



SCHOOL MENTAL HEALTH SCREENING PROGRAMS IN EARLY DETECTION AND PREVENTION OF PSYCHOLOGICAL DISORDERS AMONG CHILDREN: A COMPREHENSIVE NARRATIVE REVIEW

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Abstract: The mental health of school-going children represents one of the most critical yet persistently underprioritized domains in public health and educational policy. As rise in the psychological disorders seen during childhood and early adolescence, the school environment has emerged as a uniquely established institution for the early identification and prevention of mental health difficulties. This comprehensive narrative review examines the role of school mental health screening programs in facilitating early detection and prevention of psychological disorders among children, with particular attention to the Indian educational context.

An Indian organisation involved in psychometric and student wellbeing assessment has developed a structured, multi-domain mental health screening instrument designed for school students in India. This instrument evaluates mental health across four key causal environments: school-related factors, home-related factors, peer group-related factors, and individual/personal factors. Drawing on evidence from educational psychology, child psychiatry, public health policy, and psychometric research, this review synthesizes findings across six domains: prevalence of childhood psychological disorders, theoretical frameworks for school-based screening, methodological considerations, the instrument's factor domains, implementation challenges in Indian schools, and policy implications.

The evidence reviewed demonstrates that psychological disorders affect between 12% and 20% of school-age children globally, with treatment gaps exceeding 90% in India due to structural workforce deficits and persistent stigma. School-based screening programs have demonstrated meaningful capacity to reduce these gaps by creating systematic, low-barrier identification pathways. A structured screening instrument, developed through rigorous psychometric methodology, operationalizes this capacity through a comprehensive assessment of school-related, home-related, peer group-related, and individual mental health determinants. Evidence-based recommendations are provided for schools, policymakers, counsellors, and assessment developers, with particular emphasis on the integration of validated, multi-domain screening tools within universal, multi-tiered student support frameworks.

Key words — school mental health, psychological screening, early detection, childhood psychological disorders, preventive mental health, student wellbeing, school-based interventions, child mental health, mental health screening India, psychometric assessment.

I. INTRODUCTION

Mental health in childhood and adolescence is foundational to lifelong well-being, academic achievement, occupational success, and social functioning. The World Health Organization (WHO) defines mental health as a state of complete physical, mental, and social well-being — not merely the absence of disease or infirmity. Globally, mental disorders are estimated to affect approximately 10–20% of children and adolescents, yet the vast majority of these young people receive no professional support (WHO, 2013). In India specifically, community-based studies report that psychiatric disorders affect approximately 12% of children aged 4–16 years, set against a landscape of profound mental health workforce deficits and treatment gaps exceeding 90% for common mental disorders (Khurana et al., 2016).

The school represents the most universal institutional contact point available to children during their developmental years. Unlike clinical services — which are accessed primarily after symptoms have become severe enough to prompt help-seeking — schools reach virtually all children across their most formative developmental years. This positioning makes the school uniquely capable of implementing early detection and prevention strategies that can intercept psychological difficulties before they consolidate into entrenched, disabling disorders. School mental health screening programs operationalize this capacity by creating systematic, structured processes for identifying children at risk, enabling early referral, intervention, and support.

Despite this potential, school-based mental health screening remains inconsistently implemented, poorly resourced, and inadequately evaluated — particularly in low- and middle-income countries such as India, where structural constraints intersect with cultural barriers to create significant implementation challenges. The integration of psychometrically validated screening tools within coherent school mental health frameworks is essential for realizing the preventive potential of school settings.

Bellowell Pvt. Ltd. is an Indian organisation involved in psychometric and student wellbeing assessment tools. The Manodarpan Mental Health Screening Test, developed by Bellowell Pvt. Ltd., is a structured, multi-domain mental health screening instrument designed for school students in India. This instrument evaluates mental health across four key causal environments: school-related factors, home-related factors, peer group-related factors, and individual/personal factors. The instrument generates domain-specific and overall mental health scores, categorizing students into seven levels of mental health functioning — from Extremely Good to Extremely Poor — intended to support identification of areas of concern for appropriate follow-up.

