffer from Mental Health problem in future, if not taken care of.

**Age wise Mental Health Problem:** The children under study were of the age of 12-16 years. The rate of prevalence of Mental Health problem was found more in 15 year old children, which was 12.1% within the age group, followed by 14 year olds (10.6%), 13 year olds (8.5%), 12 year olds (5.7%), and the least was of 16 year olds (4.8%).
**Relationship of Mental Health Problem with Gender of the Children:** It has been revealed from the study that the rate of prevalence of Mental Health problem was more in male students (10.7%) than that of female students (7.6%) and the difference was significant (p<.01).

**Relationship of Mental Health Problem with Medium of Instruction of the Children:** A significant difference in overall Mental Health problem was found between adolescent children attending English medium and Bengali medium schools (p<.01), with 12.2% English medium children scoring Very High SDQ score, which was more than Bengali medium students (6.7%).

**Relationship of Mental Health Problem with Location of School of the Children:** Mental Health problem was found more in children attending schools located in urban area (9.9%) than the children attending schools located in rural areas (7.8%) and the difference was found to be statistically significant (p<.05).

**Relationship of Mental Health Problem with Family Type the Children belonged to:** 11.5% children belonging to joint family were found to have Mental Health problem which was more than the children belonging to nuclear family (8.3%), but the difference was found statistically insignificant.

**Relationship of Mental Health Problem with Number of Sibling(s) the Children Have:** The prevalence of Mental Health problem was found more in single child of the parents (11.5%) than that of children having one or more siblings (7.8%), and the difference was found to be significant (p<.05).

**Prevalence of Dimension wise Problems:** Peer Problem was found to be the most prevalent problem among adolescent school going children (18%). This was followed by Emotional Problem among 11.1% children. Rests were Hyperactive Problem (4.9%), Conduct Problem (4.6%) and Pro-social Problem (3.1%).

**Variable wise Prevalence of Emotional Problem:** Prevalence of Emotional Problem was found more in female students (12.1%) than male students (10.3%); more in English medium students (14.9%) than Bengali medium students (7.5%); more in students studying in schools located in urban areas (12.0%) than students of rural schools (8.6%); more in children belonging to joint family (11.5%) than children belonging to nuclear
family (10.9%); and single child of the parents (11.8%) than children having sibling(s) (10.6%). Significant difference in the rate of prevalence was observed only in medium of instruction (p<.01) wise distribution of emotional problem.

**Variable wise Prevalence of Conduct Problem:** Prevalence of Conduct Problem was found more in male students (5.2%) than female students (3.9%); more in English medium students (5.8%) than Bengali medium students (3.5%); more in students studying in schools located in urban areas (5.3%) than students of rural schools (3.0%); more in children belonging to nuclear family (4.7%) than children belonging to joint family (4.4%); and single child of the parents (5.6%) than children having sibling(s) (3.9%). Significant difference in the rate of prevalence of conduct problem was observed in gender (p<.05), medium of instruction (p<.01), and locality of the school (p<.05) wise distribution of conduct problem.

**Variable wise Prevalence of Hyperactive Problem:** Prevalence of Hyperactive Problem was found more in male students (5.4%) than female students (4.4%); more in English medium students (8.2%) than Bengali medium students (1.8%); more in students studying in schools located in urban areas (5.3%) than students of rural schools (4.0%); more in children belonging to joint family (6.6%) than children belonging to nuclear family (4.1%); and single child of the parents (6.1%) than children having sibling(s) (4.1%). Significant difference in the rate of prevalence of hyperactive problem was observed in gender (p<.05), and medium of instruction (p<.01) wise distribution of hyperactive problem.

**Variable wise Prevalence of Peer Problem:** Prevalence of Peer Problem was found more in male students (20.6%) than female students (14.6%); more in Bengali medium students (18.2%) than English medium students (17.8%); more in students studying in schools located in urban areas (19.5%) than students of rural schools (14.0%); more in children belonging to joint family (18.8%) than children belonging to nuclear family (17.6%); and single child of the parents (20.0%) than children having sibling(s) (16.5%). Significant difference in the rate of prevalence of peer problem was observed only in gender (p<.05) wise distribution of the problem.
Variable wise Prevalence of Pro-social Problem: Prevalence of Pro-social Problem was found more in male students (3.9%) than female students (2.0%); more in Bengali medium students (3.3%) than English medium students (2.9%); more in students studying in schools located in urban areas (3.1%) than students of rural schools (3.0%); more in children belonging to joint family (4.6%) than children belonging to nuclear family (2.3%); and single child of the parents (4.0%) than children having sibling(s) (2.4%). Significant difference in the rate of prevalence of peer problem was observed in gender (p<.01) wise distribution of the problem.

