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School Counselling and Referral Pathways for Adolescent Substance Use in Rural Darjeeling

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ABSTRACT

Adolescent substance use in rural schooling contexts is shaped not only by individual risk factors but also by the capacity of schools and local systems to deliver timely counselling and referral-linked rehabilitation. This article develops an implementation-focused analysis of the effectiveness of school-based counselling combined with structured referral pathways in rural upper-primary and secondary schools in Darjeeling District across 2019-2024. Using a qualitative case study logic with mixed-methods options, the paper links effectiveness to three governance and implementation determinants: (i) multi-level coordination (district, block, school) across education, health, and social welfare; (ii) institutional capacity (human resources, training, infrastructure, privacy, specialist support, and transport); and (iii) street-level discretion exercised by teachers and school leaders under conditions of resource scarcity and stigma. The analysis is grounded in rights-based inclusive education mandates (RPwD Act 2016, Section 16; UNCRPD, Article 24) and policy commitments to counselling and school health supports in national education and health programming, including the School Health Programme under Ayushman Bharat which explicitly recognizes substance abuse and psychosocial concerns as emerging priorities for school health action. The paper offers an evidence-informed thematic framework for evaluating implementation and outcomes (screening, counselling uptake, referral completion, and self-reported reduction), and presents practical recommendations for strengthening referral governance, safeguarding confidentiality, and building rural institutional capacity. It contributes a rural governance and discretion lens to school-based substance use interventions within inclusive education systems.

Keywords- school counselling, adolescent substance use, referral pathways, rural schools, inclusive education policy, street-level bureaucracy, implementation capacity.

I. INTRODUCTION

Substance use during adolescence is a major public health and educational concern because it intersects with school attendance, learning outcomes, psychosocial wellbeing, and protection risks. Schools are also one of the few universal platforms capable of reaching adolescents early, including those who may not access formal health services. However, the effectiveness of school-based responses depends less on the existence of policy mandates and more on how implementation works in practice: who does what, with what capacity, under what constraints, and how discretion is used at the school level.

The 2019 national evidence base in India highlighted that alcohol, cannabis, opioids, and inhalants are used across age groups, and that treatment access is limited: a press release summarizing the national survey reported that only about 1 in 38 people with alcohol dependence reported getting any treatment, and that inhalant use prevalence among children and adolescents exceeded adults. This matters for rural school systems, where stigma, limited specialist services, and transport barriers can further reduce the probability that an adolescent will move from identification to effective help.

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This article focuses on the effectiveness of school-based counselling combined with referral-linked rehabilitation pathways in rural schools in Darjeeling District during 2019-2024. The period is analytically important for three reasons. First, it spans the consolidation of school health initiatives and inclusive education commitments. Second, it covers the COVID-19 disruption and the subsequent recovery phase, during which psychosocial needs and risk behaviors often increased while service access weakened. Third, it captures an implementation reality: rural schools operate within multi-grade classrooms, infrastructure gaps, limited privacy for counselling, and constrained specialist support, all of which influence whether counselling and referrals can meaningfully reduce substance use.

The paper is intentionally implementation-centered. Rather than treating effectiveness as only an individual-level outcome, it defines effectiveness as a chain of linked conditions: (i) credible identification and engagement, (ii) accessible, acceptable counselling, (iii) reliable and safe referral completion, and (iv) sustained follow-up in school and community. This aligns with policy implementation theory and street-level bureaucracy, which explain why formal mandates often diverge from everyday practice when front-line actors must improvise under constraints (Lipsky, 1980).

II. POLICY AND THEORETICAL FRAMEWORK

2.1 Rights-based inclusive education and supportive services

The Rights of Persons with Disabilities Act, 2016 places duties on governments and recognized educational institutions to provide inclusive education and related supports. Section 16 requires governments and local authorities to endeavor that funded or recognized educational institutions provide inclusive education and includes duties such as enabling participation and monitoring progress. Section 17 further lists system measures, including teacher training, resource centers, and support services that enable inclusion.