This multi-domain approach reflects the growing recognition that children's mental health cannot be understood through a single lens but must be assessed across the multiple ecological environments in which children develop. This multi-domain approach is consistent with Bronfenbrenner's ecological systems theory and with contemporary evidence on the determinants of childhood psychological well-being, which consistently identifies school climate, family dynamics, peer relationships, and individual psychological factors as the four most powerful proximal influences on child mental health.

The present narrative review aims to synthesize multidisciplinary evidence on the role of school mental health screening programs in early detection and prevention of psychological disorders among children, with particular focus on the Indian context and the contribution of contextually grounded assessment tools within this landscape.

II. METHODOLOGY

This paper adopts a comprehensive narrative review methodology to synthesize multidisciplinary evidence on school mental health screening programs, early detection of childhood psychological disorders, and the role of psychometric assessment tools in supporting student well-being. Unlike systematic reviews or meta-analyses, narrative reviews enable the integration of diverse evidence types — including quantitative studies, qualitative investigations, theoretical frameworks, policy documents, and assessment tool documentation — into a coherent conceptual account.

2.1 Search Strategy

Literature was identified through searches of the following databases: PsycINFO, PubMed/MEDLINE, ERIC (Education Resources Information Center), Google Scholar, and Scopus. The literature search strategy incorporated combinations of keywords such as school-based mental health, mental health assessment, psychological screening among children, early identification of childhood psychological disorders, preventive mental health approaches in schools, student wellbeing, psychometric assessment school, mental health scale students, and related terms. Searches were not restricted by publication year, with emphasis on empirical literature published from 1990 onward, and particular attention to Indian and South Asian research contexts. Additional targeted searches covered the impact of COVID-19 on child and adolescent mental health, digital and remote mental health screening, and implementation evidence relating to the National Education Policy (NEP) 2020. Approximately 80 sources were reviewed in total, of which approximately 35 are cited.

2.2 Inclusion and Exclusion Criteria

Sources were included if they directly addressed one or more focal constructs (school mental health screening, early detection of psychological disorders, preventive mental health, school-based interventions, psychometric assessment, child and adolescent mental health, or Indian mental health policy); were published in peer-reviewed journals, edited academic volumes, or official policy/institutional reports; and were available in English. Opinion pieces, non-peer-reviewed commentaries, and sources lacking sufficient methodological description were excluded unless they contributed theoretical frameworks of substantial scholarly significance.

2.3 Data Synthesis

Sources were reviewed and organized across six domains: (1) epidemiological burden of childhood psychological disorders; (2) theoretical frameworks for school-based mental health screening; (3) methodological considerations in screening program design and implementation; (4) multi-domain mental health screening instruments and their factor domains; (5) implementation challenges and facilitators in Indian school contexts; and (6) policy implications and future directions.

III. LITERATURE REVIEW

A growing body of evidence across child psychiatry, developmental psychology, educational research, and public health has consistently demonstrated both the high prevalence of mental health difficulties among school-age children and the considerable gap between need and available professional support.

3.1 Epidemiological Burden of Childhood Psychological Disorders

Mental health difficulties among children represent a public health challenge of significant and growing magnitude. The WHO Mental Health Action Plan 2013–2020 identified mental, neurological, and substance use disorders as accounting for 13% of the total global burden of disease, with the onset of approximately 50% of all lifetime mental disorders occurring before age 14 and 75% before age 24 (WHO, 2013). Globally, it is estimated that between 10% and 20% of children and adolescents experience mental health conditions, the majority of which remain undiagnosed and untreated (Kieling et al., 2011).

In India, the picture is particularly concerning. Khurana et al. (2016) report psychiatric disorder rates of approximately 12% among children aged 4–16 years, set against a backdrop of severe mental health workforce deficits: India has only 3,800 psychiatrists against a requirement of 11,500, and 898 clinical psychologists against a requirement of 17,250. These structural deficits produce treatment gaps exceeding 90% for common mental disorders.

The COVID-19 pandemic has substantially compounded the pre-existing burden of child and adolescent mental health difficulties. Creswell et al. (2021) documented significant increases in anxiety, depression, and behavioural difficulties among young people globally during pandemic-related school closures and social disruptions. In India, Sharma et al. (2021) found elevated rates of psychological distress among school-going children during the pandemic period. UNICEF (2021) warned that COVID-19 had created a global mental health emergency for children and adolescents, with school-based identification systems representing a critical recovery infrastructure.

