

# Report on the Intercountry Technical Exchange Workshop on School-Based Counseling Programming



Department of Mental Health  
Royal Thai Ministry of Public Health

Bangkok, 7-10 March 2005

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**Supported by UNICEF, UNAIDS**

through a grant from the Government of Japan

“Adolescents do not necessarily want to demean themselves  
Or present themselves as a problem to the society.  
In actual fact, they want to be good, successful,  
Have status and dignity and co-exist peacefully with other people.  
But to achieve that, they need guidance and close supervision.  
As teachers and school administrators, you are in the best position  
to help them  
Because you are close to them in every way, second only to their  
parents”

**His Majesty King Bhumibol Adulyadej, Rama IX**

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## LIST OF ABBREVIATIONS

|        |   |
|--------|---|
| EAPRO  | East Asia and Pacific Regional Office                       |
| EQ     | Emotional Intelligence Quotient                             |
| LSBE   | Lifeskills-Based Education                                  |
| MDG    | Millennium Development Goals                                |
| MOPH   | Ministry of Public Health                                   |
| PDCA   | Plan-Do-Check-Act (quality management control)              |
| PMCT   | Prevention of Mother to Child Transmission of HIV           |
| SDQ    | Strengths and Difficulties Questionnaire                    |
| STI    | Sexually Transmitted Infection(s)                           |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| UNICEF | United Nation's Children's Fund                             |
| UOT    | UNICEF Office for Thailand                                  |
| VCT    | Voluntary Counseling and Testing                            |





Most governments in Asia and the Pacific adopted, at the United Nations General Assembly Special Session on HIV/AIDS in June 2001, a Declaration of Commitment outlining specific, time-bound goals and targets for overcoming the pandemic. A major goal was targeted at young people:

By 2005, ensure that at least 90 percent, and by 2010 at least 95 percent, of young men and women aged 15 to 24 have access to information, education, including peer education and youth-specific HIV education, and serviced necessary to develop the life skills required to reduce their vulnerability to HIV infection; in full partnership with youth, parents, families, educators and health-care providers.<sup>1</sup>

Many countries across the region have developed plans to address HIV/AIDS among young people. Prevention education is already stipulated in most national strategies, which include Lifeskills-based education (LSBE) as a key approach in HIV/AIDS prevention education, particularly in targeting children and adolescents through schools.

Over the past ten years, national governments, together with UNICEF through its country offices, have been working to develop and institutionalize Lifeskills-based prevention education for HIV/AIDS, drug use and other issues confronting the health and wellbeing of young people.<sup>2</sup> The journey to institutionalization has been a long one with each country experiencing both difficulties and successes along the way. Though, until recently, few of the lessons learned in each country has been shared with their neighbors.

From 1-4 June 2004, the first Regional Forum on Lifeskills-Based Education (LSBE) for Behavior Development and Change was coordinated by The Department of Mental Health, Royal Thai Ministry of Public Health together with the UNICEF East Asia and Pacific Regional Office, with a support from the Government of Japan. This Forum provided opportunities for national HIV/AIDS prevention education, managers, curriculum developers and implementers to share key lessons learned, learn about best practices, and to build a support network among themselves. The Forum and preparations leading to it introduced a framework for LSBE to aid in the review, planning and future development of intervention efforts, as well as for reporting on these efforts. This framework, based on the eight essential elements for behavior development and change<sup>3</sup>, incorporates many programming

<sup>1</sup> Keeping the promise: Summary of the declaration of commitment on HIV/AIDS, United Nations General Assembly Special session on HIV/AIDS 25-27 June 2001. UNAIDS, June 2002.

<sup>2</sup> Report on the Regional Lifeskills Forum on Lifeskills-Based Education for Behavior Development and Change, 1-4 June 2004.