The UN Convention on the Rights of Persons with Disabilities (UNCRPD), Article 24 recognizes the right to education and commits States Parties to an inclusive education system at all levels and lifelong learning, including supports needed to facilitate effective education. Although adolescent substance use is not automatically framed as disability, school-based counselling and referral-linked rehabilitation intersect with inclusive education in two practical ways:

- Comorbidity and psychosocial needs: some adolescents who use substances also experience mental health conditions or psychosocial distress that create learning barriers and require support.
- Non-discrimination and support: inclusive education systems are expected to provide enabling supports and safe learning environments for learners facing participation barriers, which in rural contexts often includes psychosocial support and referral linkages.

A useful operational bridge is the national school health architecture. The Operational Guidelines for the School Health Programme under Ayushman Bharat explicitly note an increased focus on emerging social morbidities including substance abuse and psychological and emotional disorders, delivered via trained teachers as Health and Wellness Ambassadors with inter-ministerial coordination. This provides a policy-aligned platform for school-based prevention, early identification, and referral.

2.2 Policy implementation theory: governance, capacity, and coordination

Policy implementation theory explains why outcomes depend on governance arrangements, coordination costs, and capacity constraints. Classic implementation work emphasizes that policy success requires multiple aligned decisions across levels and agencies, and that implementation failure can occur at any link in the chain (Pressman & Wildavsky, 1973). In rural districts, the number of clearance points increases: school staff, block offices, district education administration, health services, police/community actors, and rehabilitation providers.

To analyze implementation, this paper uses three linked constructs:

- Governance arrangements: role clarity, interdepartmental coordination, accountability, and information flows (district, block, school).
- Institutional capacity: human resources, training, infrastructure, privacy, transport, referral partners, and monitoring systems.
- Discretion: decisions by teachers and school leaders about who to identify, what to document, how to counsel, whether to refer, and how to follow up.

2.3 Street-level bureaucracy and discretion under constraints

Street-level bureaucracy theory focuses on front-line public workers (including teachers) who interact with clients (students) and exercise discretion due to limited resources and ambiguous goals (Lipsky, 1980; Lipsky, 1969). In the context of adolescent substance use:

- Teachers and head teachers decide whether to treat substance use as a discipline issue, a health issue, or a child protection issue.
- Discretion shapes confidentiality: whether a student is referred, whether parents are contacted, and how records are kept.
- Workload and resource constraints can lead to coping behaviors such as rationing counselling time, informal referrals, or avoidance of cases perceived as risky.

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III. REVIEW OF RELATED LITERATURE

3.1 School-based interventions for adolescent substance use

Evidence indicates that schools can play a protective role by delivering evidence-based prevention and early intervention programs, especially those that develop social competence and refusal skills and address normative beliefs (Griffin &Botvin, 2010). However, prevention-only approaches are insufficient when adolescents are already using substances; early identification and brief interventions plus referral are needed.

School-based brief interventions (often motivational interviewing-based) have been studied in high school settings, with reviews highlighting their potential to reduce use and related risk behaviors for some adolescents, while noting heterogeneity and implementation challenges (e.g., Patton et al., Cochrane-style review). The mechanism is typically a structured, time-limited counselling approach that increases motivation, teaches skills, and supports referral when risk is higher.

3.2 Indian and sub-national evidence on adolescent substance use

Studies from India show non-trivial prevalence among school students and highlight drivers such as easy availability, tension relief, peer influence, and the gap between knowledge and behavior (e.g., West Bengal high school survey findings). Recent nationwide evidence on school-going adolescents (published 2025) further supports the need for school-linked responses and underscores early initiation risks (Dhawan et al., 2025).

At the national population level, the 2019 survey summary indicates substantial numbers needing help for alcohol and opioid use disorders, and emphasizes limited treatment access. For rural districts, this implies that referral-linked pathways must address both service availability and the practical costs of reaching care.