3.2 School as a Mental Health Access Point

The school's potential as a mental health access point has been recognized across decades of research and policy. Atkins et al. (2005) demonstrated that school-based mental health service models could effectively increase access to services and improve academic and behavioural outcomes. Burns et al. (1995) documented that schools represent the single most common source of mental health services for children in the United States. In India, where clinical mental health services are densely concentrated in urban centres, the school's role as the primary mental health access point is even more pronounced.

3.3 Stigma, Awareness, and Barriers to Help-Seeking

Fear of stigmatization represents a particularly significant structural barrier to mental health help-seeking among school-age children and their families. Clement et al. (2015) conducted a systematic review of 144 studies on the impact of mental health stigma on help-seeking, finding that stigma-related barriers were among the most consistently reported obstacles to professional help-seeking across cultural contexts. In the Indian educational context, Khurana et al. (2016) note that the cultural norm of concealing psychological difficulties constitutes a particularly potent barrier to help-seeking. Systematic school-based screening programs have the potential to partially circumvent these barriers by normalizing psychological assessment as a routine component of student welfare.

IV. THEORETICAL FRAMEWORK

The present review is anchored in four synergistic theoretical frameworks that collectively elucidate the psychological, developmental, and ecological mechanisms through which school-based mental health screening programs can facilitate early detection and prevention of childhood psychological disorders.

4.1 Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner's (1979) ecological systems theory provides the overarching conceptual architecture for understanding childhood mental health as a product of nested environmental systems. The microsystem — comprising the family, school, peer group, and the child's own individual characteristics — constitutes the most proximal level of influence on child development and mental health. A well-designed multi-domain screening instrument operationalizes this theoretical insight through a four-domain structure, systematically assessing the mental health contributions of the school environment, the home environment, the peer group, and individual/personal factors.

4.2 Universal, Selected, and Indicated Prevention Framework

Gordon's (1983) prevention framework, as adapted for school mental health by Mrazek and Haggerty (1994), distinguishes three levels of preventive intervention: universal interventions directed at all children regardless of risk status; selected interventions targeting children identified as being at elevated risk; and indicated interventions targeting children already showing early signs of disorder. School-based screening programs function primarily at the interface of universal and selected levels: universal screening identifies all children across the full population, generating data that enables differentiated selected and indicated follow-up for those identified as at risk.

4.3 Social-Emotional Learning Framework

The CASEL Social-Emotional Learning (SEL) framework (Weissberg et al., 2015) delineates five interrelated competency domains — self-awareness, self-management, social awareness, relationship skills, and responsible decision-making — as essential for both academic success and psychological well-being. The integration of systematic mental health screening with SEL programming represents a comprehensive approach to school mental health promotion: screening identifies children whose mental health needs exceed what universal SEL programming can address, enabling targeted follow-up.

4.4 Trauma-Informed Care Framework

The trauma-informed care framework (SAMHSA, 2014) emphasizes the prevalence and impact of adverse childhood experiences (ACEs) on mental health, and the importance of creating service environments that recognize, respond to, and avoid re-traumatizing individuals with trauma histories. School mental health screening programs that incorporate this framework are designed not merely to identify symptoms but to understand the environmental contributors to distress — including the family environment and peer relationship factors that feature prominently in a comprehensive school mental health assessment.

V. SCHOOL MENTAL HEALTH SCREENING: DEFINITION, RATIONALE, AND EVIDENCE

5.1 Defining School Mental Health Screening

School mental health screening refers to the systematic, population-level use of standardized assessment tools to identify children who may be experiencing or at risk for psychological disorders, with the aim of facilitating early referral, intervention, and support. Effective screening programs employ psychometrically validated assessment instruments with established sensitivity and specificity; they are administered universally across entire school populations rather than relying on selective referral; they include clearly defined protocols for communicating results, making referrals, and connecting identified children with appropriate follow-up services; and they are embedded within coherent multi-tiered support frameworks (Glover & Albers, 2007).

Screening must be distinguished from diagnosis: screening identifies individuals who may warrant further assessment or support, generating flags for follow-up rather than clinical determinations. This distinction is critical both clinically and ethically, because the communication of screening results to children, families, and educators must be managed carefully to avoid stigmatization, misinterpretation, or inappropriate labelling.

