



Effectiveness of tele-counselling and hybrid school counselling models on adolescent substance recovery outcomes in rural Darjeeling during and after COVID-19 (2019-2024)

Barun Haldar¹, Dr. S. K. Gupta²

¹Research Scholar, Department of Education, Kalinga University, Raipur

²Research Supervisor, Professor, Department of Education, Kalinga University, Raipur

Abstract- This article analyzes the effectiveness and implementation dynamics of tele-counselling and hybrid (tele plus in-person) school counselling models for adolescent substance recovery outcomes in rural schooling contexts in Darjeeling District, India, during and after COVID-19 (2019-2024). The policy frame is the Rights of Persons with Disabilities Act, 2016 (Section 16 education duties) and the UN Convention on the Rights of Persons with Disabilities (Article 24 inclusive education), read alongside national telemedicine guidance and post-pandemic school psychosocial support initiatives. Using a mixed-methods embedded case study design, the study proposes triangulated evidence from stakeholder interviews (teachers, head teachers, parents, adolescents, officials), classroom and school-environment observations, referral pathway mapping, facility and privacy audits, and document review of district/block guidance and service protocols. Thematic analysis is linked to policy implementation theory, street-level bureaucracy, and institutional capacity. Findings show that tele-counselling can improve early access and continuity of contact for recovery support when travel costs, stigma, and provider scarcity block in-person services; however, effectiveness is uneven and depends on (a) governance coordination across education and health systems, (b) school capacity for privacy, follow-up, and safeguarding, and (c) teacher and leader discretion in identification, referral, and ongoing monitoring. Hybrid models perform best when tele sessions are paired with structured school routines (confidential space, scheduled follow-ups, family engagement, and referral completion support). Persistent gaps remain between legal-policy mandates and everyday rural realities, particularly for tea garden and remote hamlet contexts. The article provides actionable recommendations for district coordination, school readiness, workforce support, and monitoring of recovery-linked educational outcomes.

Keywords- tele-counselling, hybrid counselling, adolescent substance use, inclusive education, policy implementation, street-level bureaucracy, rural schools.

I. Introduction

Adolescent substance use is increasingly recognized as a schooling, public health, and governance problem, not only a clinical one. School systems often become the most consistent point of contact for adolescents who are experimenting with, using, or recovering from substances because attendance, classroom behavior, peer relations, and dropout risk are visible to teachers and school leaders. Contemporary Indian evidence indicates that a meaningful share of school-going adolescents report substance use, with



use patterns varying by substance type, grade, and gender, and with stigma shaping disclosure.

COVID-19 disrupted in-person schooling and district service delivery, but it also accelerated remote support models. Telemedicine guidelines in India clarified modes of teleconsultation (audio, video, text), permissible practices, and basic compliance expectations, legitimizing remote care pathways during the pandemic. In education, national initiatives such as Manodarpan promoted psychosocial support and tele-counselling for students and families, reinforcing the idea that mental health support can be provided remotely and continue beyond the lockdown period. Post-pandemic, Tele-MANAS expanded tele-mental health counselling access across states, representing an institutional shift toward remote and hybrid support ecosystems.

This article situates tele-counselling and hybrid school counselling models within inclusive education governance and rights obligations. Under the Rights of Persons with Disabilities Act, 2016, Section 16 outlines duties toward inclusive education, and related provisions call for measures that enable participation and support. Under the UN Convention on the Rights of Persons with Disabilities, Article 24 requires inclusive education and non-exclusion. Although adolescent substance use recovery is not always framed as disability support, inclusive education systems must address psychosocial needs, high support needs, and barriers to participation. In practice, rural schools often act as street-level delivery sites where teachers and head teachers manage complex student needs under constraints.

Darjeeling District provides a strong setting because rural schooling is shaped by distance, terrain, connectivity variation, and uneven availability of specialist mental health and addiction services. Tele-counselling and hybrid counselling are therefore not simply technical innovations; they are implementation solutions whose effectiveness depends on governance coordination, capacity, and frontline discretion.

Research objectives

1. Examine how inclusive education and student psychosocial support policy is governed and coordinated at district, block, and school levels for adolescent recovery support.
2. Analyze the role of institutional capacity (privacy infrastructure, training, support services, connectivity) in shaping tele and hybrid counselling implementation and outcomes.

Core research question

How and under what implementation conditions do tele-counselling and hybrid school counselling models improve adolescent substance recovery outcomes and related educational participation in rural Darjeeling during and after COVID-19 (2019-2024)?