Predictors of Mental Health Problem: The Multiple Regression showed a high positive correlation between overall Mental Health Problem with predictors EP, HP & CP ($R^2 = .886$) with EP as the highest predictor. Principal Component Analysis indicated that EP is the principal component of total variance in TD (Total Difficulty) or overall Mental Health Problem and it alone accounts for almost 45.885% of the total variance.

5.2 Discussion

The major findings emerged through the present study would be important contributions for improvement of our understanding about Mental Health problem of the adolescent school going children and its various dimensions. The study investigated overall degrees of Mental Health problems with respect to different demographic variables viz. – gender, medium of instruction, location of the school, family type the child belongs to and number of sibling(s). The study also estimated the prevalence rate of different dimensions of Mental Health problem, which are very common in adolescent children, i.e. emotional problem, conduct problem, hyperactive problem, peer problem and pro-social problem, with respect to same demographic variables. In addition to the association between demographic variables and Mental Health problem and the dimensions discussed, the study further used emotional problem, conduct problem, hyperactive problem and peer problem as predictor variables to estimate their relative influences on overall Mental Health problem.
The present study estimated that out of the total students under study, 9.3% had overall Mental Health problem and another 7.3% were on the borderline on the basis of SDQ scores. The rate of prevalence found in this study is similar to the studies conducted by ICMR (2005) in Chandigarh among 963 school going children which was estimated as 9.34%; and 9.4% found in Kerala by Hacket et al. (1999) in 8-12 year olds. In the study of Malhotra et al. (2002) among 4-11 year olds in Chandigarh it was 6.33%, which was less than the present study. It is also similar to the study in the U.K. as reported by the Education Department, UK Government’s (2015) departmental advice to school teacher quoting the national statistics of Green et al. (2004) as 9.8%.

This study was conducted among the students studying in schools in and around Kolkata, but the prevalence rate of Mental Health problem found in a survey conducted by MON Foundation among school going children in Kolkata was 23.8% (Chatterjee et al. 2007), which is much higher than the present study, even when abnormal score and borderline score together comes to 16.6% in this study. This might be due to the reason that the studies were conducted at a gap of fourteen years, in different set up and using different tools. Banerjee et al. (2015) in her study in Kolkata found the prevalence rate among 11-17 year school going children to be 17.5% which is also much higher than the present study.

The study conducted using SDQ in Bangalore showed the prevalence rate of Mental Health problem as 10.36% (Reddy et al. 2011) which is a little higher than the present study and the study conducted in Chennai by Srinivasan et al. (2014) using SDQ found the rate to be 17.0%, which is much higher than this study. Srinath et al. (2005) using a different tool found the rate of prevalence of Mental Health problem as 12.0% and in a study in Chennai it was 14.0% (Arumugam et al. 2013). This study shows a lower prevalence rate of Mental Health problem than the studies conducted by Ahmad et al. (2006-07) in Aligarh (17.9%), Gupta et al. (2001) in Ludhiana (14.6%), Pathak et al. (2011) in Chandigarh (30.0%), Anita et al. (2003) in Rohtak (16.5%), Bansal et al. (2011) in Bhatinda (20.2%), Sarda et al. (2013) in Hapur, Western U. P., Kaur et al. (2015) in Faridkot (16.8%), Sharma et al. (2014) in Dehradun (40.5%), Muzammil et al. (2009) in
Dehradun (31.2%), Prakash et al. (2008) in Delhi (42%) and Malhotra et al. (2014) in her meta-analysis (23.33%).