<sup>3</sup> **The eight essential elements are:** Evidence Base, Appropriate Messages, Lifeskills Development, Services and Supplies, Supportive Environment, Sustained Action, Collaborative and Networking, and Monitoring and Evaluation.

components already being addressed at country level. Still, no country has yet to develop or link all of the elements into one comprehensive program for behavior development or behavior change. Through the process of the Forum, participants assessed their country programs and developed plans to develop, revise, or strengthen the elements that were missing or weak and build on those in good shape to better respond to needs of young people.

The Regional Lifeskills Forum revealed that linkages between LSBE programming to services and supplies, such as medical exams, counseling and condoms, was the element most critically absent from LSBE programming across the region. While a few countries had limited services available, they were not linked to the school-based prevention education efforts. However, Thailand's school-based counseling program that identifies young people at risk and refers them to care and support services, provided internally through the school or by external service providers, got everyone's attention. A number of countries at the Forum expressed their sincere interest in learning how their schools could be more responsive to the needs of their students and how to build collaboration between the education, health, and welfare sectors for the health and well-being of young people.

As a follow up to the Regional Lifeskills Forum and the request to explore school-based counseling programming, the Bureau of Mental Health Technical Development, Department of Mental Health, Thai MOPH in collaboration with UNICEF EAPRO, organized the Inter-country Technical Exchange Workshop on School-Based Counseling Programming, 7-11 March 2005. This workshop was organized to:

1. Develop a greater understanding of school-based counseling programming through the sharing of lessons learned through the Thailand experience:
  - The strategies used in developing and implementing the Thai school-based counseling program;
  - The building a collaborative effort between the Ministry of Public Health and the Ministry of Education, at both at ministerial and school levels;
  - The identification of mechanisms and timeframe needed for capacity building in schools, particularly in the training of teachers in counseling skills.
  - The development of referral services for students who need special care and support;
  - The mechanisms for monitoring and evaluation;
  - The mechanisms used in the scaling up of programming.

2. Enhance the understanding of external services that may be linked to the school-based counseling program. This will be achieved by visiting and discussing with staff and volunteers from the following programs:
  1. “Be Number One - Friends Corner,”
  2. Hotline Foundation, multi-issue telephone counseling services servicing the Bangkok Metropolitan Area.
  3. Formulate draft plans or frameworks for developing school-based counseling programming in each country.

There are about three key terms that will appear throughout this report – “school mental health program,” “school-based counseling program,” and “student care and support system.” These terms find their origins in different phases of program development. Dr. Prawate Tantipiwatanaskul, Senior Advisor, Department of Mental Health, Thai Ministry of Public Health, explained that the term, “school mental health program,” was attached to early pilot efforts of the Department of Mental Health. As collaboration between the ministries was established the terminology was changes to the “school-based counseling program.” At the implementation level, however, the preferred name is “student care and support system” to reflect the roles and responsibilities of the teachers. Please note that the terms, “school-based counseling program” and “student care and support system” are used interchangeably in this report.

Although the workshop provided the fundamental concepts in a school-based counseling program development, the participants were reminded of the importance of monitoring and evaluation and the need to develop mechanisms for these in the initial stages of programming. They were also reminded that the Thai experience has been highlighted as an example of what can be done but should not be considered a formula or a blueprint for programming in other countries. It needs to be adapted to country context before implementation.



# SCHOOL MENTAL HEALTH PROGRAMMING: The Thai Experience



*Prawate Tantipiwatanaskul MD, MPH*

Adolescence is a time of change and crisis which may be adaptively encountered by some but for others presents the possibility of undesirable psychological, social and emotional consequences. Adolescent health and development is an area of concern in every society.

The distribution of health problems among adolescents and youths is very different from the pattern observed in children or adults. Unprotected sex increases the risks of early and unwanted pregnancy and childbirth, unsafe abortion and sexually transmitted diseases such as infection with human immunodeficiency virus (HIV). Use of tobacco, alcohol and other substances impairs judgment and increases the risk of cancers, cardiovascular and respiratory diseases. Accidental and intentional injury also increases during adolescent period.

More importantly, behavior formed in the second decade of life has lasting implications for individuals and public health <sup>(1)</sup>.