3.3 School mental health and implementation in India

School mental health programs in India face barriers such as limited trained personnel, unclear role definitions, inconsistent monitoring, and uneven convergence between education and health sectors (Raman et al., 2023). Implementation reviews of adolescent and school health programs in India similarly stress planning and monitoring gaps and the complexity of multi-sector coordination (Jain et al., 2022).

This matters because school-based counselling for substance use requires similar system conditions: training, supervision, confidentiality, referral partners, and follow-up mechanisms.

3.4 Inclusive education governance and support services

Inclusive education under Samagra Shiksha is designed to provide support services including guidance and counselling and convergence with line departments. This provides an enabling policy logic for embedding counselling and referral pathways in schools, but the practical question is whether rural governance and capacity make that feasible.

IV. RESEARCH METHODOLOGY

4.1 Research design

A qualitative case study with mixed-methods options is appropriate to evaluate how counselling and referral-linked rehabilitation work in rural schools and why effectiveness varies. Two feasible designs are:

Option A: Mixed-methods, sequential explanatory

- Quantitative: program monitoring data and student screening/counselling/referral records (de-identified), plus pre-post self-report screening (e.g., CRAFFT) and school attendance/discipline indicators.
- Qualitative: interviews, observations, and audits to explain variation in uptake and outcomes.

Option B: Qualitative case study (implementation effectiveness focus)

- Primary emphasis on governance, capacity, and discretion, using interviews, observations, facility audits, and document review.
- Outcome evidence treated as triangulated indicators (e.g., referral completion rates reported by schools/partners; perceived change narratives).

Because this draft is meant to be adapted to your available data and approvals, the remainder specifies a robust mixed-methods approach that can be scaled up or down.

4.2 Study setting and sampling

Setting: Rural upper-primary and secondary schools in selected blocks of Darjeeling District.

Sampling (illustrative template; replace with your final sample):

- Schools: purposive sample of 10-15 rural schools to capture variation in size, distance to health facilities, and staffing.
- Participants:
    - Teachers (including designated counsellors/Health and Wellness Ambassadors where applicable)
    - Head teachers/school leaders
    - Parents/guardians
    - Block Resource Centre and district officials (education, health, social welfare)

- Referral partners (primary health centers, district hospital/de-addiction services, NGOs)

Sampling logic:

- Maximum variation sampling to capture differences in capacity and referral access.
- Inclusion of both implementing and less-implementing schools to analyze discretion and constraints.

4.3 Data sources

Primary qualitative:

- Semi-structured interviews (45-90 minutes)
- Focus groups (parents, teachers) where safe and appropriate
- Classroom and school climate observations (non-intrusive)
- Counselling process observations (only with strict consent and safeguarding; otherwise simulated role-play observations with staff)

Facility and accessibility audits:

- Private space availability, basic accessibility, sanitation, safe storage for records, and transport connectivity.

Documents:

- District and block circulars, school-level registers, training materials, referral MoUs, child protection guidelines, and relevant scheme documents.

Quantitative (if available and ethically permitted):

- De-identified counselling registers: number of sessions, themes, follow-up
- Referral logs: referral initiation, completion, and feedback loop
- Student screening tool (CRAFFT or similar) administered confidentially with safeguards
- Attendance, dropout risk indicators, and disciplinary incident logs

4.4 Measures and instruments

- Substance use risk screening: CRAFFT is widely used for ages 12-21 and supports brief intervention triage (Knight et al., 1999; Bernard et al., 2005).
- Implementation indicators:
  - Coverage: proportion of target grades reached by awareness sessions and screening
  - Uptake: counselling sessions initiated per identified student
  - Referral completion: proportion completing at least one referral visit
  - Follow-up: school contact after referral and adherence supports
- Context indicators:
  - Staff workload, training exposure, supervision access
  - Distance/time to referral services, transport availability
  - Presence of local NGOs or youth programs

4.5 Data analysis

Qualitative:

- Thematic analysis (Braun & Clarke, 2006) with a coding framework aligned to governance, capacity, and discretion.
- Recommended coding families:
  - Governance: role clarity, coordination routines, accountability, data flow
  - Capacity: staffing, training, infrastructure/privacy, referral partners, transport
  - Discretion: identification decisions, confidentiality practices, parent engagement, discipline vs support framing
  - Stigma and community norms: gendered expectations, fear of labeling, community surveillance

Quantitative:

- Descriptive statistics for trends across 2019-2024 (screening coverage, counselling uptake, referral completion).
- Pre-post comparisons for screened students (where ethically permissible), with sensitivity analyses for missing follow-up.
- Integrate with qualitative findings using joint displays (Creswell & Plano Clark, 2018).

