

Voices from Schools and Experts: Qualitative Insights for Codesigning an Adolescent Mental Health Programme in Bangladesh

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Abstract

Background

Globally, one in five adolescents experiences a mental health condition annually, yet in Bangladesh the treatment gap reaches 94.5%. A whole-school approach, grounded in the Health Promoting Schools (HPS) framework, emphasises school–community partnerships, supportive environments, curriculum integration, and enabling policy support. This study conducted a multi-level needs assessment to identify systemic gaps and capacities to inform the co-design of a universal school-based mental health programme (SBMHP) for adolescents.

Methods

A cross-sectional qualitative needs assessment was undertaken using sixteen focus group discussions and six key informant interviews with students ($n = 48$), teachers ($n = 36$), parents ($n = 36$), and mental health professionals ($n = 6$). Data were transcribed verbatim and analysed in NVivo 14 using a hybrid thematic approach. Deductive coding was guided by research questions and interview guides, while inductive coding captured emergent contextual insights. Triangulation across stakeholder groups enhanced analytic rigour. The HPS framework was applied post-analysis as an interpretive lens.

Results

A substantial mismatch emerged between adolescents' mental health promotion needs and schools' capacity to deliver coordinated preventive supports. Despite stakeholder awareness, efforts were constrained by fragmented policies, limited institutional capacity, urban-centred tertiary services, and weak school–family–community collaborations. Mapping of findings onto the HPS framework indicated only partial alignment across governance, environment, curriculum, engagement, and service integration domains.

Conclusions

The study identifies structural and institutional determinants shaping adolescent mental health promotion in Bangladeshi schools and informs the co-design of a culturally responsive, scalable SBMHP, contributing to limited evidence from low- and middle-income contexts.

1 Background

Adolescents constitute approximately 16% of the global population, with the majority residing in low- and middle-income countries (LMICs), where the mental health treatment gap for this age group is estimated to reach up to 85% [1–4]. This disparity is further illustrated by the severe workforce shortage in the

South-East Asian region, where only 0.5 mental health workers are available per 100,000 children and adolescents [5]. Bangladesh, a South Asian country with a population of approximately 171 million, has nearly one-third of its population comprising children and adolescents [6]. An estimated 13.6% of individuals in this age group experience mental disorders, while the treatment gap for psychiatric conditions remains critically high at 94.5% [7, 8]. The country has only 0.01 child and adolescent psychiatrists per 100,000 children and adolescents, and mental health services are largely concentrated in metropolitan areas, leaving non-metropolitan regions substantially underserved [9, 10]. Moreover, there is no structured referral system for child and adolescent mental health services [7].

School-based health promotion is a well-established global strategy, initiated by the World Health Organization in 1978 and formalised through the Ottawa Charter in 1986 [11]. School-based mental health interventions are among the most effective approaches for improving the mental health and wellbeing of children and adolescents; however, such structured interventions are currently unavailable in Bangladesh [10, 12]. In this context, the present study aimed to conduct a multi-level needs assessment to identify systemic gaps, existing capacities, and enabling factors to inform the co-design of a culturally appropriate school-based mental health programme (SBMHP) for adolescents, integrating the WHO-recommended Health Promoting Schools (HPS) framework [13].

2 Methods

2.1 Study design

This study adopted a cross-sectional qualitative design using focus group discussions (FGDs) and key informant interviews (KIIs) to conduct a needs assessment among adolescent students, parents, teachers, and mental health professionals in Bangladesh [14, 15]. Qualitative approaches are particularly appropriate in low- and middle-income country (LMIC) contexts, where mental health needs, help-seeking behaviours, and service pathways are strongly shaped by sociocultural norms, stigma, and resource and system constraints, which may not be adequately captured through quantitative measures alone [16, 17]. FGDs were used to explore shared meanings, collective experiences, and community norms related to adolescent mental health within school and family contexts, while KIIs enabled in-depth examination of structural, policy, and service-level perspectives from stakeholders occupying key professional and leadership roles [18, 19]. The combined use of FGDs and KIIs facilitated triangulation of perspectives and supported the identification of locally salient priorities, implementation barriers, and contextual strengths, which are essential for the design of feasible and culturally responsive school-based mental health (SBMH) programme in resource-constrained settings [20–22].