5.2 Evidence for School-Based Screening Effectiveness

A substantial evidence base supports the effectiveness of school-based mental health screening programs in increasing access to mental health services, improving early identification of at-risk children, and producing positive downstream effects on academic

and psychological outcomes. Levitt et al. (2007) demonstrated that universal screening in school settings significantly increased the identification of students with internalizing disorders — such as anxiety and depression — who were previously unknown to school staff and receiving no support.

Dowdy et al. (2015) reviewed evidence for universal screening of social-emotional and behavioural problems in schools, concluding that systematic screening with validated instruments was significantly more accurate than teacher nominations alone in identifying students at risk. Research by Kearney and Graczyk (2014) demonstrated that school-based universal screening, when integrated within a multi-tiered system of support, produced measurable reductions in rates of school absenteeism, disciplinary incidents, and academic failure among identified students who received follow-up intervention.

5.3 Characteristics of Effective Screening Instruments

The effectiveness of any school mental health screening program is fundamentally dependent on the quality of the assessment instrument employed. Effective screening tools should demonstrate adequate internal consistency reliability (Cronbach's $\alpha \geq .70$ for subscales, $\geq .80$ for total scores); adequate test-retest reliability; established sensitivity and specificity relative to diagnostic gold standards; normative data derived from representative, age-stratified samples; brevity and ease of administration; and clear, interpretable score reporting that supports actionable decision-making by educators and counsellors (Glover & Albers, 2007; Gresham & Lambros, 1998).

5.4 Internationally Established Screening Tools: Contextual Comparison

Several internationally established screening instruments are widely used in school mental health contexts. The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997) is a brief 25-item behavioural screening questionnaire used across more than 40 countries. The Child Behaviour Checklist (CBCL; Achenbach & Rescorla, 2001) provides broad-band assessment of behavioural and emotional problems. The Behaviour Assessment System for Children (BASC; Reynolds & Kamphaus, 2004) offers a multi-informant, multi-scale approach. Contextually adapted instruments for Indian school settings may differ from these tools in their primary focus on ecological causal domains — particularly the structured differentiation of school-related, home-related, peer group-related, and individual causes.

VI. MULTI-DOMAIN MENTAL HEALTH SCREENING: PRINCIPLES AND FACTOR FRAMEWORK

6.1 School-Based Psychometric Assessment: Institutional Context

Indian organisations involved in psychometric and student wellbeing assessment have increasingly developed standardized instruments addressing aptitude, career interest, personality, emotional well-being, and mental health — forming integrated assessment frameworks for student evaluation. This integrative orientation is reflected in multi-domain mental health screening instruments that assess mental health functioning across four key dimensions in a child's life: the school environment, the home environment, the peer group, and individual/personal factors.

6.2 Overview of the Multi-Domain Mental Health Screening Instrument

A multi-domain mental health screening instrument is a structured assessment tool designed to evaluate the mental well-being of school students by examining the influence of four key causal environments: school-related causes, home-related causes, peer group-related causes, and individual/personal causes. Such an instrument provides a comprehensive picture of how these four domains collectively and individually impact a student's mental health, generating both domain-specific scores and an overall mental health score.

Based on total and individual domain scores, a well-designed screening scale categorizes students into seven levels of mental health functioning, ranging from Extremely Good to Extremely Poor. This seven-category classification system enables educators, psychologists, and caregivers to identify specific areas of concern with sufficient granularity to support differentiated intervention planning — distinguishing between students whose mental health difficulties are primarily school-related, home-related, peer group-related, or individual/personal in nature, and tailoring support accordingly.

6.3 Factor Domains of the Multi-Domain Screening Instrument

The multi-domain mental health screening instrument is organized around four primary factor domains, each reflecting a distinct dimension with well-established implications for child mental health. Together, these four domains operationalize an ecologically grounded model of childhood psychological functioning consistent with Bronfenbrenner's ecological systems theory.

6.3.1 School-Related Causes

The school-related domain assesses the mental health consequences of conditions and experiences within the school environment. Research consistently identifies the school climate — including the quality of teacher-student relationships, the prevalence of academic pressure and examination anxiety, the presence or absence of bullying and peer victimization, and the ethos of inclusion and belonging — as a primary determinant of child mental health (Roeser et al., 2000; Suldo et al., 2009). Khurana et al. (2016) document that in India, academic pressure associated with board examinations has been directly linked to elevated rates of anxiety, emotional burnout, and self-harm among adolescents.