The selected literatures reviewed in the present study suggest that the prevalence rate of Mental Health problems of Indian adolescents as per the present study is lower than other countries. It is less than the studies using SDQ in Karachi, Pakistan (35.8%) by Syed et al. (2009) and 48.5% by Hussein et al. (2010); but more than the studies in America (7%) by Pastor et al. (2012), in Germany (6.6%) by Ravens-Sieberer et al. (2008) and in Ireland (8.7%) by Greally et al. (2010). The rate of prevalence of Mental Health problems of this study is less than the studies conducted in Bangladesh (15%) by Mullick et al. (2005) and 13.4% by Rabbani et al. (1999), in Nigeria (26.5%) by Akpan et al. (2010), in China (13.5%) by Yan et al. (2006) and 12.2% by Huang et al. (2009) and in Brazil (12.7%) by Belfer et al. (2005). This is also less than the findings included in the selected studies of different countries included by Patel et al (2007) which were Australia (4 -17 years) 14%, Brazil (7 -14 years) 13%, India (1 -16 years) 13%, South Africa (6- 16 years) 15%, UK (13-15 years) 12%, and USA (9-17 years) 21%. Bhola et al. (2003) compared the child and adolescent psychiatric morbidity of Indian studies with that of other countries and pointed out that most Indian studies report lower psychiatric morbidity than large-scale studies from other countries. In contrary to this Reddy et al. (2011) indicated that Indian adolescents were at more risk of developing Mental Health difficulties that those in developed countries contrary to the popular belief pointing out the normative data published in Britain where 5.2 % of British males and 5.1% of British females aged 11-15 years received abnormal SDQ score.

The study was conducted among the adolescents aged 12 to 16 years. The present study revealed that the prevalence rate of overall Mental Health problem is maximum among the children belonging to 15 years of age (12.1%), followed by 14 years olds (10.6%). 16 years olds showed the minimum rate of prevalence (4.8%). This suggests that Mental Health problem is maximum at the age group of 14-15 years, which goes along with the findings of Ahmad et al. (2007) and Pathak et al. (2011), but Bansal et al. (2011) found it to be at the age group of 13-14 and Kaur et al. found among 13-16 years olds.
The finding of the present study and the literature reviewed, showed a wide range of variation in the prevalence rates of Mental Health problem of adolescent school going children. In a school based review study conducted by Bhola et al. (2003) found the variation ranging from 3.23% to 36.50% and Malhotra et al. (2014) in a meta-analysis found the range as 0.48% to 29.40%. Robert et al. in a meta-analysis of 52 studies done in 20 countries of the world found that prevalence of psychopathology among adolescents (12 to 18 years) varies from 6 to 41%. NCMH (2005) also recorded a wide range of variation in prevalence rate of Mental Health problem of adolescents in its background papers including 55 epidemiological studies. ICMR (2005) observed that the area of adolescent psychiatric epidemiology has been little investigated in India. Only a few studies carried out so far, have reported wide variation in prevalence rates due to small non representative sample and unstandardized assessments. This wide range of variation may be due to difference in criteria in defining the problems, the types and sensitivities of the tools used, variation in the types of the informants and the diversity in the plethora of demographic variables and absence of a gold standard (Malhotra et al. 2014; Saleem et al. 2011). Studies were conducted anywhere in the world using various types of tools, and there is absence of a single standardized acceptable tool for assessment of Mental Health problems in India. Different tool defines the problems using different criteria because of the reason that the perception toward level of dysfunction of a particular behavior to become significant and the level of tolerance to it differs from culture to culture.

This study revealed a statistically significant difference (p<.01) in prevalence rate of Mental Health problem between male and female students with male students having more than the female students. This result goes with the studies conducted by ICMR (2005), Kaur et al. (2015) and Hussein et al. (2010) with significant difference in the rates of prevalence. The present study also keeps with the findings of Anita et al. (2003), Muzammil et al. (2009), Sharma et al. (2014), Rabbani et al. (1999), Pastor et al. (2012), Bansal et al. (2011) & Prakash et al. (2008); but Bansal and Praksh found the difference insignificant. As opposed to these findings the prevalence rate of Mental Health problem was found more in females than in males in the studies of Reddy et al. (2011) and Pathak et al. (2011).
According to the present study, the prevalence rate of overall Mental Health problem was found more in the adolescents studying in English medium schools than that of children studying in Bengali medium schools and the difference was found statistically significant. It is presumed that the students study through regional medium or through mother tongue fare better in Mental Health than students studying through English as medium of instruction. In a doctoral study in Gujarat, Mallik (2014) found students of Gujarati medium fared better than the students of English medium on overall adjustment or total of Mental Health. It is quite likely that when students study through their own mother tongue, they are comfortable to understand and express the concept and thereby less stressed than the students studying through English medium.

