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Beyond the Blackboard: Integrating Mental Health into Jharkhand's Education System

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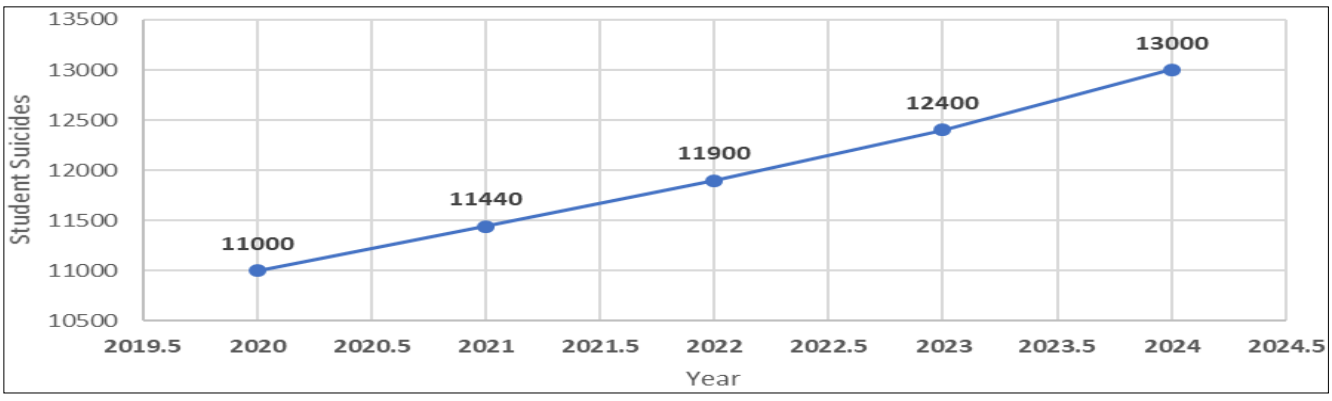
Abstract
The rising incidence of mental health issues among Indian school-aged children—reflected in growing rates of anxiety, depression, and suicide—signals a deepening crisis. In states like Jharkhand, systemic underinvestment and cultural stigma further compound the problem. This study examines the potential of school-based mental health interventions, especially the role of teachers as first responders, in bridging care gaps. Drawing on secondary data from the National Crime Records Bureau (NCRB), National Mental Health Survey (NMHS), and reports from CIP Ranchi and WHO, the study analyzes trends in adolescent mental health, professional shortfalls, and budget allocations. it. Findings underscore a critical shortage of trained mental health professionals in Jharkhand, a growing youth suicide rate, and persistent rural–urban disparities in diagnosis and care. Despite policy advancements such as Tele-MANAS and NEP 2020, implementation remains fragmented. The authors argue for a capacity-building model centered on teachers and supported by professional social workers to deliver low-cost, localized mental health support. It recommends integrated training, community linkages, and curriculum-based emotional literacy as sustainable solutions for school ecosystems. The article advocates for a capacity-building approach that empowers teachers to identify, manage, and refer students in psychological distress by examining systemic gaps and emerging best practices. The discussion highlights the context of Jharkhand, where institutional mechanisms are still evolving, and argues that teacher-led psychosocial support is a scalable and sustainable model that can bridge the current service gap in school mental health provision.

Keywords: Mental health, Jharkhand, governance, intervention, psychosocial support

Introduction
The urgency of the mental health crisis among school-aged children in India is becoming increasingly apparent. A Business Standard report (2024) revealed that India witnessed over 13,000 student suicides in a year, marking a disturbing upward trend of more than 4% annually. These numbers underscore a more profound crisis in educational spaces, which is often overlooked due to stigma, a lack of awareness, and the absence of trained professionals within schools.

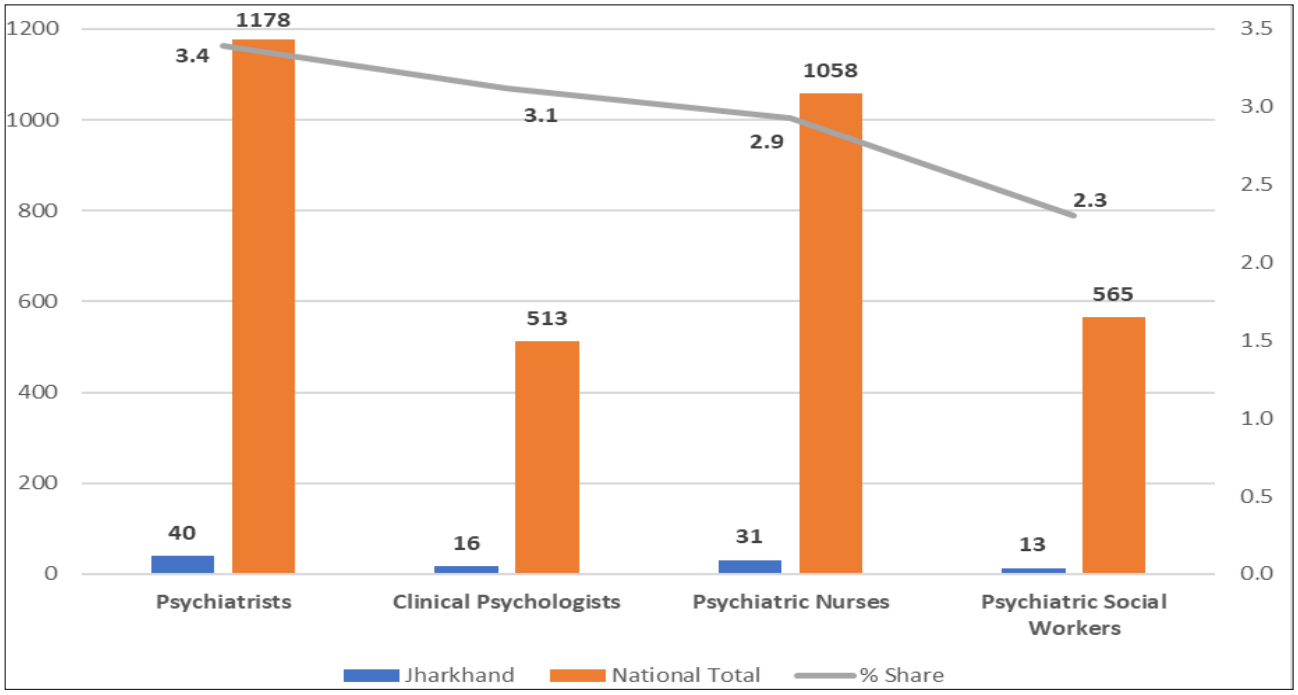
Materials and Methods
This study adopts a mixed-method secondary data approach, relying on publicly available datasets from institutional sources such as the National Crime Records Bureau (NCRB), National Mental Health Survey (NMHS 2015–16), the World Health Organization, the Ministry of Health and Family Welfare, and the Central Institute of Psychiatry (CIP), Ranchi. Reports from journals and specific portals, such as Frontiers in Education and ScienceDirect, as well as policy briefings from The Hindu and TalkToAngel, were also used. A structured cleaning and transformation process was applied to numeric datasets using Excel and Power BI. Graphs were constructed to visually map trends such as suicide rates, state-level distribution of mental health professionals, and budget allocations. Descriptive statistics were employed to compare national and state-level metrics, and thematic clustering was used to group insights under institutional gaps, service delivery challenges, and potential interventions. Qualitative policy insights were thematically analyzed and integrated to support interpretations of quantitative findings, particularly regarding educational strategies and mental health frameworks in low-resource settings, such as Jharkhand. No primary human subjects were involved, and all data were sourced from publicly available domains.