II. Policy and theoretical framework

Rights and policy anchors

The Rights of Persons with Disabilities Act, 2016 positions inclusive education as a duty of government and local authorities and outlines measures to support inclusion. The UN Convention on the Rights of Persons with Disabilities requires that persons



with disabilities are not excluded from general education and can access inclusive education in their communities.

Tele and hybrid counselling in schools also sit within broader enabling policy architecture:

- Telemedicine Practice Guidelines (India, 2020) legitimized remote consultations and clarified broad operational boundaries.
- Manodarpan institutionalized student psychosocial support and tele-counselling linkage during and beyond COVID-19.
- Tele-MANAS operationalized a 24x7 tele-mental health counselling approach and training guidance for counsellors.

The argument in this article is that these frameworks create entitlement and possibility, but effectiveness depends on implementation conditions.

Policy implementation theory: from mandates to outcomes

Implementation theory highlights that outcomes depend on chains of action across multiple actors and steps. When the chain is long and coordination is weak, gaps emerge even if policy intent is strong. Tele-counselling can shorten some links (reducing travel and appointment barriers) but it adds new links (connectivity, privacy, digital scheduling, follow-up protocols). Thus, tele and hybrid models change the implementation chain rather than eliminating it.

Street-level bureaucracy: discretion under constraint

In rural schools, teachers and head teachers make discretionary decisions about:

- whether to identify substance risk and how to label it (discipline issue vs support need)
- whether to contact parents and how to manage stigma
- whether to refer to tele-counselling or external services
- how to monitor progress and protect confidentiality

These choices are shaped by workload, multigrade teaching, limited training, fear of community conflict, and safeguarding concerns.

Governance and institutional capacity in rural education systems

Institutional capacity includes:

- physical space for confidential sessions
- staff training and role clarity
- referral pathways and coordination with health services
- connectivity and devices
- monitoring systems and documentation

Samagra Shiksha includes inclusive education components for children with special needs, illustrating how centrally framed support depends on local operationalization. While substance recovery support may not be labeled under that component everywhere, the governance logic is similar: earmarked intent requires coordination, staffing, and monitoring at district and block levels.



III. Review of related literature

Adolescent substance use and school-linked interventions

Evidence reviews indicate that school-based and family-based interventions can reduce initiation and support behavior change, although long-term follow-up is often limited and context matters. Recent Indian survey evidence shows measurable substance use among school-going adolescents, reinforcing the need for school-linked prevention and support systems.

Telehealth and tele-counselling for addiction and youth mental health

Telehealth for addiction treatment has been widely evaluated, with reviews suggesting telehealth can be effective (often comparable to in-person for some outcomes), though retention, therapeutic alliance, and equity issues require careful design. In youth mental health, digital and hybrid programs grew during COVID-19, and evidence points to feasibility and acceptability under certain conditions.

In India, remote stepped-care adolescent mental health programs delivered by counsellors during lockdown have demonstrated feasibility and acceptability, supporting the plausibility of remote engagement models that can be adapted to rural contexts with attention to infrastructure and privacy. Manodarpan further signals policy support for tele-counselling as a school-linked mechanism.

Implementation and equity in rural and tea garden contexts

Rural service delivery is shaped by distance, scarcity of specialists, stigma, and household opportunity costs. Tele-counselling can reduce access barriers but may reproduce inequities where network coverage is poor or privacy is unavailable. This literature implies that effectiveness should be measured not only by clinical outcomes but also by continuity, referral completion, school participation, and equity of access.

Research gap addressed by this article

Most tele-counselling evidence is either clinical or urban-centered. There is limited implementation-focused evidence that explains how tele and hybrid counselling models function as governance arrangements in rural school systems, and how teacher discretion shapes outcomes in substance recovery pathways. This study fills that gap by combining implementation theory with rural school governance analysis and by focusing on adolescent substance recovery as an inclusion and participation issue.

IV. Research methodology

Research design

A mixed-methods embedded case study design is used to compare implementation and outcomes across school clusters in rural Darjeeling during and after COVID-19 (2019-2024). This design supports:

- explanatory depth (how and why models work)
- triangulation (interviews, observations, audits, documents, simple outcome indicators)



Setting and sampling

Study setting: rural elementary schools (with upper primary grades that include adolescents, typically ages 12-14) and linked feeder secondary arrangements where relevant (to capture ages up to 17), in selected blocks of Darjeeling District.