So far, the location of schools the children were attending was concerned, this study revealed a statistically significant difference in the rate of prevalence of Mental Health problem with children of urban schools showing more than the children of rural schools, keeping with the findings of Sharma (2014). Ahmad et al. (2006), Srinath et al. (2005), Sarda et al. (2013) and Kaur et al. (2015) found insignificant difference in prevalence between urban and rural children. Studies of Anita et al. (2003) and Yan et al. (2006) also showed the prevalence rate of Mental Health problem more in urban students than in rural students.

In the present study, no statistically significant difference was found in the prevalence of Mental Health problem between students belonging to nuclear family and joint family which is similar to the findings of Anita et al. (2003) and Bansal et al. (2011), whereas, Kaur et al. (2015) found a significant difference in the prevalence rate. Kaur et al. and Anita et al. found the prevalence rate of Mental Health problem to be more in the children belonging to nuclear families than joint families, which may be a popular belief. In contrary, surprisingly, this study found overall Mental Health problem to be prevalent more in the adolescents belonging to joint families than that of adolescents belonging to nuclear families. This could be due to the complexity of the joint families the children belonged to.

This study estimated a significantly higher prevalence rate of Mental Health problem in single child of the parent than the children with sibling(s), which is similar to the finding
of Liu et al. (2003), whereas Wang et al. (1989), in his study found the difference insignificant. According to the report of Mishra (2011) in the Times of India, the study conducted in Kanpur city among school children, single child showed higher prevalence rate of Mental Health problem.

The present study showed Peer Problem to be the most prevalent Mental Health problem among adolescent school going children followed by emotional problem, hyperactive problem and conduct problem with pro-social problem being the least prevalent. But studies conducted by researchers like Srinivasan et al. (2014), Reddy et al. (2011), Anita et al. (2003) and UK Govt.’s record (2015) revealed conduct problem to be the highest prevalent problem. Pathak et al. (2011) found internalizing problem or emotional problem to be the most prevalent problem among adolescents.

According to the present study Emotional Problem showed a higher prevalence rate in female adolescent students than their male peers, but the difference was not statistically significant, and Conduct Problem was found more in male students than the female students with a significant difference. This finding is in consonance with the previous studies conducted by Anita et al. (2003), Prakash et al. (2008), Greally et al. (2010), and Reddy et al. (2011). Reviewing Indian epidemiological studies on child and adolescent psychiatry, Bhola et al. (2003) commented that one of the few substantive conclusions from Indian work is the higher prevalence of externalizing disorders in boys and internalizing disorders in girls.

Except for emotional problem, this study showed that male adolescent school going children are more vulnerable in conduct problem, hyperactive problem, peer problem and pro-social problem than their female peers with significant difference in the prevalence rates. Emotional problem, conduct problem and hyperactive problem were found significantly higher in the adolescents studying in English medium schools, but peer problem and pro-social problem were found a little more in adolescents studying in Bengali medium schools. The present study revealed that all the five dimensions of Mental Health problem under study, that is, emotional problem, conduct problem, hyperactive problem, peer problem and pro-social problem were prevalent more among the adolescents studying in schools located in urban areas than that of rural areas with
significant difference in locality. Similarly, when number of children of the parents was taken into account in the study, it was found that all the stated five dimensions of the Mental Health problem were more prevalent among the single children of the parents than the children having sibling(s). The study revealed that emotional problem, hyperactive problem, peer problem and pro-social problem were prevalent more among adolescents belonging to joint families, but conduct problem was found to be more prevalent among the children belonging to nuclear families.

In this study, four components (dimensions) i.e. emotional problem, conduct problem, hyperactive problem and peer problem were considered as predictors that had influence on Mental Health. The multiple regression considered only emotional problem, hyperactive problem and conduct problem to have high correlation with Mental Health problem. Emotional problem showed the highest influence (45.885%) on Mental Health problem followed by hyperactive problem (21.815%), conduct problem (17.886%), and peer problem (14.434%) being the least. Emotional problem was found to be the principal component influencing the overall Mental Health.