2.2 Data collection

Semi-structured FGD and KII guides were piloted with five participants (one from each stakeholder group) to assess clarity, cultural relevance, and language appropriateness [18]. Feedback informed minor refinements to wording, prompts, and sequencing. Piloting aimed at instrument refinement rather than analytic generalisation (Supplementary Table S6, S7). School participants were invited through a notice

issued by the head teacher, and experts were invited via email. All consented participants took part in the discussions and interviews. A total of 16 FGDs were conducted: 8 with students, 4 with parents, and 4 with teachers, with 6 participants per FGD, yielding 96 participants overall. Student FGDs were stratified by gender (4 exclusively for boys, 4 for girls) and included participants from urban and rural locations and mainstream and faith-based schools, ensuring diverse perspectives (Supplementary Tables S1-S3). In addition, 6 KIIs were conducted with mental health experts: 2 child and adolescent psychiatrists, 1 adult psychiatrist, 1 school psychologist, 1 clinical psychologist, and 1 mental health researcher (Supplementary Table S4). The number of FGDs and KIIs was determined based on study objectives, diversity of stakeholder groups, and qualitative principles of information power, capturing sufficient depth and breadth of perspectives relevant to school-based mental health programme design. Each FGD or KII was conducted 90–120 minutes in online settings, was audio-video recorded, and notes were taken to capture non-verbal cues and contextual details. No non-participants were present during discussions, and no repeat interviews were conducted. Data collection continued until thematic redundancy was achieved within stakeholder groups, indicating adequate information to address the research questions.

FGDs and KIIs explored mental health awareness and experiences, community strengths and limitations, knowledge of child and adolescent mental health (CAMH) and school-based mental health (SBMH) services, stakeholder collaboration, and the structure and implementation of school-based programmes.

2.3 Data Analysis

All transcripts were managed and analysed using NVivo 14 (21). A reflexive thematic analysis approach was employed, following Braun and Clarke's six-phase method [23] (Table 1). The analysis used a hybrid approach: predefined thematic domains, derived from the research questions and FGD/KII guides, provided a deductive analytic focus, while codes and subthemes were generated inductively from participant data to capture contextually salient perspectives [23–25]. These predefined themes ensured comprehensive coverage of areas relevant to the needs assessment and future programme co-design. The WHO Health Promoting Schools (HPS) framework guided gap identification and was applied post-analysis as an interpretive lens rather than an a priori analytic framework [27]. This facilitated identification of gaps and opportunities at individual, school, and community levels, consistent with a social-ecological perspective on adolescent mental health. Throughout the analysis, researcher reflexivity was maintained via reflective memos and team discussions, and adherence to the COREQ 32-item checklist [28] ensured transparency, credibility, and rigour in reporting qualitative methods.

Table 1
Phases of thematic analysis

Phase	Description of the process
1. Familiarising with data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial code	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.
Note. Source: Reproduced from Braun V, Clarke V. Using thematic analysis in psychology. <i>Qualitative research in psychology</i> . 2006;3(2):77–101.	

[Insert Table 1 here]

2.4 Reflexivity and Trustworthiness

The primary researcher's professional background in mental health (Psychiatrist) informed sensitivity to the topic and facilitated engagement with expert participants, while reflexive awareness was maintained to minimise assumptions and over-interpretation [29, 30]. Two researchers independently coded all transcripts, and discrepancies were resolved through team discussion to enhance consistency and credibility. Analytic decisions were documented in an audit trail throughout the process. Emerging subthemes and codes were discussed within the research team to enhance credibility and analytic rigour [31, 32] (Supplementary Table S5). Trustworthiness was further supported through method triangulation (FGDs and KIIs), stakeholder triangulation (students, parents, teachers, professionals), use of verbatim quotes to ground interpretations, and transparent documentation of analytic procedures [31, 33, 34].