Graph 1: Annual Student Suicides Increase by 4%

This line chart illustrates a consistent 4% annual increase in student suicides across India, reaching over 13,000 deaths. This harrowing statistic—originally from NCRB data and cited in Business Standard (2024)—serves as a wake-up call. It provides a quantitative grounding to the article's central argument: mental health in schools is a crisis, not a choice. The graph illustrates why schools must serve as immediate intervention spaces, demonstrating that delays can be costly in terms of lives lost. Mental health in children is not just about diagnosing disorders; it involves nurturing resilience, emotional intelligence, and coping mechanisms from an early age. As the Frontiers in Education journal (2024) emphasizes, promoting mental health within school settings leads to better academic outcomes, reduced behavioural issues, and more emotionally supportive learning environments. However, the infrastructural and pedagogical preparedness to integrate mental health into daily educational practices is still lacking, especially in low-resource settings like Jharkhand.

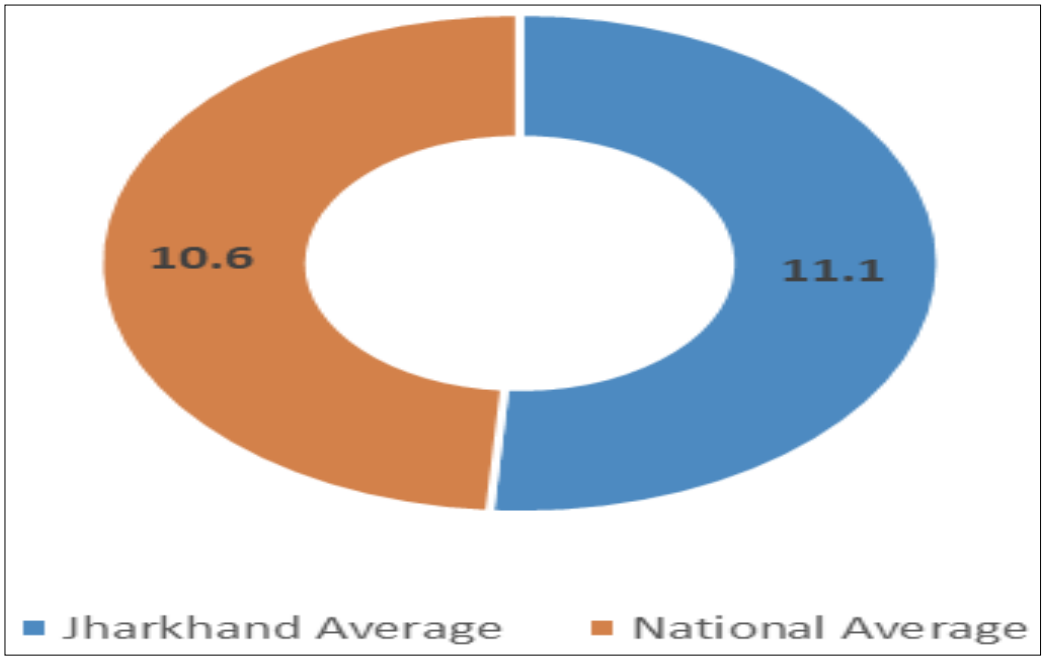
Mental Health Status in Jharkhand



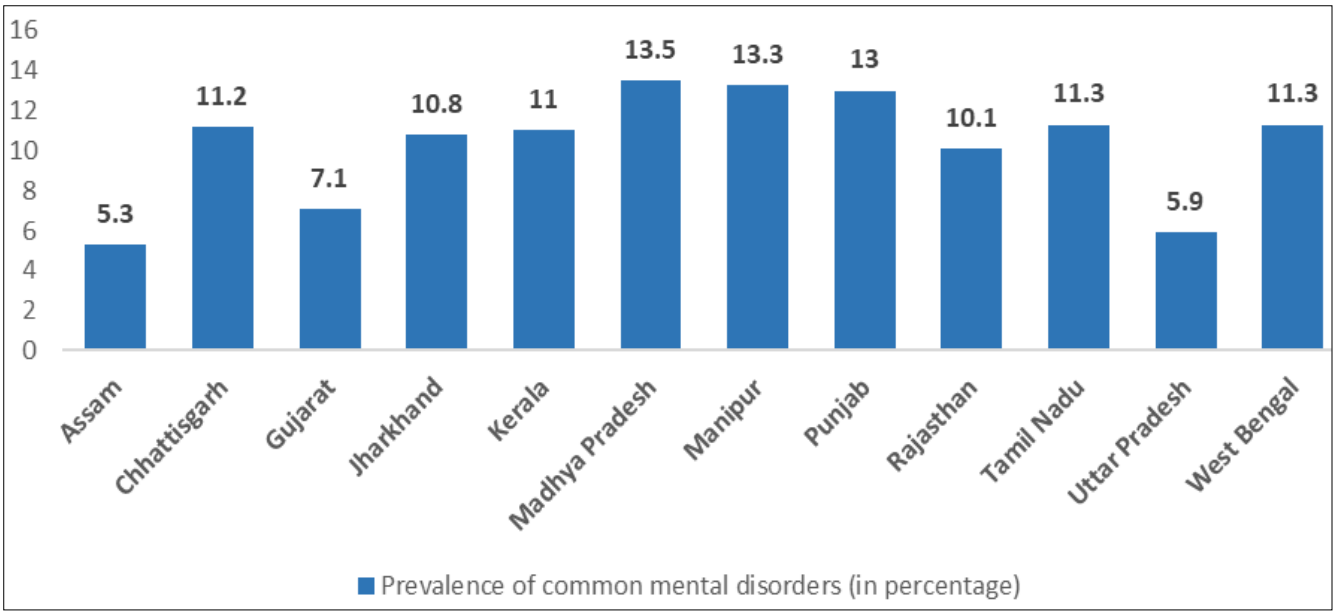
Graph 2: State/UT-wise Number of Mental Health Professionals under DMHP (2024)

This Clustered Column chart highlights the acute shortage of mental health professionals, particularly in Jharkhand. The state has significantly fewer professionals per capita compared to other large states. The visual supports the point that schools must compensate for these shortages by building teacher capacity. It connects well to the article's advocacy for teacher-led psychosocial support.

Mental Health Burden: Jharkhand vs. National Average



This donut chart illustrates the disparity in mental disorder prevalence between Jharkhand and the national average, underscoring the state's elevated mental health burden. Jharkhand presents a critical case when discussing the urgency of school-based mental health interventions. A recent survey conducted by the Central Institute of Psychiatry (CIP), Ranchi, reveals that approximately 11.1% of the state's population suffers from various mental disorders. This figure surpasses the national average in several categories (Hindustan Times, 2019) [3]. This prevalence is compounded by inadequate access to mental health professionals and services, particularly in rural and tribal belts, where cultural stigma and social taboos further inhibit early detection. According to the National Mental Health Survey (NMHS) 2015–16, the national average prevalence of mental disorders among adults in India is 10.6%.



Graph 3: State-wise Prevalence of Common Mental Disorders – NMHS 2016

Drawing from the National Mental Health Survey (2016), this graph shows Jharkhand's elevated burden of common mental disorders relative to other surveyed states. With prevalence higher than many better-resourced regions, it reinforces that Jharkhand is both underserved and disproportionately affected, necessitating urgent structural reforms in school mental health programming. The Health Dossier 2021, published by the National Health Systems Resource Centre, outlines the acute shortage of psychiatrists, psychologists, and social workers in community healthcare settings. Moreover, Sharma *et al.* (2022) [5] highlight that underreporting, lack of awareness, and systemic neglect obstruct early intervention. Given the limited institutional capacity, schools have the potential to become early detection points and safe spaces for psychosocial support. In this context, empowering teachers becomes desirable and essential for mitigating long-term psychological risks among Jharkhand's youth.