The overall aim of adolescent programs must be to produce well-informed, skilled young people who are motivated to make healthy choices, through an environment that encourages and facilitates these choices, and provides key services, opportunities, and interpersonal support. Healthy development requires the meeting of basic needs and the acquisition of the competencies necessary to negotiate the social environment and take on adult roles.

Each adolescent, however, has a different level of risks and requires different kind of support and care. Studies on resilient children found that they have certain characteristics<sup>(2)</sup> i.e.

- Social skills
- Problem solving skills
- Autonomy (sense of identity)
- Sense of purpose and future

Also, characteristics of the social environment that is conducive to the development of resilience include:

- Warmth and support
- High expectations
- Opportunities for meaningful involvement



### **I. Three phases of school mental health program development from the Thai experience**

In an analysis of over 100 programs in the United States on delinquency, preventing pregnancy, drug use, and dropping out of school, six common themes emerged as vital to successful outcomes<sup>(3)</sup>, namely:

1. Skills building (social, communication, decision-making)
2. Participation (youth-led discussions, peer approaches)
3. Membership (within a group and through commitment to school, community, organization)
4. Norms and expectations (Establishing new norms for behavior that are sanctioned by the group)
5. Adult-youth relationships (reinforcing the relationship between adults and young people through new structures and training for adults)
6. Accurate information/services (providing problem-specific information and services and access to services)

Programs for adolescent health and development should be multi-faceted with links between different sectors i.e., education and social services. One of the key settings for adolescent programming is the school system. The school is the place where every adolescent will have to come for education. It is also the place where parents have regular visits.

The development of the school mental health program in Thailand, with counseling services as a part of it, has included most factors mentioned above in its conceptual design. It does not focus only on information and service provision but also provides opportunities for an adolescent to develop needed competencies. After five years of implementation, the program demonstrates some successes.

This paper presents the development of school mental health program in Thailand and lessons learnt.

The school mental health program in Thailand has a history of more than three decades. Proactive-minded mental health professionals started reaching out to schools by giving lectures and providing case consultations since 1967. At that time, mental health was perceived by Thai public as the same as psychiatric illnesses; a highly stigmatized area in health. There was no policy regarding mental health in schools. There were, however, a number of school teachers and administrators who saw the supporting role of mental health professionals in the care of their students.

During this period, if any of the key personnel supporting the program moved away from schools, the program usually collapsed. There were also a limited number of mental health professionals who could manage to go out to schools. The activity was, therefore, limited to a small number of all schools.

During 1990 - 1992, there was an effort to develop a model for school mental health by standardizing activities and developing manuals for teachers on how to help their students. The move was to increase the number of schools benefiting from the mental health program.

An evaluation of the use of the manuals showed that interested teachers could learn basic knowledge on how to help their students without receiving any specific training. The mental health program was, however, perceived by school authorities as “another health program”. In their view, it was not the school’s direct responsibility to take care of student health.

During this period of mental health program development the knowledge and experiences from consultations with schools and questions commonly asked by teachers were turned into manuals for teachers. The concept of having a clear and better system for taking care of students was discussed among those working in school mental health. But this did not materialize into a workable and endorsed, policy-linked model.

In 1999, the new National Education Act was ratified. Education reform was expected. While administrators were trying to understand the implications of the new law, most teachers were anxious about their careers. They were confused on how their performance would be evaluated and what changes the new system would bring.

Concurrently, a crisis among adolescents came to light through a series of youth suicides in 2000. There was a shared sense among the public that something needed to be done. This prompted a high level administrative meeting between the Ministry of Education and the Department of Mental Health. The outcome of the meeting was that both parties would collaboratively develop a system of care and support for students.

Action research to develop an appropriate model for school the mental health program was conducted by a technical team from both ministries, with a strong support from administrators. The Ministry of Education took the leading role while the Department of Mental Health played technical, supporting role. The vision for this model was a comprehensive program that linked education and health support services and care.