3 Results

The findings synthesise perspectives from students, parents, teachers, and mental health professionals on adolescents' mental health conceptualization, experiences, available services, stakeholder collaboration, and expectations for school-based mental health (SBMH) programme implementation. Across stakeholder groups, participants reported emotional and behavioural difficulties among adolescents, limited help-seeking, weak school-family-community engagement, and scarce or absent

services. These themes situate current practices within the WHO Health Promoting School (HPS) framework, providing a foundation for co-designing culturally appropriate and feasible interventions.

[Insert Table 2]

Table 2 Themes and subthemes	
Theme	Subthemes
1. Conceptualisation and experiences	Understanding of mental health Mental health concerns Help seeking
2. Community strength and constrains	Family environment School environment Community
3. Fragmented child and adolescent mental health service	Existing services Pattern of help seeking/coping
4. Absence of school-based mental health service	Existing SBMH services Upcoming SBMH services
5. Collaboration, Structure, Implementation	School Family MHP Collaboration Targets, approaches, settings and evaluation of SBMH program Barriers & Strength SBMH programme Implementation
Note. SBMH = School Based Mental Health	

3.1 Conceptualisation and experiences

3.1.1 Understanding of mental health

Stakeholders consistently conceptualised mental health holistically, encompassing emotional, cognitive, behavioural, and social functioning. It was framed as a dynamic state of balance and effective functioning rather than merely the absence of illness. Teachers emphasised emotional regulation and coping:

“I understand mental health as an individual’s ability to handle stress and how he reacts in a particular situation.” (UST04)

Emotional distress (e.g., stress, nervousness), behavioural dysregulation, and functional impairments were seen as key indicators. Participants highlighted promotive factors, including healthy lifestyle practices, supportive family environments, meaningful relationships, and opportunities for enjoyment and autonomy. Students reinforced the link between mental health, mindset, emotions, and the ability to manage life challenges.

3.1.2 Lived experience

Building on stakeholders' conceptual understanding, this section presents their lived experiences of adolescent mental health concerns and help-seeking in everyday contexts. Across groups, challenges were described primarily as psychosocial stressors and age-specific behavioural changes.

Students reported multiple, interrelated stressors, including intense academic pressure, parental comparison, problematic mobile phone and internet use, bullying, family conflict, and financial hardship. Many described difficulties expressing distress to adults, which intensified emotional burden and contributed to internalised stress:

"We are unable to express our feelings to parents or teachers—and when they don't understand us, it creates mental pressure." (RMG06)

Parents and teachers observed behavioural changes during adolescence, such as stubbornness, hyperactivity, withdrawal, and declining academic engagement. These changes were often interpreted as developmental or disciplinary issues, with academic stress frequently cited as a trigger:

"Often, we see that children break down mentally due to academic pressure, especially when exams approach." (USP03)

Mental health professionals reported that anxiety and depressive disorders were the most common conditions in this age group, aligning with global trends. They noted that children and adolescents typically seek clinical care only when persistent, unresolved psychosocial distress progresses to a moderate or severe level that impairs daily functioning.

3.1.3 Help seeking

Responses to mental health concerns varied by age, role, and context. Students primarily relied on peers and online sources, reflecting limited opportunities to share difficulties with trusted adults and perceived barriers within families and schools:

"We cannot say anything to the parents or teachers. If we could share our difficulties, it would be better for us." (RSG01)

Teachers provided mostly informal support but faced constraints related to time, training, and institutional expectations. Parental help-seeking differed by setting: rural parents were often unaware of

professional mental health services and relied on traditional or faith-based healers for severe behavioural concerns, whereas some urban parents accessed private mental health care.

3.2 Community strengths and constraints

Participants identified psychosocial factors that functioned as both strengths and constraints for adolescent mental health. Strong family bonds within a collectivist culture and religiosity were widely viewed as protective, providing emotional support, moral guidance, and coping resources. These sociocultural assets were seen as potential foundations for community- and school-based mental health initiatives, particularly in contexts where formal services are limited.