The Need for School-Based Interventions

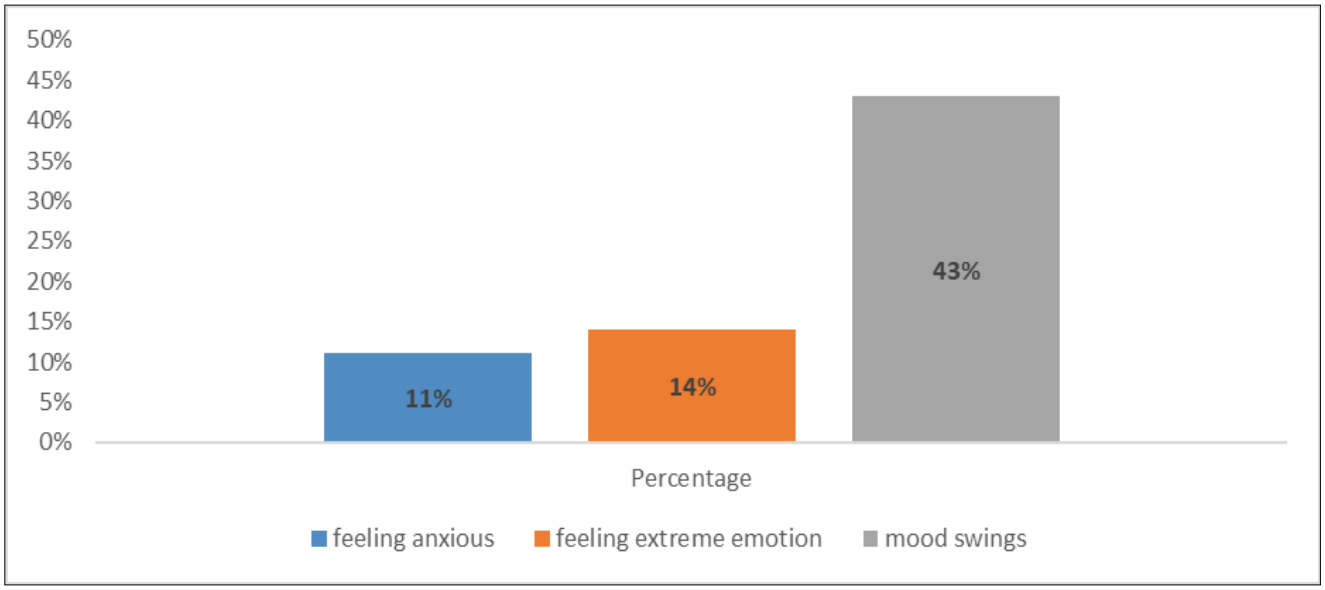


Fig 4: Evidence from NCERT's Mental Health Survey – Economic Survey 2024

This bar chart reveals concerning mental health trends among adolescents: 43% experience mood swings, 14% feel overwhelmed, and 11% report anxiety. Post-COVID, this visual supports the assertion that school-based mental health interventions must be integrated into regular pedagogy, rather than being treated as occasional or remedial add-ons. These figures, though alarming on their own, reflect only a portion of the broader psychological toll the COVID-19 pandemic has had on young people. Prolonged school closures, social isolation, academic uncertainty, and increased screen time have all contributed to a surge in emotional distress among students. According to Psychology Today, disruptions to core youth-serving institutions—such as schools, extracurricular activities, and peer networks—have left adolescents particularly vulnerable to depression, anxiety, and self-esteem issues. This visual evidence underscores the pressing need to integrate mental health support into the core curriculum, rather than treating it as an occasional or reactive measure. Integrating emotional literacy, peer support systems, and access to trained counselors within the school environment can help normalize mental health conversations and provide early intervention.

As the data suggests, the emotional well-being of students is no longer a peripheral concern—it is central to their academic success and long-term development.

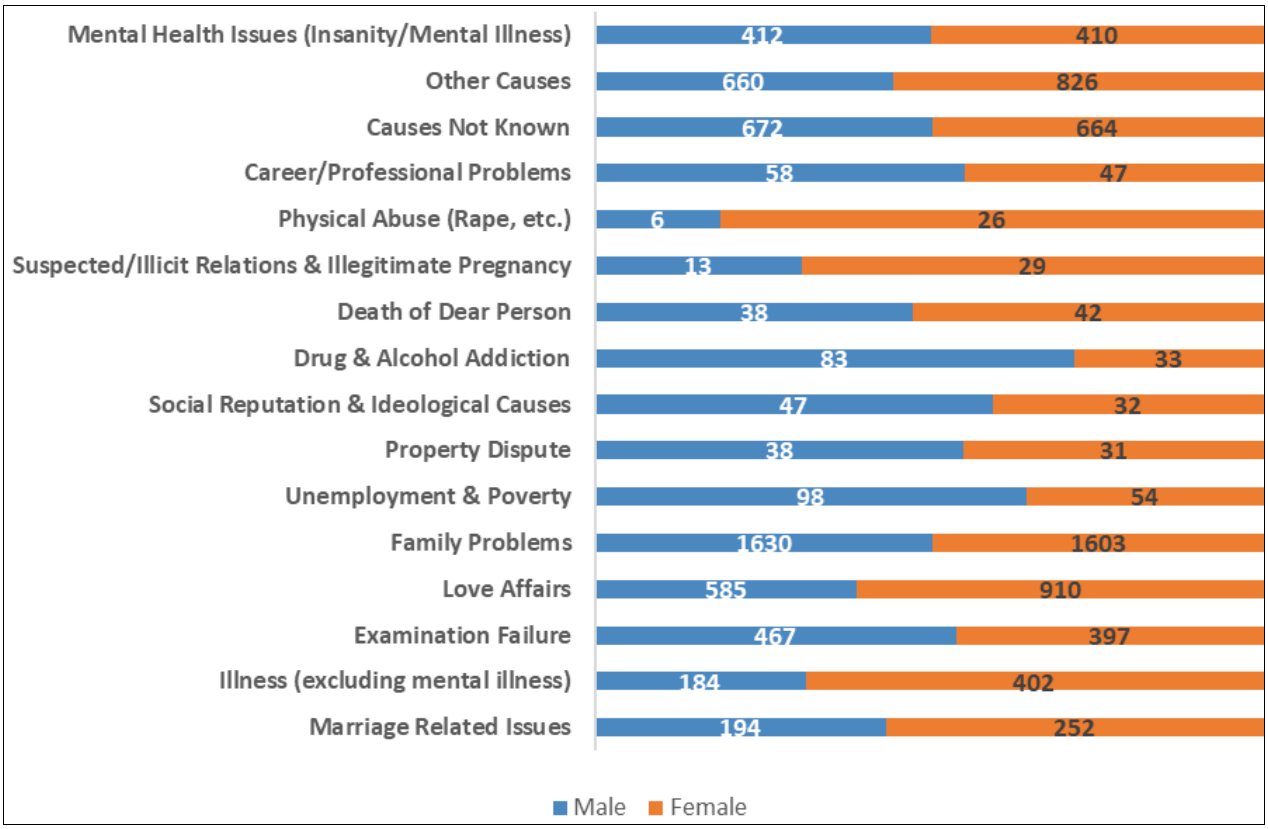
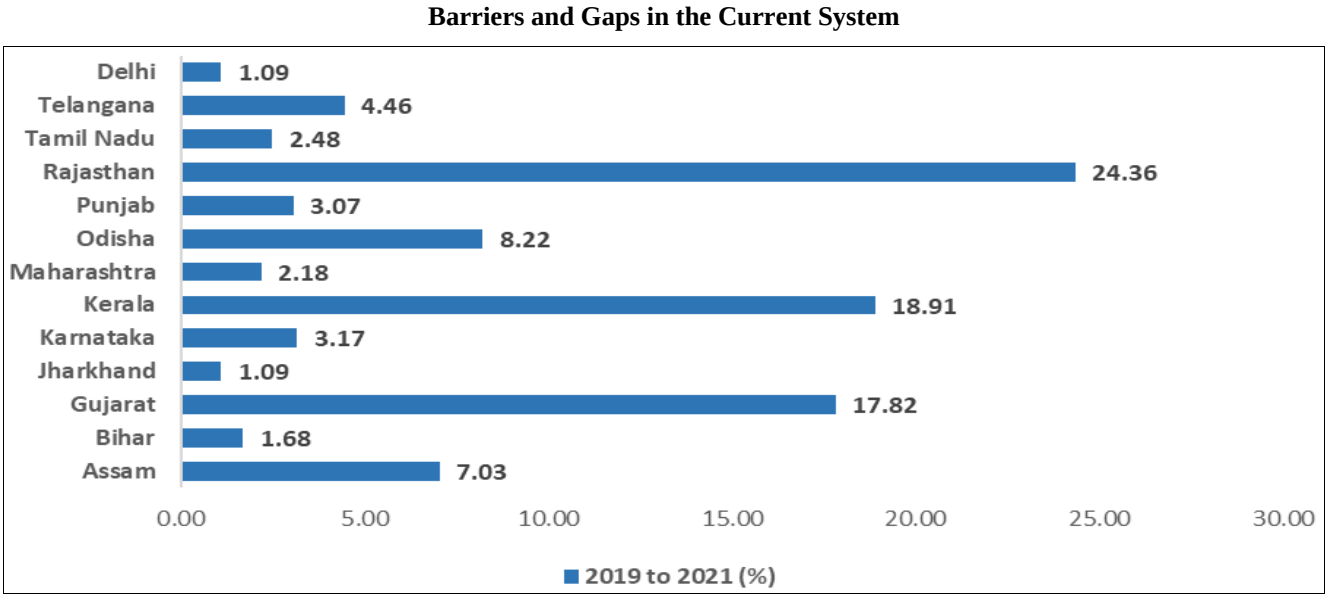