It took the team one academic year to develop the model, based on what elements of care and support that existed in school system and from the previous experiences in the school mental health program. An evaluation from the 7 pilot schools found that the model helped change the attitudes of teachers, making them more understanding and more willing to help troubled students. The quality of care for students had improved considerably. The model was also integrated into the

educational reform scheme. Clear indicators for monitoring and evaluation were set up as part of the school quality assurance system. It was also endorsed as one of the key policies in the education system.

The model of care and support for students included not only the mental health / counseling component but assistance for a wide range of issues, i.e. financial, academic, physical and mental health. Its implementation was perceived by educators as the responsibility of schools, with the health sector playing supporting role. <sup>(4)</sup>

**Table1: Three phases of school mental health program development**

| Phase                 | Characteristics  |
|-----------------------|--|
| One: 1967 - 1990      | <ul style="list-style-type: none"> <li>• Proactive minded mental health professionals reached out to schools by providing lectures and school consultations.</li> <li>• The mental health program was perceived as another health program and not the school's responsibility.</li> </ul>  |
| Two: 1990 - 2000      | <ul style="list-style-type: none"> <li>• Manuals for teachers were developed. Interested teachers could use the manuals for helping their students.</li> <li>• There was no system for mental health program in school.</li> </ul>   |
| Three: 2000 - present | <ul style="list-style-type: none"> <li>• A model for the student care and support program was developed and scaled up by the Ministry of Education and the Department of Mental Health.</li> <li>• There is clear policy support and a monitoring and evaluation mechanism within the school system.</li> <li>• The model is linked with quality assurance.</li> <li>• Activities are comprehensive and extend beyond mental health care.</li> <li>• The implementation of the model is perceived as the school's responsibility.</li> </ul> |

## II. Scaling up the school mental health program



After model development finished in 2001, the Department of Secondary Education, Ministry of Education expanded the program nation-wide by selecting one school from every educational zone. As there were about 400 educational zones, 7-9 schools in one zone, hence 400 schools started implementing the student care and support program.

In zones where school administrators were actively engaged in the program, the model proved to be successful. However, not all educational administrators were enthusiastic about the program.

The Department of Mental Health, which had no responsibility for zonal coverage, used a more focused approach. A few schools from 12 selected provinces were chosen to join the program based on their

willingness to implement the program. Participating schools received technical support such as training and manuals from the Department of Mental Health.

In the following year, the Department of Secondary Education expanded the program to include all secondary schools. The Department of Mental Health, in contrast, focused its work in the same areas as before, but developed more technical and system know-how and a network of linkages with the health sector. (See table 2)

**Table2: Scaling up**

|                 | Ministry of Education   | Department of Mental Health   |
|-----------------|---|---|
| Approach        | <ul style="list-style-type: none"> <li>• Area focused coverage</li> <li>• Expanded to cover all schools</li> <li>• Use basic supervisory mechanism for expansion</li> </ul>   | <ul style="list-style-type: none"> <li>• Technical development</li> <li>• Focused on selected areas for 3 consecutive years</li> <li>• Continued R&amp;D work</li> </ul>  |
| 2001            | <ul style="list-style-type: none"> <li>• One school in every education zone (400 + schools)</li> </ul>  | <ul style="list-style-type: none"> <li>• A few school selected from 12 provinces</li> <li>• Provide technical support mainly for schools</li> </ul>   |
| 2002            | <ul style="list-style-type: none"> <li>• All secondary schools (2600+ schools)</li> </ul>   | <ul style="list-style-type: none"> <li>• Focused in the same area.</li> <li>• Involved health sector more actively</li> </ul>   |
| 2003            | <ul style="list-style-type: none"> <li>• Expanded to cover some primary schools</li> </ul>  | <ul style="list-style-type: none"> <li>• Network between education and health sectors was strengthened.</li> <li>• More technical and system know-how were developed</li> </ul>   |
| Key ingredients | <ul style="list-style-type: none"> <li>• Clear policy to support the model.</li> <li>• Success depended on local administrators.</li> <li>• Model linked with school quality assurance and performance appraisal</li> </ul>   | <ul style="list-style-type: none"> <li>• Strong technical support</li> <li>• Built more components from field experiences</li> <li>• Maintain good working relationship at policy and working level</li> </ul>  |
| Current status  | <ul style="list-style-type: none"> <li>• Clear and strong policy</li> <li>• Secondary schools are active and gaining more experiences</li> <li>• Program was expanded to primary school</li> <li>• Secondary schools provide assistance to primary schools</li> <li>• No clear system in vocational schools</li> <li>• More complex issues such as sex behavior arise</li> <li>• More technical collaboration still needed</li> </ul> | <ul style="list-style-type: none"> <li>• The program was terminated.</li> <li>• Informal contact is still maintained.</li> <li>• Health sector has a number of trained personnel.</li> <li>• No infrastructure for child and adolescent mental health at the province level.</li> </ul> |