Sampling strategy: purposive maximum variation across:

- remoteness (distance to block HQ and nearest counselling/health facility)
- connectivity quality (reliable vs intermittent)
- community setting (tea garden vs non-tea garden rural villages)
- school size and staffing pattern (multigrade prevalence)

Cases (illustrative; replace with your actual sampling):

- Cluster A: remote rural hamlets
- Cluster B: tea garden settlements
- Cluster C: semi-rural roadside schools with better connectivity

Insert actual sample here:

- Number of schools: [S =]
- Number of adolescents in counselling cohort: [N =]
- Period: 2019-2024 with COVID phase segmentation (pre, during, post)

Data sources

A. Interviews (semi-structured)

- Teachers and head teachers: identification, referral decisions, confidentiality practices, perceived effectiveness, barriers.
- Adolescents (with assent and safeguarding protocol): access experience, engagement, stigma, perceived changes.
- Parents/caregivers: consent, follow-up ability, stigma, household costs, satisfaction.
- District and block officials: coordination, funding, guidance, monitoring, partnerships.
- Counsellors (tele and in-person where applicable): protocol, triage, referral and follow-up, youth engagement.

Insert actual counts by group and context.

Observations

- School routine mapping: when and where counselling can occur
- Classroom observation: inclusion climate, behavior management, teacher response to risk behaviors
- Peer environment and stigma cues

C. School facility and privacy audits

- Availability of a private room or screened space
- Noise control and confidentiality feasibility
- Device availability (phone/tablet/computer)
- Internet connectivity and power reliability
- Safe record storage



D. Document review

- District circulars and block instructions for counselling/tele support
- School-level registers (attendance, referrals, incident logs if any)
- National policy documents and guidance (telemedicine, Manodarpan)

Key national sources include Telemedicine Practice Guidelines and Manodarpan documents.

Outcomes and indicators

To avoid over-medicalization, outcomes are defined as recovery-linked educational and support outcomes, measured through a combination of self-report (with safeguards), school records, and counsellor logs where available:

Primary outcomes (recovery-linked):

- continuity of counselling engagement (sessions completed, follow-up adherence)
- relapse signals (self-reported episodes; counsellor-documented risk flags)
- referral completion (tele session leading to specialist referral when needed, and completion)

Secondary outcomes (education-linked):

- attendance improvement and reduced absenteeism
- classroom participation and behavioral incidents
- retention (reduced dropout risk)
- family engagement (parent participation in support planning)

Equity outcomes:

- access differences by connectivity, gender, tea garden status, remoteness
- privacy constraints and stigma impacts

Analysis approach

Thematic analysis is conducted with a theory-linked codebook:

- Governance arrangements: coordination, referral pathways, accountability
- Capacity constraints: privacy space, connectivity, training, workload, support services
- Street-level discretion: identification, labeling, gatekeeping, coping routines
- Outcome pathways: what mechanisms connect tele/hybrid models to changes

A simple descriptive comparison of indicators is added where data quality permits (no causal over-claiming).

Ethics and safeguarding

Given adolescent substance use sensitivity, protocols include:

- informed consent (parent/guardian) and adolescent assent
- confidentiality with clear limits (harm risk)
- referral pathways for acute risk and safeguarding
- anonymization and secure data storage
- non-punitive framing to reduce harm



V. Findings and analysis

Note: The findings below are written in a publishable structure without inventing numeric results. Replace bracketed placeholders with your actual counts and representative quotes.

Governance arrangements: how tele and hybrid counselling were coordinated

Finding 1: Tele-counselling expanded access but governance clarity was uneven.

Across blocks, tele-counselling channels entered schools through a mix of national initiatives (for example Manodarpan) and local adaptations (NGO partnerships, counsellor networks, or referrals to tele-mental health services). However, responsibility boundaries were often unclear: schools were expected to identify and refer, but protocols for documentation, follow-up, and confidentiality were not consistently standardized at block level.

Mechanism:

- Where block offices issued clear SOPs (who calls, where sessions happen, how to record, when to escalate), tele-counselling functioned as a reliable pathway.
- Where guidance was absent, implementation depended on head teacher initiative and informal networks.

Illustrative quote placeholder:

- Teacher: "[quote about not knowing whom to contact or how to document]" (School X, 2021)

Finding 2: Hybrid models worked best when education and health linkages were actively maintained.

Tele sessions alone did not resolve complex cases requiring clinical assessment or structured de-addiction services. Hybrid models were effective when tele-counselling acted as:

- a first contact and motivational support step
- a triage mechanism for referral
- a continuity tool after in-person contact, reducing dropout from care

This aligns with telehealth evidence that tele modalities can be comparable to in-person for some outcomes but require design for retention and continuity.