Fig 5: Below Age 18 years – Male and Female cause-wise Suicide Distribution (2021)

This Stacked Bar chart disaggregates child suicides by causes—academic pressure, abuse, family conflict, and untreated mental illness top the list. The chart reinforces that schools are uniquely positioned to spot early warning signs and mitigate these stressors, primarily through trained staff and peer support programs. The number is 412 for males and 410 for females. The cause of death is mental health; that number is not ignorable; they represent a critical public health signal that demands urgent attention. These numbers challenge the long-standing assumption that mental illness rarely leads to fatal outcomes in India. Recognizing these deaths is not just a statistical exercise—it is a moral imperative to strengthen mental health systems, improve early detection, and ensure that no life is lost to silence or invisibility.

Despite the growing evidence that mental health significantly affects learning outcomes, Indian schools are still not structured to offer adequate support. The need for school-based interventions is clear. Studies in *ScienceDirect* (2024) indicate that students dealing with trauma, family problems, or social exclusion are more likely to exhibit absenteeism, poor academic performance, or behavioural issues and eventually drop out. Teachers interact with students daily and are uniquely positioned to observe changes in mood, attendance, behaviour, and peer interaction. However, most educators lack the training to respond appropriately to these cues. This lack of preparedness is especially problematic in Jharkhand, where access to professional mental health services remains limited. A report published on the TalkToAngel portal (2024) suggests that integrating mental health education into teacher training and school curricula facilitates the early identification of psychological distress and fosters a more supportive school environment overall. By mainstreaming mental health into school life, we can reduce stigma and normalize help-seeking behaviour. It also fosters a sense of shared responsibility among teachers, administrators, and the broader school community to prioritise student well-being alongside academic achievement.



Graph 6: State/UT-wise Offences including Mental and Physical Cruelty against Children by Caretakers in Juvenile Homes (2019–2021)

This chart shows institutional cruelty in Child Care Institutions (CCIs), including those in Jharkhand. It underscores systemic neglect and justifies the need for preventive support structures in mainstream schools—before vulnerable children end up in high-risk institutions. This reinforces the urgent need to shift from reactive institutionalization to proactive, community-based care. Embedding early intervention frameworks within schools—such as mental health screening, peer mentorship, and family outreach—can serve as a protective buffer, reducing the likelihood that at-risk children are funnelled into institutional systems in the first place. Prevention, not containment, must become the cornerstone of child protection policy.