4.6 Ethics and safeguarding

Work with minors requires strong safeguards:

- Institutional ethics approval and permissions from education authorities.
- Informed assent from students and consent from parents/guardians, with additional protections where disclosure may increase harm.
- Strict confidentiality, secure data storage, and clear limits of confidentiality (risk of harm to self/others).
- Referral pathways for high-risk cases (including self-harm risk, violence, or severe dependence).
- Do-no-harm protocols to avoid stigmatization or punitive consequences.

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V. FINDINGS AND ANALYSIS

Important note for use: The themes below are written as an evidence-informed analytic template that should be validated and illustrated using your actual transcripts, observations, and records. Replace any bracketed examples with your own data.

5.1 Governance arrangements: how coordination shapes effectiveness

Theme 1: Fragmented mandates and unclear ownership

Rural schools often operate under multiple overlapping mandates (education quality, child protection, school health, inclusive education), but substance use counselling falls between departments. Where district-level coordination is weak, schools interpret substance use primarily as discipline. This reduces early help-seeking and undermines counselling uptake.

Mechanism:

- When schools lack a formal referral protocol, staff avoid documenting cases to prevent reputational risk.
- Students perceive counselling as surveillance rather than support, reducing disclosure.

Illustrative quote (replace with verbatim):

- "If we write the case, tomorrow it becomes a police matter. Better we handle quietly." [Teacher]

Theme 2: Coordination routines matter more than committees

District and block-level committees may exist, but effectiveness depends on routine coordination: a named focal person, a predictable referral channel, and a feedback loop. Without feedback from referral partners, schools cannot support continuity of care, and students often drop out after the first referral visit.

This aligns with implementation theory: when the chain of decisions and actions is long, slippage occurs at each link unless coordination reduces transaction costs (Pressman & Wildavsky, 1973).

Theme 3: Data flows and accountability are weak at the last mile

Even when policies emphasize monitoring and supportive services, school-level reporting may be inconsistent due to:

- Lack of simple tools (forms, registers, confidentiality protocols)
- Fear of blame or inspection
- Limited digital connectivity

A rights-based frame (inclusive education and non-discrimination) requires monitoring of participation and progress, but practice often focuses on compliance rather than learning from data.

Governance implication:

- Effectiveness improves when accountability is oriented toward problem-solving (supportive supervision) rather than punitive inspection.

5.2 Capacity constraints: the practical limits of rural implementation

Theme 1: Human resource gaps and role overload

Most rural schools do not have dedicated counsellors. Teachers tasked with counselling often have full teaching loads, administrative duties, and multi-grade responsibilities. This leads to rationing: only the most visible or disruptive cases receive attention, while quiet users remain invisible.

Teacher-delivered mental health work can be effective in some contexts but requires training, supervision, and realistic workload expectations (Lawson et al., 2025). In India, reviews highlight persistent capacity constraints and uneven program coverage (Raman et al., 2023).

Theme 2: Training is episodic; supervision is rare

One-off trainings do not produce sustained counselling quality. Rural staff reported needing:

- Refresher training
- Case consultation support
- Clear referral criteria
- Scripts for difficult conversations with parents

The School Health Programme under Ayushman Bharat envisions trained teachers as Health and Wellness Ambassadors and explicitly recognizes substance abuse as an emerging priority, but translation into rural practice depends on training quality and follow-up.

Theme 3: Infrastructure and privacy determine disclosure

Counselling requires privacy. Many rural schools lack a confidential room. Students fear being seen entering a "counselling space," especially in small communities where teachers know families personally. This undermines disclosure and makes counselling sessions superficial.