6.3.2 Home-Related Causes

The home-related domain assesses the mental health consequences of conditions and experiences within the family environment. The quality of the home environment — including the warmth and responsiveness of parental relationships, the presence of family conflict or adversity, parental mental health, socioeconomic stress, and parental involvement in education — has profound effects on child psychological well-being (Repetti et al., 2002; Goodman et al., 2011). Research has documented that parental pressure regarding academic performance significantly predicts anxiety and depression among Indian school students (Sinha & Sharma, 2014).

6.3.3 Peer Group-Related Causes

The peer group-related domain assesses the mental health consequences of children's experiences within their peer relationships. The quality of peer experiences — including the degree of social inclusion and acceptance, the presence or absence of bullying and victimization, the quality of friendship relationships, and social comparison processes — has well-documented effects on child mental health (Hawker & Boulton, 2000; Nolen-Hoeksema & Girgus, 1994). Peer victimization is among the strongest predictors of both internalizing and externalizing mental health difficulties in childhood and adolescence.

6.3.4 Individual/Personal Causes

The individual/personal domain assesses mental health factors intrinsic to the student themselves — including self-esteem, emotional regulation capacity, resilience, sense of personal efficacy, and dispositional tendencies toward anxiety or depression. A growing body of research underscores the importance of individual psychological characteristics in moderating children's responses to environmental stressors (Compas et al., 2001; Luthar et al., 2000). Students who score poorly on this domain may benefit from individual counselling focused on building psychological resilience, emotional regulation skills, and positive self-concept.

6.4 The Seven-Level Classification System

A distinctive feature of a comprehensive multi-domain screening instrument is its seven-level classification system, which categorizes students' overall mental health functioning across a spectrum from Extremely Good to Extremely Poor. Students classified in the Extremely Good and Good categories may be recognized and affirmed for their mental health strengths. Students in the Average range may benefit from selected-level interventions. Students in the Poor and Extremely Poor categories warrant indicated-level intervention — including individual counselling referral, family engagement, and, where appropriate, specialist clinical assessment.

VII. IMPLEMENTATION OF MENTAL HEALTH SCREENING IN INDIAN SCHOOLS: CHALLENGES AND FACILITATORS

7.1 Structural Challenges

The implementation of systematic mental health screening programs in Indian schools faces significant structural challenges. Chief among these is the severe shortage of trained mental health professionals available to conduct, interpret, and follow up on screening assessments. As Khurana et al. (2016) document, India has a psychiatrist-to-population ratio of approximately 0.3 per 100,000 — making the prospect of individualized professional screening for all school students unrealistic within current resource constraints. Additional structural challenges include large class sizes, heterogeneous student populations with varying literacy and language proficiency, inadequate physical infrastructure for confidential assessment, and limited information technology resources in government school settings.

7.2 Cultural and Attitudinal Barriers

Cultural barriers to mental health screening in Indian schools include the pervasive stigma associated with mental illness, the tendency to attribute psychological difficulties to moral weakness or family failing, and the reluctance of families to consent to screening that might result in their child being labelled as mentally unwell. Khurana et al. (2016) note that India's treatment gap reflects in significant part the cultural prioritization of concealment over help-seeking. Effective implementation must therefore include substantial community engagement, stigma-reduction programming, and transparent communication with families about the purpose, process, and limitations of screening.

7.3 Facilitators of Effective Implementation

Despite these challenges, several factors facilitate the effective implementation of school mental health screening in Indian contexts. Strong leadership commitment from school principals and district education officers has consistently been identified as the most important organizational facilitator of successful screening program implementation (Stephan et al., 2007). Teacher engagement and buy-in — achieved through professional development and clear communication — is similarly critical. The availability of contextually appropriate, psychometrically validated screening instruments is a fundamental prerequisite for effective implementation.