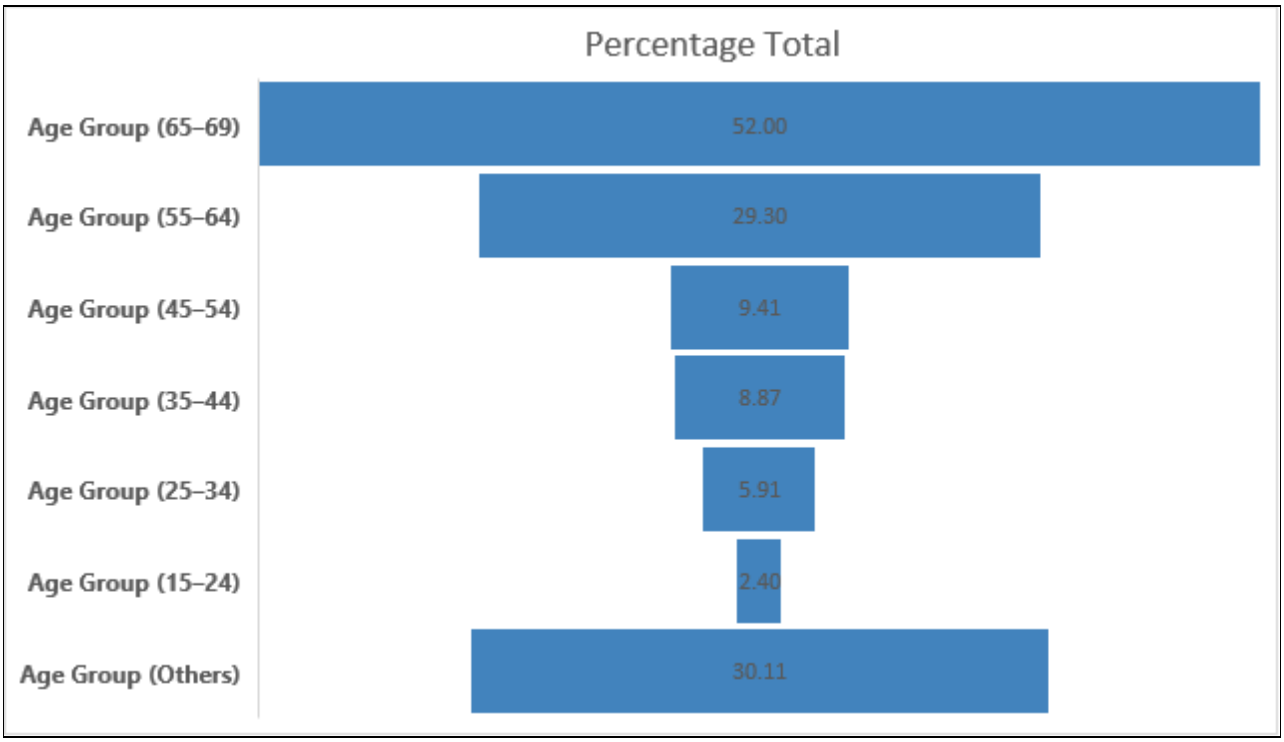
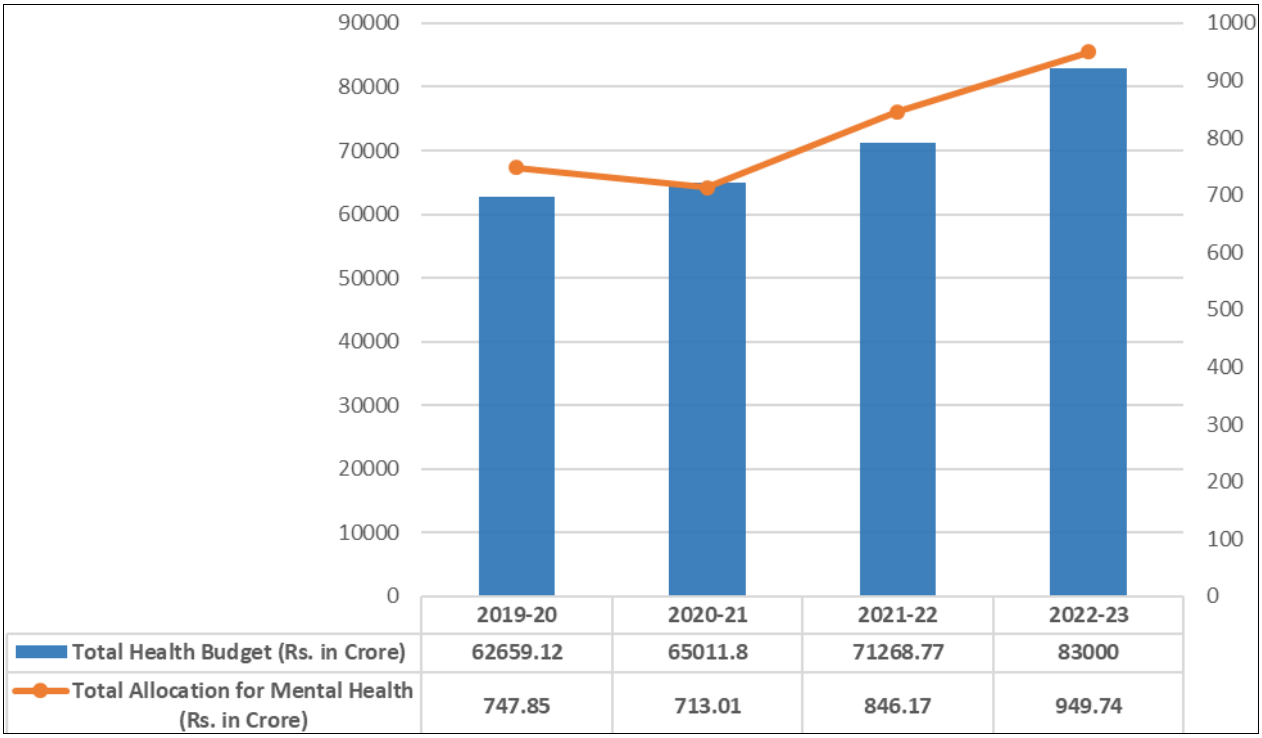


Fig 7: Distribution of Deaths Due to Mental and Behavioural Disorders (MCCD 2020)

This funnel chart shows the distribution of causes of mental health-related deaths. The data visually affirms that failure in early diagnosis and care has fatal outcomes. It supports your call for school-based early intervention frameworks as an urgent public health need. The data reveals that deaths attributed to mental and behavioural disorders are most concentrated in middle-aged and older adults, particularly those between 35 and 64 years. Within this range, the highest number of deaths is linked to psychoactive substance use, especially among men. This trend reflects the long-term impact of untreated addiction, chronic stress, and limited access to sustained psychiatric care.

Notably, the elderly population (65 years and above) also shows a significant burden, primarily due to organic mental disorders such as dementia and age-related cognitive decline. These cases often go underdiagnosed in earlier

stages, surfacing only when complications become fatal. In contrast, younger age groups (below 25 years) report relatively fewer medically certified deaths. However, this may be due to underreporting, misclassification, or deaths being recorded under external causes like injury or suicide rather than psychiatric conditions. This underrepresentation in mortality statistics reinforces a dangerous invisibility surrounding psychiatric conditions in India's public health narrative. Strengthening diagnostic training, improving certification processes, and integrating mental health into primary care are critical to not only capturing the accurate scale of psychiatric mortality but also preventing it.



	2019-20	2020-21	2021-22	2022-23
Total Health Budget (Rs. in Crore)	62659.12	65011.8	71268.77	83000
Total Allocation for Mental Health (Rs. in Crore)	747.85	713.01	846.17	949.74

Fig 8: Budget allocation for Mental Health (2019–20 to 2022–23)

This chart reveals only modest increases in national mental health funding over a four-year period. When juxtaposed with rising mental illness cases, it demonstrates a mismatch between budget trends and the rising need, justifying your advocacy for localised, low-cost, school-integrated mental health responses. The implementation of mental health services within schools in India is challenged by entrenched taboos, a lack of systemic planning, and inadequate infrastructure. A Roots Foundation (2023) report finds that many school authorities still treat mental health as an individual issue rather than a systemic one, often overlooking signs of distress due to a lack of training or discomfort with the topic. While the National Education Policy (NEP) 2020 rightly emphasizes the importance of mental well-being in students' overall development, its execution remains fragmented. In Jharkhand, translating policy into practice is slow, and there is no clear roadmap to equip schools with trained mental health professionals or guidance counsellors. As the Hindu (2023) points out, the policy framework lacks localized strategies tailored to states like Jharkhand, where the student population includes tribal communities with distinct socio-cultural contexts.

Furthermore, although the Centre has selected Jharkhand for targeted mental health programs (The New Indian Express, 2023), the state still lacks a comprehensive school mental health strategy. This absence of a comprehensive strategy is a significant gap that needs to be urgently addressed. Existing mental health initiatives tend to focus more on clinical care at the district level and rarely extend into the educational ecosystem.

The Role of Teacher Training in Bridging the Gap

In the absence of full-time school counsellors, especially in semi-urban and rural areas, equipping teachers with basic psychosocial and counselling skills becomes a viable and urgent strategy. A structured three-day training module can be a foundational step toward building teacher capacity to recognize and respond to mental health concerns. Such training should cover the fundamentals of child psychology, emotional development, identifying red flags for anxiety or depression, and delivering Psychological First Aid (PFA). It should also include trauma-informed pedagogical approaches that prioritize emotional safety, respect for diversity, and the promotion of student agency. Research from Frontiers in Education (2024) confirms that when teachers are better equipped to support students' well-being, it has a positive impact on classroom engagement, reduces conflict, and enhances peer relationships. In the context of Jharkhand, where school staff often serve as social workers and community influencers, their enhanced mental health literacy can have a ripple effect across the educational ecosystem. Importantly, teacher training should not function in isolation. Building linkages with local healthcare units, District Mental Health Programs (DMHPs), and Child Protection Units can strengthen referral chains and ensure teachers are not overburdened.