Conversely, pervasive stigma, low mental health awareness, supernatural explanatory beliefs, authoritarian parenting, limited parent–child communication, and weak parent–teacher collaboration were identified as major barriers to early recognition and support. These challenges were particularly pronounced in rural and socioeconomically disadvantaged contexts, where parents often had limited time, resources, and awareness to monitor children’s emotional wellbeing or engage proactively with schools. One teacher illustrated this lack of awareness:

“One day a parent visited my room in school and asked me to take care of his daughter. When I asked which grade she was in, he smiled and said he did not know.” (RST04)

Teachers emphasised that such limitations reflected structural poverty and survival pressures rather than parental disinterest. Socioeconomic constraints also affected teachers and school environments, particularly in rural and faith-based schools, where low salaries, job insecurity, and heavy workloads limited attention to students’ psychosocial needs. As one teacher noted:

“We do not even receive a salary equivalent to an average hotel waiter—how can we think about child and adolescent mental health?” (RMT02)

This economic precarity reinforced an academically driven school culture in which examination performance was prioritised over wellbeing, and emotional or behavioural concerns were addressed reactively rather than preventively. Although parent–teacher meetings were formally mandated, weak school–family collaboration further constrained coordinated responses. Mental health experts additionally highlighted structural barriers, including shortages of trained professionals, limited CAMH infrastructure, and inadequate referral pathways, particularly outside urban centres.

Collectively, these findings underscore the need for interventions that leverage cultural strengths while addressing systemic and familial constraints, consistent with a socio-ecological perspective.

3.3 Fragmented Child and adolescent mental health service

Across school-based stakeholders, child and adolescent mental health (CAMH) services were perceived as largely unavailable, with existing were confined to few urban tertiary institutions. Mental health

professionals confirmed that services are heavily concentrated at specialist and urban levels, with limited integration into primary, community, or school-based systems. Experts also highlighted substantial resource constraints, including financial limitations, inadequate infrastructure and shortage of trained professionals. Child adolescent mental health clinics, Child Development Centres (CDCs) and selected non-government organisation (NGO) initiatives were acknowledged but described as narrow in scope, fragmented, and insufficient to meet population-level needs. The absence of structured referral pathways between schools and services further limited early identification and continuity of care. These findings illustrate a substantial mismatch between adolescent mental health needs and service availability, reinforcing the importance of school-linked, preventive, and accessible support mechanisms.

3.4 Absence of School-based mental health service

Across stakeholders, formal SBMH services were largely absent in mainstream schools, with only a few urban, well-resourced schools providing limited services, and completely absent in faith-based schools. Where structures existed, such as disciplinary committees, they were framed around behavioural control rather than psychosocial support. One parent noted:

“As far as we have observed, schools have been utilised for two health-related activities annually: “National Vaccination Campaign” and “Nationwide Deworming Campaign.” (RSP05)

School students highlighted that mental health content is minimally represented in textbooks and rarely emphasised by teachers, who prioritise examinable subjects. Mental health professionals noted that existing SBMH initiatives are confined primarily to urban, or international-curriculum schools, limiting equity and scalability. Stakeholders reported barriers including low awareness, stigma, lack of teacher training, curriculum overload, and limited policy commitment. Nevertheless, emerging facilitators were identified, such as growing public awareness, increasing parental interest, and recent policy recognition of SBMH within national mental health policy and strategy, indicating a potential window for implementation if structural barriers are addressed.

3.5 Collaboration, programme structure and implementation

3.5.1 School Family Community Partnership

Students, parents, and teachers consistently emphasised the importance of psychologically safe, supportive socio-emotional environments. Students’ reluctance to disclose concerns reflected fears of judgement and punishment, while parents and teachers acknowledged challenges balancing job and academic priorities with emotional support. In this regard one parent explained:

“Within the family, if we have a good bond among family members—including parents, children, siblings—it supports the healthy development of children” (USP02)

Participants highlighted limited skills among adults to communicate empathetically with the adolescents. Effective collaboration was described as requiring structured communication between schools, families, and professionals, with teachers positioned as key intermediaries. Engagement with religious leaders was viewed as a culturally appropriate strategy to strengthen community-level support:

“Even religious leaders are the first help seeking figures for physical health issues in our community. If the religious leaders say something, people try to follow that.” (UST05)

Overall, stakeholders indicated that collaboration across family, school, and community is essential for early identification, support, and prevention of mental health concerns among adolescents, and must be formalised to be effective.