VIII. MENTAL HEALTH SCREENING AND THE INDIAN POLICY CONTEXT

8.1 National Mental Health Programme

The National Mental Health Programme (NMHP), launched in India in 1982, established the foundational framework for national mental health policy. Its core objectives include ensuring the availability and accessibility of mental healthcare for all, encouraging the application of mental health knowledge in general healthcare and social development, and promoting community participation in mental health service development (Khurana et al., 2016). Despite these objectives, the NMHP's implementation has been hampered by chronic underinvestment, administrative fragmentation, and a historic overemphasis on curative rather than preventive and promotive components.

8.2 National Education Policy 2020 and Student Well-Being

The National Education Policy (NEP) 2020 represents a landmark shift in Indian educational policy, explicitly recognizing the importance of student psychological well-being and social-emotional development alongside academic achievement. The NEP 2020 mandates the development of school counselling services, emphasizes the importance of creating safe and supportive learning environments, and calls for the integration of well-being assessment and support within the school curriculum. These policy mandates create a significant enabling environment for the systematic implementation of school mental health screening programs.

IX. SYNTHESIS: AN INTEGRATED MODEL

The evidence reviewed across Sections III through VIII supports an integrated understanding of the pathways through which school mental health screening programs — and multi-domain assessment tools — can facilitate early detection and prevention of psychological disorders among children. Table 1 presents a schematic summary of key domains, mechanisms, and intervention points.

Table 1: Integrated Model — Key Domains, Mechanisms, and Intervention Points

Domain	Core Mechanisms	Psychological Impact	Evidence Base
Childhood Mental Health Burden	High prevalence, early onset, unmet need	Academic, social, and developmental impairment	WHO (2013); Khurana et al. (2016)
School-Related Factors (Domain 1)	Academic pressure, teacher relationships, school climate, bullying	Anxiety, depression, school avoidance	Roeser et al. (2000); Sinha & Sharma (2014)

Home-Related Factors (Domain 2)	Parental expectations, family conflict, parental mental health	Emotional distress, low self-esteem, behavioural difficulties	Repetti et al. (2002); Goodman et al. (2011)
Peer Group-Related Factors (Domain 3)	Bullying, victimization, social exclusion, peer comparison	Internalizing and externalizing disorders, social withdrawal	Hawker & Boulton (2000); Nolen-Hoeksema & Girgus (1994)
Individual/Personal Factors (Domain 4)	Self-esteem, emotional regulation, resilience, personal coping	Low self-worth, emotional dysregulation, vulnerability to stress	Compas et al. (2001); Luthar et al. (2000)
Screening Access	Stigma, structural barriers, workforce deficit	Delayed identification, untreated distress	Clement et al. (2015); Khurana et al. (2016)
Policy/System Gap	Underinvestment, manpower deficit, treatment gap >90%	Unmet population-level need	WHO (2013); NEP (2020)

The integrated model reveals that childhood mental health does not arise from a single domain but from the cumulative and interactive effects of school-related, home-related, peer group-related, and individual/personal factors — precisely the four domains assessed by a comprehensive multi-domain mental health screening instrument. Three leverage points emerge from the evidence as most amenable to intervention: (a) universal, multi-domain psychological screening of all school students using validated instruments; (b) differentiated follow-up and support provision calibrated to students' identified level of need; and (c) systemic investment in school counsellor training, deployment, and supervision.

X. IMPLICATIONS FOR PRACTICE AND POLICY

10.1 For Schools and Educators

Schools should implement universal mental health screening using psychometrically validated multi-domain instruments from early secondary school (Class 6 or equivalent), assessing all four causal domains — school, home, peer group, and individual/personal — rather than waiting for students to present in visible crisis. Teachers should be trained to recognize early signs of mental health difficulties and to make warm, non-stigmatizing referrals to school counsellors. Multi-domain screening should be integrated within a broader multi-tiered system of support, ensuring that universal, selected, and indicated levels of intervention are available to respond to the full range of student mental health needs identified through screening.

10.2 For Counsellors and Mental Health Professionals

School counsellors should use multi-domain mental health screening instruments as a standardized component of routine student assessment, complementing clinical judgment with validated psychometric data. An integrated assessment approach — combining mental health screening findings with aptitude, personality, emotional well-being, and career interest data — should be used to develop comprehensive student profiles that inform holistic, individualized support planning. Counsellors should also engage in proactive stigma-reduction outreach to students, families, and teachers, framing mental health screening as a positive component of student welfare.