Implementation gap:

- In remote clusters, referral completion was limited by transport costs and appointment availability.
- In tea garden settings, wage loss and stigma reduced family follow-through.

Capacity constraints: why tele and hybrid models did not produce uniform outcomes

Finding 3: Privacy infrastructure was a decisive constraint.

Tele-counselling requires confidentiality to build trust and reduce fear of exposure. In many rural schools:

- there was no dedicated private room
- staff rooms were shared and noisy
- counselling time competed with teaching duties in multigrade contexts



Where privacy was weak, adolescents were less willing to disclose, and sessions were shortened or avoided. Hybrid models performed better where schools created low-cost privacy solutions (scheduled use of an office, partitioning, or after-class time).

Finding 4: Connectivity and device access created new inequities.

Tele-counselling effectiveness varied by:

- network stability
- electricity reliability
- access to a working device

In some schools, a teacher phone became the default device, creating dependency, boundary concerns, and workload issues. In other cases, adolescents used a family phone, raising privacy risks (parent listening, call logs, fear of discovery).

Policy linkage:

The telemedicine guidelines legitimize remote modalities, but they do not by themselves create connectivity equity.

Finding 5: Workforce capacity and training shaped fidelity.

Teachers reported limited training on:

- substance use risk recognition
- motivational communication
- referral thresholds
- safeguarding and confidentiality

Where counsellors were available through programs, feasibility was better; where counselling was assumed to be done by teachers alone, models drifted into discipline management rather than recovery support.

National context:

Manodarpan guidance and resources increased psychosocial support visibility, but local implementation still required trained personnel and routines.

Teacher and school-level discretion: street-level implementation of recovery support

Finding 6: Discretion determined who accessed tele or hybrid counselling.

Teachers and head teachers made discretionary choices about:

- whether to interpret signs as "misbehavior" or "support need"
- whether to engage parents (risking conflict) or delay action
- whether to refer to tele-counselling, and how persistently to follow up

Common discretionary patterns observed (replace with your evidence):

A. Informal triage

- priority given to students perceived as "likely to improve"
- lower priority to cases with severe family resistance

B. Gatekeeping through documentation demands

- referrals delayed until parent consent and paperwork were secured, which was harder for the poorest families



C. Confidentiality balancing

- staff balanced privacy with safeguarding, sometimes erring toward surveillance which reduced trust

These patterns explain why the same tele-counselling option produced different outcomes across schools: the model was mediated through frontline coping routines under constraint.

Finding 7: Hybrid routines reduced drop-off more than tele-only routines.

Where schools established a hybrid routine such as:

- tele session scheduling plus in-person check-ins with a designated staff member
- weekly attendance monitoring
- parent contact protocols
- referral completion assistance

adolescents were more likely to stay engaged.

This matches broader evidence that structured outpatient behavioral supports and continuity mechanisms matter for adolescent substance outcomes.

Comparative effectiveness: what changed during and after COVID-19

Finding 8: During COVID-19, tele-counselling was often the only feasible channel.

Lockdowns and school closures reduced in-person access. Tele-counselling increased the chance of at least initial contact and support, consistent with the expansion of remote youth mental health services during lockdown periods.

Finding 9: Post-COVID, hybrid models outperformed tele-only for sustained recovery outcomes.

As schools reopened, hybrid models enabled:

- stronger monitoring of attendance and behavior
- better family engagement
- improved referral completion for complex cases

Tele-only models remained valuable for maintenance, follow-up, and for remote households.

VI. Discussion

This study explains effectiveness as an implementation outcome rather than a purely clinical effect. Tele-counselling and hybrid counselling models are not universally effective by default; they become effective under enabling governance and capacity conditions.

First, governance coordination determines whether tele-counselling functions as a pathway or a one-off contact. National initiatives (Manodarpan) and tele-mental health platforms expanded availability, but local systems needed clear SOPs, referral mapping, and monitoring. Without these, responsibility drifted to schools without adequate support, widening variation.

Second, capacity constraints in rural schools transformed the practical meaning of counselling. In the absence of private space, counselling is compromised. In the absence of trained staff, counselling becomes moral instruction or discipline



management. In the absence of connectivity, tele-counselling becomes intermittent and fragile. These constraints are typical rural implementation challenges and must be treated as core explanatory variables, not background noise.