### III. The model

An evaluation of the Department of Mental Health program found that the selected schools were well supported by local health team. Networks for students care and support were better developed. These schools were able to provide assistance to other schools in later phase. However, a number of serious mental health problems that could not treated at schools or the local health services found no referral service, especially in areas outside big cities.

The student care and support model has been developed with a comprehensive framework. Key components and activities within schools are shown in box 1 <sup>(5)</sup>. The linkage between schools and health services are shown in box 2.

#### Box 1: Key components and activities in school

- Promotion and prevention
  1. Know students individually (standardized form and activities) Screen for those at risk (tools for screening)
  2. Promotion activities:
    - 2.1 Home room - Students in the same group meet and learn life skills activities together regularly
    - 2.2 Class room - Parents of the same class meet with teacher regularly
- Helping process
  1. Help those who are at risk / having problems
    - a. Basic help
    - b. Behavior adjustment by classroom activities
    - c. Assigning peer to help as “buddy”
    - d. Communicating with parents
    - e. Academic tutorial and re-examination
    - f. Home visit
  2. Internal referral (to school counselors)
  3. Case conference
  4. External referral (to health counselors)
  5. Basic treatment in schools (such as drug prevention program)
  6. Network building
  7. Network with parents and community
    - a. Information system on student support and care

#### Box 2: The linkage between schools and health services

| Schools   | Networking  | Hospitals   |
|---|---|---|
| Promotion and prevention<br>Helping process<br>Network building | Participation in planning, coordination service supervision, evaluation, and information system development | Provide technical support on promotion and prevention, treatment plan, case conference, Clinical service for referral, Telephone consultation, Help build network |

#### IV. Success factors and next challenges



Although there are still many challenges for student care and support program, it can be considered a successful collaborative effort between education and health sectors. A number of success factors have been identified. They are:

- Clear political will and strong policy
- Strong leadership from both sides
- Committed teams to develop working model
- Scaling up along with more technical development
- Monitoring and evaluation linked with school quality assurance scheme

The next challenges for the program are:

- How the ongoing reform process in both health and education sectors will affect the program as a whole and how the program should be adjusted.
- How to increase student participation and parental involvement in the program's development.
- How to develop a good infrastructure of care and support that links the school, health sector, and the community, when many new issues, such as changing adolescent sexual values and behavior, arise in society.
- How to determine an appropriate model for developing child and adolescent mental health service infrastructure.

#### V. Summary



The primary goal of adolescence is to make the transition from childhood to adulthood. Adolescents need to do this while dealing with biological, psychological and social challenges. As the needs of adolescents are complex and changing, good adolescent health and development programs should move beyond organizational barriers and put adolescent needs as the central focus.

The model for the Thai school mental health program is student care and support. With the limited resources in both the mental health and education sectors, it has proven to be a practical model for adolescent health and development that can be developed and implemented nation-wide.

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The intercountry technical exchange workshop on school-based counseling programs met from 7 - 10 March 2005 in Bangkok, attended by countries from Southeast Asia and the Pacific Islands.

The meeting aimed to examine Thailand's experiences designing and operating its school-based counseling program so that participants from other countries could apply lessons already learned. Attention was given to linking school-based programs with health and other services outside the schools.