Capacity implication:

- A minimal viable counselling infrastructure includes a private corner, scheduled times, and record storage with restricted access.

Theme 4: Referral access is constrained by distance, transport, and stigma

Even if a referral is written, completion is hindered by:

- Travel cost and time to reach services
- Parents unwilling to accompany due to stigma
- Lack of adolescent-friendly services
- Fear of punitive consequences

National evidence on limited treatment access reinforces the need to strengthen referral completion mechanisms (e.g., one in 38 treatment access figure for alcohol dependence).

5.3 Teacher and school-level discretion: street-level choices that shape inclusion and care

Theme 1: Framing choices: discipline, morality, or support

Teachers choose frames:

- Discipline frame: "misconduct" leading to punishment and exclusion.
- Moral frame: "bad habits" leading to shame-based messaging.
- Support frame: "health and wellbeing" leading to counselling and referral.

Street-level bureaucracy theory predicts such variation under ambiguity and scarcity, with discretion serving as a coping mechanism (Lipsky, 1980).

Effect on outcomes:

- The support frame increases trust, disclosure, and follow-up.
- The discipline frame increases concealment and dropout risk.

Theme 2: Gatekeeping and selective visibility

Teachers may unintentionally prioritize cases that are disruptive, male, or publicly visible, while overlooking:

- Girls (higher stigma and concealment)
- Quiet or high-performing students
- Students using substances at home rather than on school grounds

This produces inequitable access to counselling, creating an implementation gap between rights-based inclusion norms and everyday practice.

Theme 3: Confidentiality dilemmas and parent engagement

In rural contexts, confidentiality is hard because:

- Teachers know families
- Parents demand to know details
- Teachers fear liability if they do not inform guardians

Discretion appears in how staff balance confidentiality against perceived safety. The result can be either over-disclosure (deterring students) or under-disclosure (missing safeguards). Effective implementation requires clear protocols, not individual improvisation.

Theme 4: Referral discretion and informal pathways

Where formal rehabilitation services are scarce or stigmatized, schools may rely on informal referrals (local NGOs, religious leaders, community elders). These can increase reach but may reduce quality and rights protections if not regulated. Samagra Shiksha emphasizes convergence with line departments and support services, which can be used to formalize safe referral networks.

VI. DISCUSSION

This analysis suggests that the effectiveness of school-based counselling and referral-linked rehabilitation in rural Darjeeling is not a single intervention effect but a system effect produced by governance, capacity, and discretion.

First, governance determines whether counselling and referral are normalized as legitimate school functions. Where district and block governance provide a named focal person, clear protocols, and feedback loops with health and rehabilitation services, counselling becomes more consistent and less punitive. Where governance is fragmented, schools tend to treat substance use as a discipline issue, undermining early engagement.

Second, capacity constraints create predictable failure points: lack of time, lack of privacy, limited training, and weak supervision. These constraints are well-documented in broader school mental health implementation in India and LMIC contexts and are likely to be amplified in rural areas (Raman et al., 2023; Grande et al., 2023).

Third, discretion is the bridge between policy and practice. Teachers and school leaders decide how to interpret a case, which students receive support, and whether referrals are pursued. Street-level bureaucracy theory explains why discretion becomes a form of rationing and risk management under constraints, and why policy compliance alone does not guarantee effective support.

The rights-based policy framework strengthens the normative claim: schools should be enabling environments with appropriate supports and non-discriminatory practices. However, rights language must be operationalized through

implementable routines (protocols, training, supervision, and referral access). The School Health Programme under Ayushman Bharat provides a credible platform for integrating substance abuse concerns into school health action, but rural implementation requires explicit design for privacy, stigma reduction, and referral completion.

VII. POLICY IMPLICATIONS AND RECOMMENDATIONS

Recommendations are organized by system level to match the governance chain.

7.1 District level

Establish a District School Counselling and Referral Cell

- Members: education, health (including adolescent health), social welfare, and child protection representatives.
- Deliverables: referral directory, MoUs with providers, standard operating procedures (SOPs), and a supervision calendar.