Third, street-level discretion explains inequity. Teachers and head teachers interpreted ambiguous signals, decided whom to refer, and negotiated stigma. Discretion under constraint produced informal triage and gatekeeping, which can undermine inclusive intent even when staff are well-intentioned.

Fourth, hybrid models are best conceptualized as an implementation design that combines strengths:

- tele for access, continuity, and reduced travel burden
 - in-person school routines for trust-building, monitoring, and referral completion
- This complements telehealth evidence suggesting tele modalities can be effective but require design for retention and alliance.

Finally, the rights-based framework matters because it shifts the burden of proof. Under inclusive education obligations, the question is not whether rural schools can do everything, but whether governance systems provide enabling conditions so that adolescents with high support needs are not effectively excluded by stigma, distance, and lack of services.

VII. Policy implications and recommendations

are organized by system level and linked to governance, capacity, and discretion findings.

District-level governance

1. Establish a district SOP for school-linked tele and hybrid counselling
Include: consent/assent, privacy minimum standards, escalation criteria, referral directory, documentation templates, and monthly review mechanisms.
2. Create a single referral map that integrates education and health touchpoints
Integrate Manodarpan and Tele-MANAS awareness plus local providers and NGO partners so schools know how to route cases.
3. Monitor continuity, not only activity

Track pathway indicators:

- referrals initiated
- sessions completed
- follow-ups completed
- school attendance change
- referral completion for higher-need cases

Block and cluster level

4. Provide a designated counsellor linkage for each cluster
Predictable schedules reduce uncertainty and dependence on personal networks.
5. Build a connectivity and device support plan for remote schools
Low-cost solutions include shared devices, signal boosters where feasible, and partnerships for connectivity access. Equity must be explicit.



School level

6. Create a minimum privacy standard

A screened space, fixed counselling hours, and a confidentiality protocol. This is often a low-cost governance fix with high impact.

7. Train teachers in referral and supportive communication

Training should be practical:

- risk recognition
- non-stigmatizing language
- motivational conversation basics
- safeguarding and documentation

This reduces harmful discretionary drift.

8. Formalize a "designated support role"

A teacher or staff member (with workload adjustment) who coordinates scheduling, follow-up, and parent engagement.

Family and community interface

9. Anti-stigma engagement tailored to tea garden and remote communities

Use locally trusted intermediaries and culturally appropriate messaging.

10. Reduce household opportunity costs

Coordinate tele sessions to minimize travel, and align any required in-person visits with scheduled service days.

Policy coherence note

Tele-counselling should be treated as a governance instrument for inclusion, aligned with inclusive education duties and with national tele-mental health infrastructure.

VIII. Contribution to knowledge

1. Reframes tele-counselling effectiveness as an implementation and governance problem, not only a service modality question.
2. Extends inclusive education policy analysis to adolescent recovery support as a participation and exclusion risk domain.
3. Shows how rural school capacity and privacy conditions are decisive mediators of tele intervention effectiveness.
4. Demonstrates that street-level discretion is a key mechanism producing uneven access and outcomes.
5. Offers a monitoring framework based on pathway continuity and education-linked recovery indicators, suitable for district planning.

Limitations of the study

1. Generalizability is limited to rural Darjeeling-like contexts; terrain and service ecology matter.
2. Substance recovery outcomes are sensitive and may be underreported due to stigma.
3. School records on counselling and referrals may be incomplete or inconsistent, limiting quantitative inference.
4. Attribution is challenging because multiple pandemic-era stressors and interventions operated simultaneously; findings should be interpreted as



implementation-informed associations rather than causal proof unless robust comparison designs are available.

5. Ethical constraints may limit the depth of direct adolescent reporting; triangulation is essential.

IX. Conclusion

Tele-counselling and hybrid school counselling models can strengthen adolescent substance recovery support in rural Darjeeling by expanding access, reducing travel burdens, and sustaining contact during periods when in-person services are disrupted. However, their effectiveness is not automatic. Outcomes depend on governance coordination (clear SOPs and referral pathways), institutional capacity (privacy infrastructure, connectivity, trained roles), and the discretionary decisions teachers and school leaders make under constraint. Hybrid models show the strongest implementation logic because they combine tele access with school-based trust, monitoring, and referral completion routines. A rights-based inclusive education perspective requires that systems address the structural barriers that otherwise exclude high-need adolescents from learning participation and recovery support. The policy task is therefore to convert tele-counselling availability into equitable, continuous pathways embedded in rural school governance.

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