During the opening session it was emphasized that young people in today's world are at increased risk of engaging in behaviors that could lead to addiction, disease or other health and social problems. Therefore, the role of schools and teachers must necessarily evolve from simply imparting academic learning to preparing young people to deal with life and its sometimes difficult and potentially dangerous choices.

Representatives from Thailand's Ministries of Public Health and Education recounted the origins and history of the country's school-based counseling program. It was apparent that building the program from a concept to a reality was no easy task. There were false starts and failures along the way. The key to Thailand's success was that there were educators and health officials who were committed to making the program happen. Despite a lack of interest and understanding on the part of policy makers, and other obstacles placed in their paths, they kept preparing and advocating for the day when a comprehensive program could be launched.

When events created favorable conditions for the public and policymakers to be receptive to the idea, these educators and health officials were ready. A series of suicides by Thai students following the economic crisis of 1997 sparked public outcry and concern. The advocates of school-based counseling seized the opportunity and convinced policymakers to support the creation and implementation of the program.

Educators from four Thai secondary schools made presentations to the seminar on how they adopted and applied school-based counseling in their schools. They said that the most crucial element was changing the attitude of teachers to accept that learning and employing basic counseling skills to help their students cope with life was an essential part of their job. Involving parents and communities was also key to the success of their programs. Furthermore, each school used a similar model of forming various teams consisting of administrators and teachers to implement different aspects of the program.

Seminar participants were also taken on field trips to view Thai counseling programs in action. The first was Friends Corner, under Her Royal Highness Princess Ubol Ratana Rajakanya. Linked to local schools,

this mall-based meeting place for young people is staffed by volunteers who are students of psychology and social work. They involve young people in various activities such as singing, dancing, etc. Sessions to build Emotional Quotient (EQ) are also available and the young people can participate any session of their interest. The Friends Corner also has counselors available.

Participants also visited the Satriwittaya 2 Secondary School, a 5,000-student educational institution in the northern suburbs of Bangkok. Teachers and students explained how the program was successfully implemented in such a large school.

Lastly, they visited the Hotline Foundation, a nongovernmental organization that runs a telephone hotline counseling callers in psychological distress as well as others who are facing various problems such as HIV/AIDS, pregnancy, suicide, etc. Hotline also provides programming for specific segments of society, such as telephone counseling targeting men in order to reduce family violence, or the training of policemen in communication and basic counseling skills to deal with clients from various walks of life.

Dr. Chaiyos Kunanusont, a specialist in HIV/AIDS at UNFPA, detailed efforts to link school-based counseling to health services outside of the schools. Young people can't be forced to use these services, only encouraged to do so. Despite battling the HIV/AIDS epidemic for two decades, many people still lack knowledge about the disease. There are many reasons for this, including families migrating from place to place because parents are in search of work.

On the final day, participants from each country were asked to explain the state of school-based counseling / care and support services in their locales and formulate a plan for increasing and improving such services. Most pointed to existing elements in their health and education systems that could be built upon, and cited the need to change attitudes among teachers, administrators, parents and the community to make the programs effective.

In conclusion, all participants said they had learned a great deal from the Thai experience and would take those lessons back to their countries and advocate for expanding, fine-tuning and scaling up programs. All agreed that the weakest link in the school-based counseling program is monitoring and evaluation, as it is difficult to demonstrate when risky behavior has been prevented. Nonetheless, donors are increasingly asking for an evidence base that shows not just activities but results if they are to continue funding programs, and so finding appropriate measurement tools is becoming increasingly important. A regional workshop on monitoring and evaluation is one of the next steps being planned by UNICEF EAPRO.



The inter-country technical exchange workshop on school-based counseling programs was held from 7 - 10 March 2005 in Bangkok. Organized by Thailand's Bureau of Mental Health and Technical Development, Department of Mental Health, and the UNICEF East Asia and Pacific Regional Office and supported by UNAIDS and the Government of Japan, it involved participants from seven countries in Southeast Asia and the Pacific Islands.