Build an adolescent-friendly referral network

- Map public facilities (PHC, CHC, district hospital, de-addiction services) and vetted NGOs.
- Set service standards: confidentiality, non-punitive approach, follow-up feedback to schools (with consent).

Monitoring focused on learning, not punishment

- Track implementation indicators: coverage, counselling uptake, referral completion, follow-up.
- Use supportive supervision visits rather than inspection-only logic.

7.2 Block level

Block-level case consultation support

- Monthly case consultation sessions for designated school focal teachers.
- Remote support options where travel is difficult.

Transport and access supports

- Coordinate with local bodies to enable travel vouchers or escorted visits for high-risk cases, minimizing dropout.

7.3 School level

Minimal viable counselling infrastructure

- Private space (even if shared), scheduled hours, safe record storage.
- Confidentiality protocol with clearly communicated limits.

Clear triage and referral protocol (example)

- Step 1: Low-risk: brief counselling and classroom-level prevention support.
- Step 2: Moderate-risk: structured counselling plan and parent engagement.
- Step 3: High-risk: immediate referral plus safeguarding plan.

Reduce stigma through whole-school culture

- Integrate life skills and wellbeing education.
- Use non-moralizing language and peer support carefully, avoiding public labeling.

Teacher capacity building

- Skills: motivational interviewing basics, trauma-informed communication, confidentiality, and referral navigation.
- Refresher training plus supervision is essential.

7.4 Cross-cutting: align inclusive education and school health

Integrate counselling and referral into inclusive education support services

- Use convergence logic and support services orientation already present in inclusive education programming, while ensuring that substance-use responses are non-discriminatory and safeguarding-centered.

VIII. CONTRIBUTION TO KNOWLEDGE

This article contributes to inclusive education and policy implementation literature in four ways:

1. It reframes "effectiveness" for rural school-based substance use interventions as an implementation chain, not only an individual outcome.
2. It integrates a rights-based inclusive education framework with school health policy to justify counselling and referral as enabling supports within education systems.
3. It applies street-level bureaucracy theory to explain why teacher and school leader discretion is a central determinant of equitable access to counselling and referral.
4. It offers a practical governance-capacity-discretion analytic framework that can be used to design evaluations and strengthen district-level implementation in rural contexts.

IX. LIMITATIONS OF THE STUDY

- If the study relies primarily on qualitative data, outcome attribution (substance use reduction) may be indirect and mediated through self-report and perceived change narratives.
- Selection bias may occur if schools with stronger leadership or external NGO presence are more likely to participate.
- Social desirability bias is likely in adolescent self-reports, particularly where confidentiality is not fully trusted.
- Referral data may be incomplete if services do not provide feedback or if families seek informal care.

X. CONCLUSION

Reducing adolescent substance use through schools is feasible but not automatic. In rural Darjeeling, the effectiveness of school-based counselling and referral-linked rehabilitation depends on whether governance arrangements create functional coordination, whether institutional capacity makes confidential counselling and realistic referrals possible, and whether teacher and school leader discretion is guided by supportive protocols rather than discipline-driven improvisation. Rights-based inclusive education mandates and national school health guidance provide a strong policy foundation, including explicit recognition of substance abuse and psychosocial concerns in school health programming. The implementation challenge is to convert these mandates into reliable last-mile routines: trained staff, private spaces, safe documentation, adolescent-friendly referral partners, and non-punitive accountability. Strengthening these conditions is likely to increase disclosure, counselling uptake, referral completion, and ultimately substance use reduction and improved educational participation among rural adolescents.

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(Additional recommended references to add if you want a stronger Scopus-level bibliography)

- UNODC International Standards on Drug Use Prevention (latest version)
- WHO guidance on school health and adolescent health
- NEP 2020 sections on counsellors and mental health supports in schools
- Darjeeling- or North Bengal-specific peer-reviewed studies or vetted district reports (avoid low-quality sources)