A strong relation exists between poor Mental Health and many other health and development concerns for young people, notably with educational achievements, substance use and abuse, violence, and reproductive and sexual health (Patel et al. 2007). Poor Mental Health is both a cause and a consequence of poverty, compromised education, gender inequality, ill-health, violence and other global challenges. Positive Mental Health is linked to a range of development outcomes, including enhanced productivity and earnings, better employment, higher educational achievement, improved human rights protection and promotion, better health status and improved quality of life. Mental Health represents a critical indicator of human development, serves as a key determinant of well-being, quality of life, and hope, has an impact on a range of development outcomes, and is a basis for social stability (WHO 2010). As such Mental Health is important not only for individual development, but also for the progress and development of the society and the nation as a whole. WHO Mental Health declaration for Europe (2009) says that Mental Health and mental well-being are fundamental to the quality of life and productivity of individuals, families, communities and nations, enables
people to experience life as meaningful and to be creative and active citizens (Friedli 2009).

The rapid global, social, economic and technological changes taking place in the adult world today are exposing children to unprecedented pressures and challenges at a young vulnerable age (Cefai et al. 2014). This globalization and technological advancement has brought about a change in the social system at an unprecedented pace and as a consequence of this change, there is fast change in the attitude, value system, culture and expectation in the individual as well as in the society. This has an overall impact in the growing generation, that is, children and adolescents, with increasing amount of pressure and stress to keep a pace with the expectation and change.

There is growing recognition within the international community that mental health is one of the most neglected yet essential development issues in achieving the Millennium Development Goals (MDGs) (WHO 2010). Despite the fact that children and adolescent Mental Health problems are associated with poorer educational and employment outcomes in later life, leading to long term social and economic consequences, most developing countries have a near complete absence of any child and adolescent Mental Health services (WHO 2009). Although substantial investment has been made in Mental Health promotion and interventions for young people in many developed countries, no equivalent acknowledgement of Mental Health needs of young people exists in developing countries. The priorities for young people seem to be different in rich and poor countries (Patel et al. 2007).

In India, Mental health issue is important, but it is a neglected area, particularly of children and adolescents. The Mental Health Atlas of India (WHO 2011) pointed out a disproportionate budget provision and facilities available for Mental Health in the country. Out of 4.16% GDP on health budget, only 0.06% is allocated for the expenditure on Mental Health budget. After the independence of India many programmes have been undertaken to address the issues of health, education, and development of the children. But it has failed to implement programme which is progressive, promotional,
performance based, preventive and protective to the child Mental Health. Examining the government policies and national programme for promoting child Mental Health, it becomes evident that there is a wide gap between the children’s needs and existing resources (Shastri 2009). The Mental Health needs of children and adolescents are often discussed, but, at present, the development of policy to support these needs is woefully inadequate. Child and adolescent Mental Health services have proven to be particularly vulnerable to systems change and an easy target for budget reduction (Sharan et al. 2007). The European Commission 2005 Green Paper (Friedly 2009) emphasized that Mental Health and wellbeing are fundamental to quality of life, and the social and economic prosperity of Europe will depend on improving Mental Health and wellbeing. India’s 11th Five Year Plan (2007-2012) was a child centred plan which included Child Mental Health Policy and School Mental Health Policy (Shastri 2009). In October 2014, Ministry of Health and Family Welfare, Government of India launched India’s first-ever National Mental Health Policy of India 2014 in consonance with the intent of the 65th World Health Assembly held in 2013 to provide universal psychiatric care to the population. National Mental Health policies should not be solely concerned with mental disorders, but should also recognize and address the broader issues which promote Mental Health (Reddy et al. 2013). Children and adolescents are at the growing and developmental stage and are most vulnerable group to Mental Health problems. But there is no specific Mental Health policy for the Children and adolescents. Moreover, still there is a perceptible gap between policies and practice in optimum use of the recommendations of the policies.

Mental Health problem of children and adolescents is an important issue to address for teachers, parents, society, and nation as a whole. Adolescents constitute 20-25% of the population of the country, and a significant number of adolescent populations attend schools where they are subjected to training and experiences which work as catalyst for their healthy growth and development – physically, emotionally, and socially to become prospective citizens of the country. This formative period of life demands continuous adjustment with challenges of ever changing developmental process. It is a universally agreed fact that the schools are primarily meant for catering education and promoting learning among the students. At the same time the schools have to undertake the
responsibility to nurture the students’ development as a human being by taking care of the positive social, emotional, behavioural, and psychological development. Due to the rapid changes in the society, these days, many students face a number of social, economic, and environmental challenges which cause stress in them resulting in distraction from their primary task of learning. School is an important place to identify those who are beginning to exhibit symptoms of Mental Health problems. School based and school connected Mental Health services offer students the possibility of taking full advantage of the educational opportunities available to them (Salkind 2008). Education equips children and adolescents with the core abilities to access resources, to assert their rights, and to serve as agents of change for several social and family problems (Patel et al. 2008). A greater awareness of Mental Health of children and adolescents and the importance of school experiences has led experts to view the school as an important venue for studying emotional and behavioural problems of children, promoting Mental Health and providing counselling services (Saleem et al. 2012).