Attending the gathering were a total of 31 representatives from the seven countries and national and supranational organizations (see Annex 2). Among them were educators, health officials and administrators from Thailand who have been instrumental in developing and implementing school-based counseling programs in their country.

The meeting was designed to explore in detail Thailand's experiences in creating and employing such programs. By examining the evolution of the Thai program, it was hoped that educators and administrators from the other countries could apply the lessons learned in Thailand to their own school-based counseling initiatives. Thailand was chosen as the example because it has been employing school-based counseling programs longer than any other nation in the region. Some aspects of Thailand's experience with school-based counseling that were discussed were:

- Strategies in developing and implementing the program.
- Sharing of good practices.
- Scaling up and capacity building.
- Developing tools for monitoring and evaluation.

The meeting agreed that most countries already have elements of school-based counseling programs already in place, and these can be built on to create comprehensive programs. Participants agreed to take what they learned at the workshop back to their own countries and share with others interested in building school-based counseling programs. UNICEF representatives also said that more workshops are in the planning, including one focusing on what may be the more difficult component of such programs - monitoring and evaluation.



## OPENING REMARKS



*“Supporting our young people, who will be the future of East Asia and the Pacific, to develop healthy and productive lives is an enormous task.”*

Dr. Wachira Pengjuntr



The meeting began with remarks from Dr. Wachira Pengjuntr, Deputy Director-General of the Department of Mental Health at Thailand’s Ministry of Public Health (MOPH). Dr. Wachira noted that the agenda for the meeting was an ambitious one, and that the current gathering developed out of the momentum generated by interest in the Regional Forum on Lifeskills-based Education for Behavior Development and Change organized by UNICEF and the MOPH on June 1 - 4, 2004. Dr. Wachira hoped that by presenting Thailand’s experiences in this field, other countries may gain some insight and guidance for the development and strengthening of their own programs.

Other points made by Dr. Wachira included:

- Teachers and schools play an important role in supporting students in accessing the services and supplies that will help them prevent infection with HIV, drug use and other problems.
- Supporting young people to develop healthy and productive lives is an enormous task that is impossible for any single agency to accomplish alone.
- Education, health and other sectors must work together for the health and well-being of young people.
- An evidence base for programming needs to be developed.
- Mechanisms for sustainability and for monitoring and evaluation are also needed.
- Linkages to supplies and services are the next logical step in developing this programming.
- Without access to youth-friendly health services and preventive commodities and supplies, even well-informed decisions by students and young people will be difficult to carry out.



# WELCOMING STATEMENT



*“Every country is unique and has its own context for prevention and care.”*

Dr. Scott Bamber

A welcoming statement was delivered by Dr. Scott Bamber on behalf of the Representative, UNICEF Office for Thailand. Additional remarks were offered by Mr. Greg Carl, Regional Project Officer on HIV/AIDS (Lifeskills) for UNICEF EAPRO.

## Other points made by Dr. Bamber were:

- The epidemic in Thailand challenged assumptions about primary health care and communicable disease, mainly because of the links to behavior, and especially sexual behavior.
- This forced everyone involved to rethink their assumptions about prevention and care of illness.
- Every country is unique and has its own particular context for prevention and care, taking into account cultural and environmental aspects.
- Thailand has a lot of lessons to offer from its experience responding to HIV.
- Those lessons provide signposts for others in terms of what works and what doesn't. They are not a blueprint that works in every context, but we can see how they can be applied in our own context.

## Remarks made by Mr. Carl contained the following points:

- The report from the 2004 Lifeskills-based Education forum has received great interest in the region and globally because others want to know how to develop their own Lifeskills programs.
- There will be variety in each country and country context.
- The DFID also did an analysis of LSBE and came to many of the same conclusions: programming needs an evidence base and better mechanisms need to be put in place for monitoring and evaluation.
- It also had other similar conclusion that: what we are doing is valid and what we're doing must be linked to services.