3.5.2 School-based mental health programme

Stakeholders consistently advocated for an SBMH programme embedded within routine school functioning rather than delivered as a standalone or time limited initiative. Participants emphasised the integration of curriculum-based learning, teacher and parent capacity-building, supportive school environments, and clear referral pathways. There was strong agreement that program content should focus on practical skills, use interactive and age-appropriate pedagogy, and remain flexible to accommodate varying school capacity. Mental health professionals highlighted teacher training in early identification and appropriate response as a critical component of effective SBMH programme implementation. They also emphasised the role of the physical school environment in shaping students' mental health and wellbeing noting that classroom designs, playgrounds and open spaces can contribute to emotion regulation and stress reduction.

Parents, teachers, and students raised concerns about suboptimal school environments, including poor campus cleanliness, absence of a canteen, inadequate green space, lack of a counselling room, and no designated prayer space. One female student noted:

“Though boys or male teachers can pray (noon prayer) at nearby mosque, we don't have such scope. So, a separate spacious prayer room in campus can solve the issue.” (RMG04)

Participants indicated that these environmental limitations negatively affected students' comfort and sense of wellbeing at school. From a settings-based perspective, these findings suggest that the physical school environment functions as a structural determinant of school-based mental health and may influence the effectiveness and acceptability of psychosocial and skills-based interventions.

3.5.3 Implementation

Participants identified competing academic demands, limited resources, and lack of formal policy support as key challenges to the implementation of SBMH programmes. Teachers expressed concern that heavy workloads and examination-oriented expectations constrained their capacity to engage in additional wellbeing-focused activities. Parents and mental health professionals similarly highlighted the absence of designated roles, sustainable funding, and institutional accountability mechanisms. A strong

emphasis was placed on the need for government-level engagement, with one mental health expert noting:

“Here the office administrations are accustomed to a top-down approach, so without direct government involvement, such programmes cannot be implemented.” (MHP03)

Long-term sustainability was viewed as contingent on cross-sectoral coordination, dedicated funding, formal role recognition, and ongoing monitoring and evaluation. Participants emphasised that, without systemic alignment between the education and health sectors, SBMH initiatives are likely to remain fragmented and short-lived.

3.6 Synthesis of Findings

The findings highlight substantial gaps between adolescents’ mental health needs and school-based support in Bangladesh, as viewed through the WHO Health Promoting Schools (HPS) framework (Table 3). Across stakeholders, formal school policy and governance structures supporting school mental health were largely absent, with leadership prioritising academic performance over wellbeing. School environments were often inadequate, with poor infrastructure, limited greenspace, and a lack of counselling or prayer facilities, compromising both physical and psychosocial support. Curricular integration of mental health was minimal, with teachers focusing on examinable content and students receiving little structured learning on emotional wellbeing. Mental health services were fragmented and largely urban-centred, leaving faith-based and rural schools underserved, and referral pathways underdeveloped, leading families to rely on informal or traditional support. While stakeholders demonstrated a holistic understanding of mental health and highlighted cultural strengths such as strong family bonds and religiosity, systemic constraints hindered the implementation of preventive and promotive approaches. These constraints included heavy workloads, limited teacher training, poor school–family collaboration, and resource scarcity. Collectively, these findings indicate that the current school system and approaches only partially align with the HPS framework, underscoring the need for a comprehensive, contextually adapted SBMH programme that integrates policy, governance, school environment, curriculum, and accessible health services.

Table 3
Stakeholder Findings Mapped to WHO Health Promoting Schools Framework

HPS Standards	Findings from stakeholders	Alignment/Gap
<i>School Mental Health Policy</i>	Lack of formal SBMH policies; no designated roles or accountability for student wellbeing; reliance on top-down decisions.	Absent; structural guidance for SBMH not in place.
<i>School Governance & leadership</i>	Teachers constrained by workloads and exam-focused expectations; school leadership prioritises academic achievement over wellbeing.	Partial; leadership recognition limited (academic), no formal programme oversight.
<i>School-Community Partnership</i>	Holistic understanding about mental health Lack of skills to support students' mental health Authoritarian parenting Parent-teacher engagement (academic issues) Emphasised skill-based mental health training Training of religious leaders	Absent; formal effective collaborative approach specified for wellbeing issues of students
<i>School environment</i>	Psychosocial environment: prevailed authoritarian norm; academic outcome focused; discrimination, bully exists emotionally safe climate lacking. Physical environment: poor cleanliness, inadequate greenspace, no counselling or separate prayer room	Partial; environment not consistently supportive of mental health and wellbeing.
<i>School curriculum</i>	Minimal mental health content in textbooks; limited teacher emphasis; focus on examinable subjects; need for interactive, skill-based learning.	Partial; curricular integration of mental health minimal.
<i>School health services</i>	SBMH services scarce, urban-centred; faith-based schools largely devoid of support; weak referral pathways; families rely on informal/traditional help.	Largely absent; services fragmented and inequitable
Note. WHO = World Health Organization, SBMH = School Based Mental Health		