Role of Professional Social Workers

Alongside trained teachers, professional social workers can play a transformative role in advancing school-based mental health systems. Their training in psychosocial assessment, community engagement, and systemic advocacy allows

them to bridge the gap between students, families, and mental health services. Social workers can conduct group sessions, facilitate peer support groups, deliver individual counselling, and engage in family outreach to address the root causes of emotional distress. Schools with limited infrastructure can also support teachers in crisis management and policy advocacy. More importantly, they can help embed mental health practices into school development plans, turning mental well-being from an "add-on" to a core component of quality education. Social workers can collaborate with teachers and administrators to develop child-centred, inclusive, and culturally responsive interventions, which is particularly crucial in a diverse state like Jharkhand.

Implications for Jharkhand

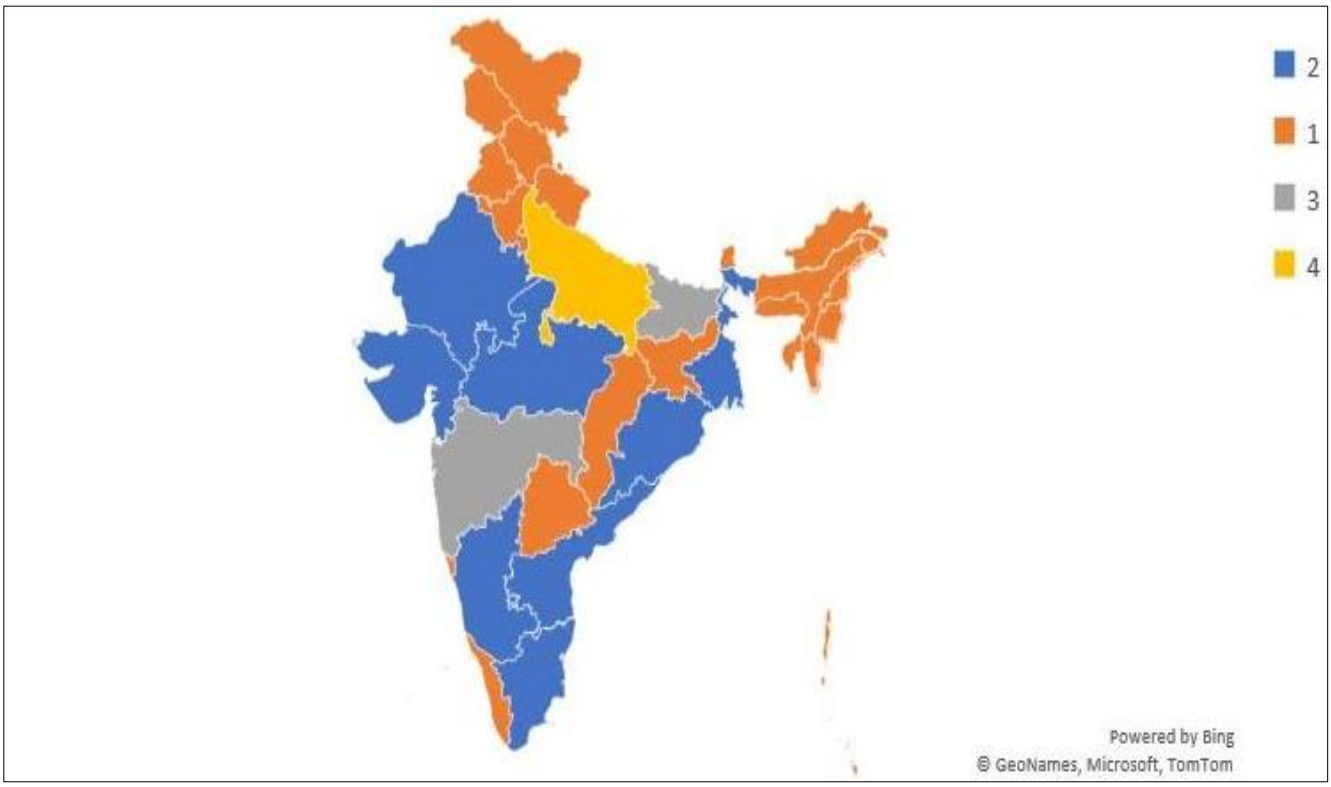


Fig 9: Tele-MANAS Cells Sanctioned as of Dec 2022

The India map shows state-wise sanctioning of Tele-MANAS mental health units. Jharkhand's inclusion signals a policy opportunity. The article appropriately recommends that schools link to these digital support structures to mitigate the professional shortage. Jharkhand's inclusion in the Tele-MANAS (Tele Mental Health Assistance and Networking Across States) initiative marks a pivotal moment in the state's mental health journey. As one of the five Regional Coordinating Centers and a designated Mentoring Institution Despite Jharkhand's formal inclusion in the Tele-MANAS network, the on-ground impact remains uneven and underleveraged. While the state hosts one of the five Regional Coordinating Centres at CIP Ranchi, outreach efforts beyond urban areas have been limited. Many rural schools and community health centers remain unaware of the service, and digital infrastructure gaps—including poor internet connectivity and lack of trained facilitators—continue to hinder effective utilization. Moreover, the absence of multilingual, culturally contextualized counseling restricts access for tribal populations, who form a significant portion of the state's demographic. Without robust monitoring, awareness campaigns, and school-level integration, Tele-MANAS risks becoming a symbolic inclusion rather than a transformative intervention in Jharkhand's mental health landscape.

Why Urban Youth Show Higher Prevalence	Why Rural Youth Show Lower Prevalence (on paper)
▪ Urban adolescents often face intense competition in academics, career expectations, and social comparison, especially amplified by social media. These stressors are linked to anxiety, depression, and burnout. ▪ Urban areas have better access to mental health professionals and diagnostic tools, which may lead to higher detection rates rather than higher actual incidence. ▪ Sedentary habits, screen overuse, disrupted sleep cycles, and reduced physical activity are more common in urban youth, all of which are associated with mental health issues. ▪ Urbanization often leads to nuclear families and reduced social cohesion, which can limit emotional support systems for adolescents.	▪ Mental health stigma is more pronounced in rural areas, leading to underreporting and reluctance to seek help. ▪ A lack of trained professionals and mental health infrastructure in rural regions means many cases go undiagnosed. ▪ In some cases, close-knit communities and traditional family systems may offer buffering effects against stress; however, this is changing with migration and modernisation.

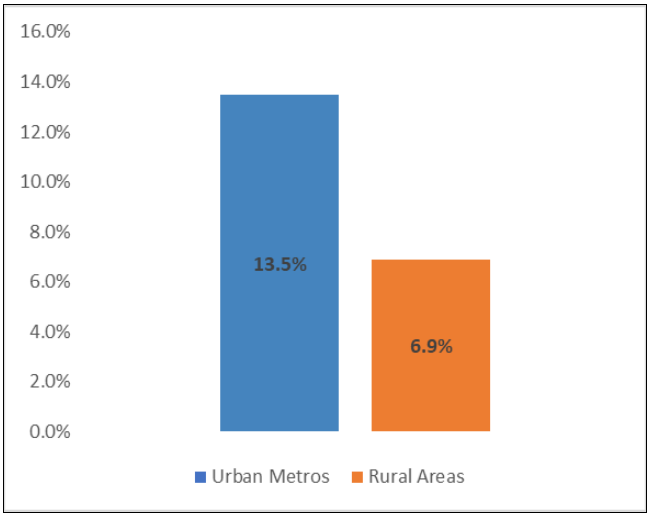


Fig 10: Child and Adolescent Mental Health – Urban vs Rural Prevalence

This bar chart compares mental disorder prevalence among urban youth (13.5%) vs rural (6.9%). The disparity highlights rural underreporting, lack of awareness, and stigma—issues especially acute in Jharkhand's tribal belts. It supports your recommendation for culturally rooted, school-based outreach and sensitization.