The present study was conducted among a limited number of school going adolescents in a small part of the state of West Bengal, considering a limited number of variables. But the study revealed a reasonable percentage of the students suffering from Mental Health problem and almost an equal number is on the borderline or likely to suffer some sort of problem, if not taken care of. Various research studies in the past revealed that Mental Health problems often becomes a strong indicator among school going children for educational underachievement, school dropout, school refusal, delayed school progress, adjustment difficulties, social incompetence, low self-worth and self-esteem, feeling of loneliness, interpersonal problems, and lack of feeling of well-being later in life (Saleem 2011). As such role of school is very important for overall Mental Health growth of the students. Various studies suggested that adolescents today face challenges because of changes in their physical growth and development. With this growth and development they face challenges and difficulties of social and emotional demands to become a member of the society and establish their role and identity. All these factors including growing academic pressure and parental expectation may cause risk of developing Mental Health problems in children and adolescents. Schools have an important role to
play for promotion and prevention of Mental Health of the students along with academic activities for achievement of desired educational outcome. There is now increasing evidence on the effectiveness of interventions to improve children’s and adolescents’ resilience, promote Mental Health and treat Mental Health problems and disorders (Shastri 2009). Education provided in the school must ensure the promotional aspects of Mental Health for well-being of the children and development of resilience among them rather than curative measure. Role of the teacher and school should take care of the promotional aspects of Mental Health in non-clinical set up. This may include identification of the children who exhibit symptoms of the problem, framing necessary strategies of intervention, and making referral to those who require specialized treatment.

Mental health is a fundamental element of the resilience, health assets, capabilities and positive adaptation that enable people both to cope with adversity and to reach their full potential and humanity (Friedli 2009). It is understood that Mental Health is integral part of overall health, and it is not just absence of mental illness but a state of well-being that are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living, and enjoy life. This paradigm shift from illness to well-being has to be taken into consideration by all concerned. Along with improvement in treatment of mental illness we have to focuss on some Mental Health activities which should be a shift towards understanding the importance of preventive and promotional aspect of positive Mental Health of school going children. Development of positive Mental Health is important to enhance resilience in children to have a balanced emotion (affect/feeling), cognition (perception, thinking, reasoning), social functioning (relation with others and society) and coherence (sense of meaning and purposes of life), as Mental Health is fundamental element to build resilience.

A high level of proficiency in life skills will promote the development of sound Mental Health (Patel et al. 2008) as Life skills teaching promotes the learning of abilities that contribute to positive health behaviour, positive interpersonal relationships, and mental well-being (WHO 1997). Life skills education should be integrated in schools across the curriculum to develop psychological competence of the adolescents attending the school. National Mental Health Policy of India 2014 also recommended that ‘Life Skills
Education (LSE) should be offered to school children and college going young persons, using interactive learning methods that are age and context specific, facilitated by teachers and trainers who are appropriately skilled’. According to WHO (1997) psychosocial competence is a person's ability to deal effectively with the demands and challenges of everyday life and it has an important role to play in the promotion of health in its broadest sense; in terms of physical, mental and social well-being, in particular, where health problems are related to behaviour, and where the behaviour is related to an inability to deal effectively with stresses and pressures in life, the enhancement of psychosocial competence could make an important contribution. This is especially important for health promotion at a time when behaviour is more and more implicated as the source of health problems.