[Insert Table 3 here]

4 Discussion

This study provides a comprehensive needs assessment for a school-based mental health programme (SBMHP) in Bangladesh by integrating perspectives from students, parents, teachers, and mental health professionals. Rather than merely identifying service gaps, the findings illuminate how sociocultural

norms, institutional priorities, and systemic constraints interact to shape the limited availability and functionality of child and adolescent mental health (CAMH) support within both mainstream and faith-based secondary schools. Situating these findings within global school mental health literature and implementation frameworks contributes to a deeper understanding of school-based mental health challenges in low- and middle-income country (LMIC) contexts.

Consistent with evidence from LMICs, formal SBMH services were largely absent, with mental health care concentrated in tertiary facilities and urban centres [35, 36]. In the absence of structured referral pathways, students' emotional and behavioural concerns were typically addressed through informal family support, self-coping strategies, or disciplinary measures, with mental health professionals involved primarily at later, clinical stages. This pattern reflects systemic centralisation of mental health services and weak intersectoral coordination between education and health systems—barriers widely documented in global mental health system analyses [37, 38]. As a result, schools are unable to fulfil their potential role as platforms for early identification, prevention, and mental health promotion.

At the interpersonal level, parenting practices and adult–child communication emerged as critical influences on adolescent mental health and help-seeking behaviours. Students and professionals described parenting patterns characterised by high control, limited emotional communication, and strong academic expectations. While these practices are often interpreted as culturally embedded, emerging scholarship suggests they are also structurally reinforced by socioeconomic pressure, educational competition, and limited parental mental health literacy [39, 40]. Empirical evidence links low emotional responsiveness and restrictive communication with adolescent internalising and externalising difficulties and shows parenting interventions to be effective for both outcomes [41, 42]. Importantly, this study avoids deficit-based cultural explanations and instead situates parenting behaviours within broader structural and institutional constraints. These findings suggest that student-only SBMH interventions are unlikely to be sufficient and underscore the importance of family-inclusive approaches that promote emotionally responsive communication and supportive parenting.

Teacher–student interactions mirrored similar authority-driven patterns, reflecting broader sociocultural norms and institutional practices within schools. Although teachers and parents demonstrated basic conceptual awareness of mental health, their capacity to respond effectively to students' psychosocial needs was limited. This gap between awareness and applied competence aligns with mental health literacy literature demonstrating that knowledge acquisition alone does not translate into supportive practice without skill-based training and enabling institutional conditions [43, 45]. Strengthening teachers' practical competencies—such as early identification, supportive communication, classroom-based psychosocial strategies, and referral decision-making—should therefore be a central component of SBMHP design. However, such task-shifting efforts must be accompanied by realistic workload adjustments and institutional support to enable prioritisation of student wellbeing alongside academic responsibilities [46, 47].

At the structural and policy level, Bangladesh has recently incorporated school mental health into its national mental health strategic plan (2020–2030), signalling increasing political recognition of adolescent mental health needs [48]. Despite this progress, the findings reveal a substantial implementation gap between policy intent and school-level practice. Similar gaps have been documented in LMICs, where school mental health policies exist but remain weakly operationalised due to limited resources, insufficient training, and competing educational priorities [49]. Without sustained investment in school leadership engagement, teacher capacity building, monitoring systems, and service linkage mechanisms, policy reforms risk remaining symbolic rather than transformative.