- comes from the National Mental Health Survey (NMHS) of India 2015-16. This is the most comprehensive national survey data available for this specific age group and urban/rural split at a broad level.
- "Mental health among the youth is a growing concern", as highlighted by the Minister of Scheduled Caste, Tribe and Backwards Class Welfare Department in Jharkhand, referencing the 11% mental illness rate among the population.

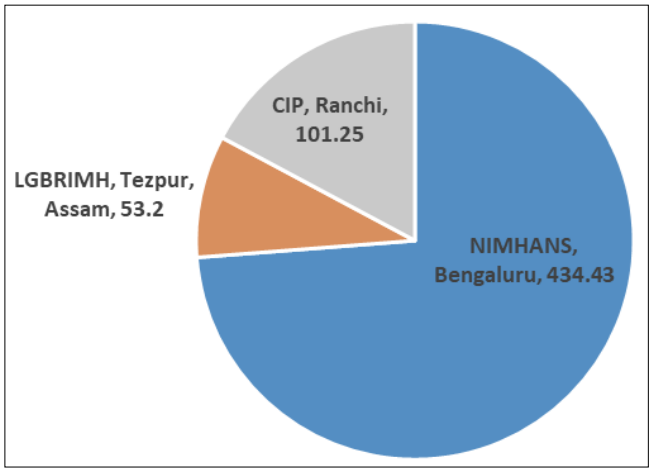
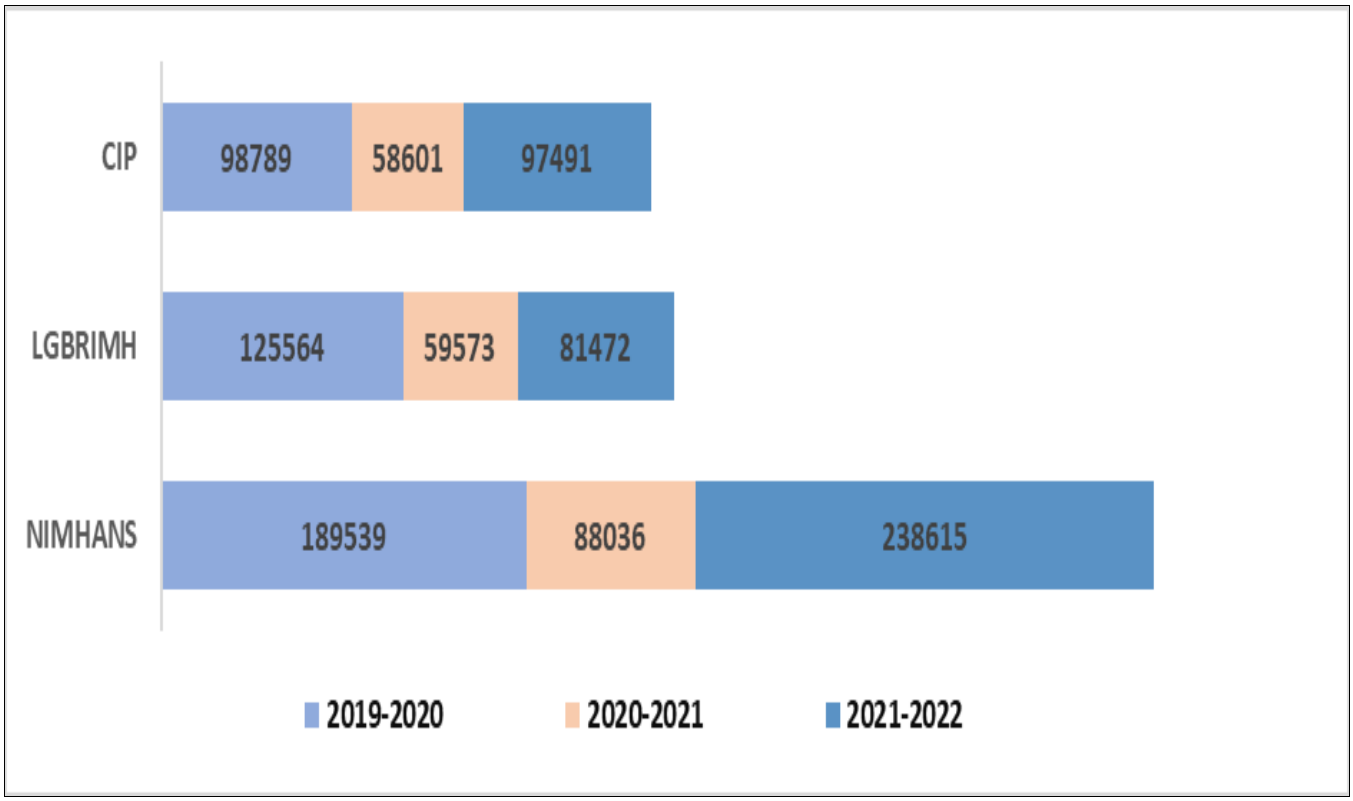


Fig 11: Fund Allocation to Mental Health Institutes (2020–21)

A pie chart comparing government funding to key mental health institutes (NIMHANS, LGBRIMH, CIP). The relatively low funding for CIP Ranchi—Jharkhand's apex institution—exposes regional disparities and financial neglect, strengthening your argument that local institutions and schools must be empowered despite budget constraints. While NIMHANS and LGBRIMH receive consistent support due to their historical prominence and regional positioning, CIP Ranchi's underfunding highlights a systemic neglect of healthcare development in Eastern India. This is not just a funding gap—it is a visibility and prioritization gap, where mental health is often overshadowed by more immediate public health concerns in underserved states. The graphs below show the treatment received after receiving funds in 2020-2021, as well as the treatment received in previous years, highlighting an increase in treatment.

OPD (Outpatient Department) number of People seeking Treatment for Mental Health Issues.



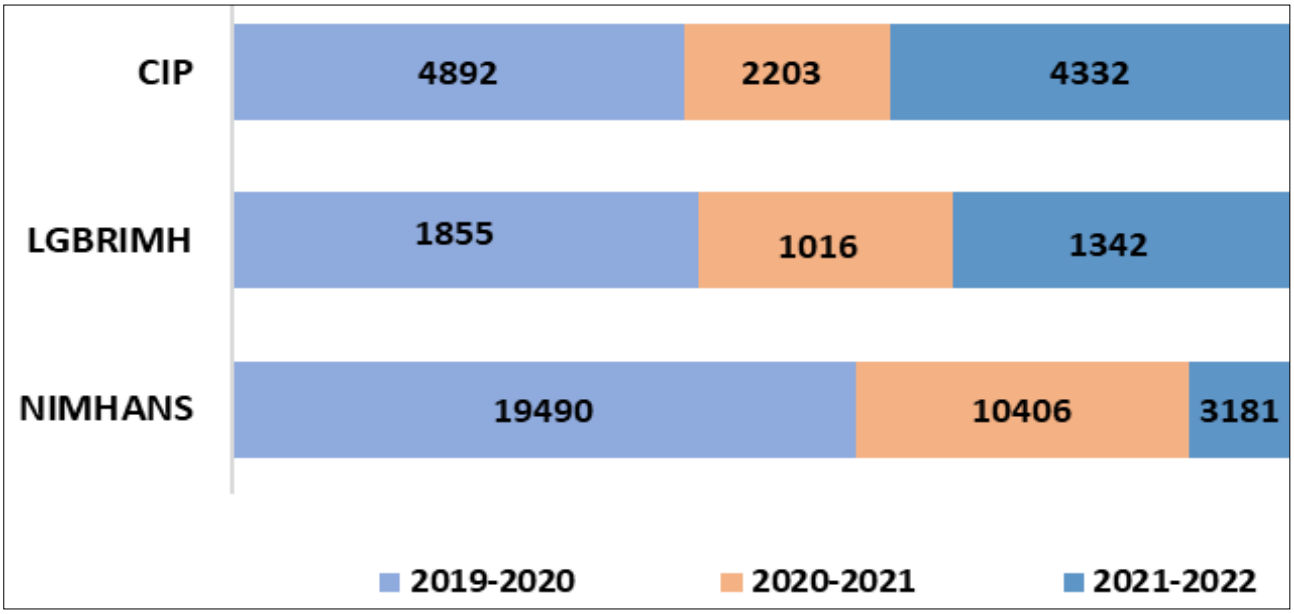


Fig 12: OPD & IPD Numbers of People Seeking Mental Health Treatment + Total Cumulative Institutional Cases IPD (Outpatient Department) number of People seeking Treatment for Mental Health Issues.