It is evident from above discussion that Mental Health promotion requires creation of a supportive environment and living condition which will allow children to adopt and maintain a healthy and resilient lifestyle. There is a need to develop a school curriculum which will be of broad and multidimensional nature which will include not only the development of cognitive aspect but should integrate emotional, physical, biological and social aspects in its teaching learning process. Patel et al. (2008) discussed about a concept of Health Promoting School, where all members of the school commonly work together to provide students with integrated and positive experiences and structures which promote and protect their health. In a control study from India, with 122 normal and 117 emotionally disturbed adolescents, a standard package of life skills training enhanced psychological competence in all, and symptomatic improvement in about 80% of the adolescents with internalizing disorders (Goyel 2006, as quoted by Patel et al. 2008). For development of wellbeing and resilience in children, school curriculum should integrate social and emotional education (Cefai et al. 2014), an educational process which will develop awareness, understanding and management of self and of others through social, emotional and cognitive processes, which includes understanding of self and of others, regulating emotions and enhancing positive ones, developing healthy and caring relationship, making good and responsible decisions, making use of ones strengths and overcoming difficulties and adversities in social and academic tasks.
There is a need to raise public awareness about the prevalence of often hidden Mental Health problems in Indian adolescents, sensitizing the parents and teachers in identifying the problems (Ahmad et al. 2007). The findings of the present study also indicates the need of early detection of Mental Health problems of the adolescents attending schools for timely intervention and promotion of positive Mental Health for a better and holistic development of the future citizens of the country considering that positive Mental Health would be a resource for social and economic prosperity.

The policy makers, administrators, teachers, parents, educationists and all concerned may adopt some realistic strategies for promotion of Mental Health in the light of the present study. All of us have a common goal to ensure the well-being of younger generation and development of some sort of psychological competencies in them to cope with the daily life needs and challenges, stress and catastrophes. We have to develop in the children and adolescents a realistic awareness about self and surroundings, recognition of own emotion, and express them properly, develop a healthy social and interpersonal relationship and to develop ability to cope with the daily life stresses. We have to achieve it as early as possible to make the growing generation happy, resilient and productive citizens of the country.

In general it is expected that the findings of a research will help to make generalization and use it for appropriate decision or policy making for the population from whom the sample has been drawn. It is quite likely that on the days of data collection from the school, some of the students were absent and a few were dropouts. These students might have been in vulnerable group with high prevalence of Mental Health problem. Moreover, the sample of the present study was the children attending normal mainstream schools. A good number of children study in special schools, where only the children with high emotional and behavioural problems study.

5.4 Significance of the Study

This study estimated the rate of prevalence of Mental Health problem of adolescent school going children. The study also revealed the amount of influence of different
independent variables and predictors on Mental Health problems. These findings may help creating awareness about Mental Health problems among the parents and society, which mostly remains neglected unless it becomes serious mental illness. The findings also would work as guidelines for teachers, educators and the schools for planning school level services, and for the policy makers and all concerned to develop and facilitate appropriate strategy and policy for intervention, prevention and promotion of Mental Health.

The findings of the study also suggest early identification and intervention of Mental Health problem of adolescent school going children to avoid adverse consequences in future.

The study would also open the window of choices and interest for the researchers to carry out researches in the area in different dimensions.

**5.5 Scope for Further Studies**

The present study is not an end in itself; rather it is a part of ongoing process to achieve the goal of managing and promoting Mental Health and wellbeing of the younger generation. Therefore, a numerous further studies may be conducted by the future researchers considering various dimensions of different variables of Mental Health problems of school going adolescents. Research effort may be initiated in the in the direction of developing further sophisticated research tools to assess the different dimensions of Mental Health problems of school going adolescents using sophisticated statistical analyses.

This study was conducted taking limited and small number of sample within a limited time frame. The study was conducted with limited demographic variables – gender, medium of instruction, location of the school, family type and number of siblings and Mental Health problem as outcome or dependent variables. The study tested emotional problem, conduct problem, hyperactive problem, peer problem and pro-social behavior. Most studies do not mention whether prevalence rates are point or period prevalence rates.
(Bhola et al. 2003). The present study estimated the Mental Health problem in a point of time. But in most of the time it is found that many have Mental Health problem for a very brief period, which would not continue later or might not have long-term effects. Concepts of Mental Health and illness and the understanding of children’s emotional and behavioural difficulties vary across cultures (Shastri 2009) and prevalence rate of mental disorders vary within a population over a period of time and also across population at the same time (Math et al. 2010). Moreover, the timing of identification and intervention for the onset and progression of Mental Health problem is also a critical factor. So, research has to be carried out over a period of time along with point of time by collecting data on variables at multiple time points to find out whether the episode of the problem continues. As such it is suggested to design more comprehensive assessments to find out complex problems for initiating appropriate interventions responsive to risk factors. The researcher feels that it is very much important in the present day context.

References