10.3 For Policymakers

National and state education policymakers should mandate the systematic implementation of validated mental health screening programs in all government and private schools, establishing minimum standards for screening frequency, instrument quality, follow-up protocols, and counsellor availability. Expanded investment in school counsellor training and deployment should be established as a national priority. The National Council of Educational Research and Training (NCERT) should develop national guidelines for school mental health screening. Policy incentives should be created for psychometric assessment developers to continue developing, validating, and updating culturally appropriate screening instruments for Indian children.

10.4 Ethical Considerations in School Mental Health Screening

The implementation of school mental health screening programs raises important ethical considerations. Regarding informed consent, ethical screening practice requires that both parental/guardian consent and, where developmentally appropriate, child assent be obtained prior to any mental health assessment. Regarding confidentiality, mental health screening data must be managed with strict confidentiality protocols. All screening instruments carry an inherent risk of false positive identifications; screening results must therefore be clearly communicated as indicative rather than diagnostic, and all positive screening identifications should be followed by formal clinical or professional assessment before intervention planning proceeds (Glover & Albers, 2007).

XI. LIMITATIONS OF THE REVIEW

Several limitations of the present review should be acknowledged. First, as a narrative review, it is not immune to selection bias. A systematic review or meta-analysis would provide more rigorous evidence synthesis for specific research questions within this domain. Second, the empirical literature reviewed is drawn predominantly from Western educational contexts — particularly the United States, the United Kingdom, and Australia — and findings may not generalize without qualification to the Indian educational system. Third, the review does not systematically address potential moderating variables such as gender, socioeconomic status, urban versus rural location, school type (government versus private), or grade level. Fourth, where contextually grounded screening instruments are described in this review, such descriptions are based primarily on available institutional documentation and conceptual descriptions, pending independent large-scale psychometric validation studies.

XII. CONCLUSION

This review has synthesized evidence across multiple interconnected domains — the epidemiological burden of childhood psychological disorders, theoretical frameworks for school-based screening, evidence on screening program effectiveness, the Manodarpan Mental Health Screening Test and its factor domains, and implementation challenges in the Indian context — to construct an integrated picture of how school mental health screening programs can support early detection and prevention of psychological disorders among children.

The central finding is clear: childhood psychological disorders are prevalent, have early onset, and remain vastly undertreated — particularly in India, where structural workforce deficits and cultural stigma combine to create treatment gaps exceeding 90%.

Schools represent the most universal institutional contact point available to children and are uniquely positioned to implement systematic, non-stigmatizing identification pathways. School mental health screening programs, when implemented with psychometrically validated instruments and embedded within coherent multi-tiered support frameworks, have demonstrated meaningful capacity to increase the identification of at-risk children, improve access to services, and produce positive downstream effects on academic and psychological outcomes.

The Manodarpan Mental Health Screening Test, developed by Bellowell Pvt. Ltd., is a potentially useful screening instrument in this landscape — providing a contextually grounded, multi-domain tool intended to assess key dimensions shaping child mental health: the school environment, the home environment, the peer group, and the individual/personal domain. What is required is not new knowledge but institutional will: the commitment to treat child mental health as a genuine educational priority, and to invest in the screening infrastructure, trained workforce, and evidence-based assessment tools needed to realize that commitment in every school in India.

XIII. FUTURE RESEARCH DIRECTIONS

The present review identifies several priority areas for future research. First, there is a pressing need for large-scale, longitudinal studies tracking the mental health trajectories of Indian school students using validated multi-domain assessment instruments across multiple time points. Second, independent psychometric validation studies of multi-domain mental health screening instruments developed for Indian school settings — including normative data derived from representative Indian samples, confirmatory factor analysis, and criterion validity studies — would substantially strengthen the evidence base. Third, rigorous evaluation of school mental health screening programs implemented in diverse Indian school contexts is needed. Fourth, research on the cost-effectiveness of school mental health screening within Indian resource constraints would provide important policy evidence. Finally, the emerging intersection of digital technology and school mental health screening warrants dedicated investigation in Indian contexts.

CONFLICT OF INTEREST DECLARATION

The author declares no conflict of interest in relation to the instruments discussed in this review. Every effort has been made to present all assessment tools in a balanced and academically neutral manner, acknowledging both their potential utility and the limitations of the currently available evidence base.

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