This chart illustrates the increasing number of OPD and IPD cases, as well as the strain on institutions like CIP Ranchi. These visuals emphasize that institutional systems alone cannot cope, reaffirming the need for decentralized mental health ecosystems that include schools, teachers, and social workers. A breakdown of OPD and IPD treatment volumes reveals another important narrative: while outpatient demand continues to surge (often linked to common mental disorders like anxiety and depression), inpatient capacity remains stagnant. This indicates a mismatch between the availability of mild-to-moderate care and the readiness for crisis-level intervention, leading to treatment delays or overcrowding at tertiary centres like CIP. Jharkhand's socio-economic disparities, tribal diversity, and varying literacy levels present unique challenges and opportunities. While the state has been identified as a target for national-level mental health initiatives, implementing school-level programs remains a challenge. Establishing a cadre of trained teachers and integrating professional social workers within schools can create a multi-tiered mental health support system. Locally contextualized training, aligned with state education and health policies, can help build sustainable models. Community participation, especially in tribal areas, should also be emphasized to reduce stigma and build culturally rooted care practices.

Discussion

Jharkhand's educational institutions must adopt a whole-school approach, where mental health is embedded in daily routines, classroom strategies, and administrative decisions. Peer education, student clubs, and parent sensitization programs can further reinforce a culture of emotional safety and resilience.

- The findings confirm a serious and growing mental health challenge in schools, particularly in Jharkhand. Institutional infrastructure and personnel remain insufficient. However, the potential of schools as psychosocial support hubs is evident.
- Teacher Training as a Scalable Solution
- Teachers are ideally positioned for early detection and response. With brief, structured training in Psychological First Aid, child development, and trauma-informed approaches, they can become effective frontline responders.
- Role of Social Workers in Educational Settings
- Social workers enhance school capacity through counselling, community engagement, and cross-sectoral coordination. Their inclusion in school ecosystems ensures continuity of care and responsiveness to diverse student needs.
- Barriers to Policy Implementation
- Despite supportive policies, operationalization is weak due to lack of localized frameworks, low budgets, and insufficient digital infrastructure.

- Recommendations
- Integrate mental health into school policy and pedagogy.
- Train teachers across rural and tribal schools.
- Promote Tele-MANAS with localized awareness and language support.
- Recruit school-based social workers under DMHP.
- Engage parents and communities in reducing stigma.

Conclusion

In resource-constrained settings like Jharkhand, integrating mental health into schools is both viable and essential. Teacher-led, school-based support systems, backed by trained social workers and policy reforms, can address the glaring service gap. Schools must evolve into emotionally safe spaces where well-being is prioritized alongside academic success. This shift will require multi-sector collaboration, but the outcome—emotionally resilient, mentally healthy youth—is worth the investment. Addressing mental health in schools is no longer optional—it is essential for building inclusive, safe, and effective learning environments. In states like Jharkhand, where access to mental health services is sparse, schools can

become the frontline of early intervention. Teacher training in Mental Health and Psychosocial Support (MHPSS), supported by social work professionals and systemic policy changes, offers a scalable and context-sensitive solution.

By investing in teacher and community capacity, we lay the groundwork for a responsive education system that recognizes emotional well-being as fundamental to a child's right to education. The path forward must prioritize integration, collaboration, and sustainability in mental health support, ensuring that no child is left behind, emotionally or academically.

Author Contributions

The first author conceptualized the study, designed the framework, and led the manuscript writing. The second author collected, cleaned, and analysed the data and developed the visualisations. Both authors contributed to the interpretation of the findings and approved the final version of the manuscript.

Data Availability

All data used in this study are publicly available from government and institutional websites, including NCRB (https://ncrb.gov.in), NMHS (https://indianmhs.nimhans.ac.in), WHO (https://iris.who.int), and Data.gov.in. Specific URLs are provided in the reference section. No proprietary or private data was used.

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Competing Interests

The authors declare that they have no competing interests.

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2. **Md Irshad Ali:** is a Data Analyst at Echo India, Delhi, with a background in Mechanical Engineering (B. Tech, JNTU Hyderabad) and a postgraduate specialization in Data Science from IIIT Bangalore. He transforms raw datasets into strategic insights through compelling storytelling and well-structured reporting that supports data-driven decisions. Irshad is skilled in bridging technical depth with business relevance, crafting concise reports, visual narratives, and analytical solutions that resonate with both technical and non-technical audiences. His work is supported by tools such as SQL, Power BI, and Excel, which he uses to build scalable and optimised workflows that turn data into actionable value.

References

1. Business Standard. Student suicide cases on the rise in India: NCRB Report, 2024. Retrieved from https://www.business-standard.com
2. Frontiers in Education. Teacher training and mental health integration in schools, 2024 Retrieved from https://www.frontiersin.org/journals/education
3. Hindustan Times. CIP survey: Jharkhand mental illness cases are higher than the national average, 2019. Retrieved from https://www.hindustantimes.com
4. National Health Systems Resource Centre. National Health Resource Repository, Health Dossier 2021. Retrieved from https://nhsrcindia.org
5. Sharma, N. *et al*. Mental Health in Jharkhand: Challenges and Policy Needs. Journal of Mental Health and Social Inclusion, 2022.
6. ScienceDirect. Impact of psychological distress on educational attainment, 2024. Retrieved from https://www.sciencedirect.com
7. TalkToAngel. Mental health challenges faced by children in Indian schools, 2024. Retrieved from https://www.talktoangel.com/blog
8. Roots Foundation. Mental Health and the Indian School System, 2023. Retrieved from https://www.rootsfoundation.in
9. The Hindu. NEP 2020 mental health integration: What is missing 2023. Retrieved from https://www.thehindu.com
10. The New Indian Express. Centre selects Jharkhand among states for mental health initiatives. 2023. Retrieved from https://www.newindianexpress.com
11. Child and Adolescent Mental Health – Urban vs Rural Prevalence, 2015-2016. https://indianmhs.nimhans.ac.in/phase1/nmhs-results.php
12. National Informatics Centre. (n.d.). Open Government Data (OGD) Platform India. https://www.data.gov.in
13. World Health Organization. Regional strategy for mental health in the South-East Asia Region, 2023. https://iris.who.int/bitstream/handle/10665/364877/9789290210177-eng.pdf?sequence=1
14. Press Information Bureau. Initiatives for mental health care in India, 2024. https://www.pib.gov.in/PressReleasePage.aspx?PRID=2034931
15. Ministry of Health and Family Welfare. State-wise prevalence of common mental disorders in 12 surveyed states: National Mental Health Survey (NMHS), 2016. [Unstarred Question Reply in Parliament]. https://indianmhs.nimhans.ac.in/phase1/nmhs-results.php