Encouragingly, several facilitators indicate readiness for SBMHP implementation. Strong family bonds, religiosity, increasing public awareness of mental health, and parental concern for adolescent wellbeing create a favourable environment for change. Leveraging these facilitators requires a socio-ecological approach that simultaneously addresses individual skills, family relationships, school environments, and system-level governance [37, 50]. Practical entry points include task-sharing models involving teachers, integration of psychosocial content into existing subjects, adaptation of interventions for rural areas and faith-based schools, and formalised referral pathways linking schools with community and clinical CAMH services. Engagement with school leadership and religious authorities may further enhance cultural acceptability and institutional ownership.

Interpreted through the WHO Health Promoting Schools (HPS) framework, the findings indicate that gaps in school-based mental health support in Bangladesh arise from misalignment across interconnected system domains rather than deficits within any single stakeholder group. While awareness of mental health and cultural assets such as strong family bonds are present at individual and community levels, these are insufficiently supported by school governance, curriculum structures, enabling environments, and accessible health services. The prioritisation of academic performance limits schools' capacity to operationalise wellbeing-focused practices, constraining implementation of comprehensive SBMH approaches. From an HPS perspective, this reflects partial and fragmented adoption of a whole-school model. Effective SBMHP implementation will therefore require systemic alignment across the HPS global standards, and referral mechanisms, embedding mental wellbeing as a core educational function rather than a peripheral concern.

5 Limitations

This study has several limitations. The small number of mental health professionals involved in key informant interviews reflects the paucity of the school-based mental health workforce in Bangladesh. Parents and students participating in focus group discussions were unfamiliar with participatory research approaches, which required additional time to explain the process. Additionally, the needs assessment was conducted online due to contextual constraints, which may have limited interaction compared to face-to-face discussions. Participants from rural areas also occasionally experienced difficulties navigating digital platforms and internet connectivity issues, which may have affected their

level of participation. Therefore, the findings should be interpreted with these contextual considerations in mind.

6 Conclusion

This study provides the first multi-stakeholder assessment of needs for a school-based mental health programme (SBMHP) in Bangladesh. Students, parents, teachers and mental health professionals identified gaps in support, limited skills to respond to psychosocial challenges, and weak school–family–community collaboration, while formal SBMHPs were largely absent, fragmented, and concentrated in few urban schools. Structural barriers—including inadequate infrastructure, scarce child and adolescent mental health workforce, and underdeveloped referral pathways—limit equity, access, and sustainability. Findings highlight the need for a comprehensive, culturally responsive SBMHP aligned with the Health Promoting Schools framework, integrating curricular interventions, teacher and parent capacity building, supportive environments, and formal school–community–health linkages to ensure scalable, sustainable, and contextually relevant implementation.

Abbreviations

Ethics approval: The study was conducted according to the ethical principles outlined in the Declaration of Helsinki and adhered to all relevant institutional and national research ethics guidelines and regulations. Ethical approval obtained from the Human Research Ethics Committee at Griffith University, Australia (Ref. No. 2024/902).

Consent to participate: Informed consent was obtained from all adult participants (teachers parents or caregivers and mental health experts). Written assent was obtained from the adolescent students, and informed consent was obtained from their parents or caregivers prior to participate in the study.

Consent for publication: All participants and the parents or caregivers of adolescent students provided informed consent for the publication of anonymised data from this study.

Availability of data and materials: The datasets generated during and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests: The authors have no competing interests.

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Author's contributions: MSU conceptualised the study and prepared the original draft of the manuscript. MSU, PH and ES designed the methodology. MSU, FBA, and TB conducted the investigation, curated the data, and administered the project. MSU, PH, and ES performed the formal data analysis. MSU and PH developed the visualisation. PH and ES reviewed and edited the manuscript and supervised the study. All authors read and approved the final manuscript.

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Declarations

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Author Contribution

MSU conceptualised the study and prepared the original draft of the manuscript. MSU, PH and ES designed the methodology. MSU, FBA, and TB conducted the investigation, curated the data, and administered the project. MSU, PH, and ES performed the formal data analysis. MSU and PH developed the visualisation. PH and ES reviewed and edited the manuscript and supervised the study. All authors read and approved the final manuscript.

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Data Availability

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