Community Child & Adolescent Mental Health Service Project
2nd Quarterly Report, January to March 2015
Dept. of Child & Adolescent Psychiatry, NIMHANS
Supported by Dept. of Women & Child Development, GoK

A. Project Objectives

With a view to addressing child and adolescent mental health service needs and gaps, the project aims to extend child and adolescent mental health service coverage, particularly to cover those who are most vulnerable. Project implementation entails a comprehensive plan to provide community-based child and adolescent mental health promotive, preventive, and curative care in urban and later in rural sites through direct service delivery and training and capacity building of child care workers from community-based governmental and non-governmental agencies/institutions and professionals, including schools, NGOs, anganwadis and health workers. The specific objectives of the project include:

i) Establishment of community-based child and adolescent services;

ii) Training and capacity building of childcare workers and staff from various governmental and non-governmental agencies, including schools;

iii) Draw from implementation experiences to develop a comprehensive community child and adolescent mental health service model that may be replicated elsewhere in the country.

B. Project Implementation: Activities and Progress

1. Mental Health Services in Schools

From January to March 2015, the project reached out to 23 schools to provide first level psychosocial and mental healthcare responses to children identified by teachers as having emotional, behavioural and learning problems. Each school was visited once per month and the team spent on an average 4 hours per visit providing assistance to approximately 8 to10 children each time. In the first two months of the quarterly, new cases identified (refer to Table 1 for demographic details and table 2 for Child & Adolescent Disorders Identified) were provided with consultation, while in the third month, follow-up services were provided to those identified and provided with intervention earlier on (Refer to table 4).

First level responses comprised of the following:

i) Assessing the Child's Mental Health Problem: This is done by using various assessment proformas already developed (and piloted in the last quarterly). Information was obtained from both the teacher as well as the child (and where possible from the child's parents), in order to understand the issue from the child and caregivers' perspective.

ii) Diagnosing the Child's Problem: Based on the information obtained from the child and teacher, a diagnosis of the child's mental health disorder was made.

iii) Providing Interventions to the Child: This consists of: recognizing and acknowledging (accepting) the child's emotions, providing reassurance, framing the problem in such a way as to help the child gain insight/ understanding of the problem and its consequences, and suggesting to the child certain steps he/she can to reduce the problem. This last part

depends on the problem—for instance, a child with anxiety may be taught relaxation exercises, or a child with anger issues may be taught anger management techniques.
iv) Providing Inputs to the Teacher: The teacher is first helped to understand the nature of the child's problem and then provided with inputs on how to support the child and assist him/her with the problem identified. For instance, in case of an ADHD child, the teacher is first given information on the ADHD symptoms, including what causes it, and then requested to provide some one on one time daily and get the child to do attention enhancing paper-pencil tasks, or for a child who has social anxiety, the teacher is asked to involve the child in leadership roles and gently encourage the child to participate in group games/ clubs.
v) Referral to Tertiary Mental Healthcare Facilities: While children with mild to moderate problems are assisted through direct intervention and inputs to the teacher, others whose problem is more severe, thereby requiring psychiatric medication and/or in-depth therapeutic intervention (over a longer period of time) were referred to a tertiary mental healthcare centre. Other than severity of the disorder, certain other criteria are considered for referral, such as the type of disorder and/or the context of the problem: children with PTSD, self-harm issues, severe conduct symptoms that include violent behaviour would warrant depth assessments and longer term therapeutic work; also, children in extremely difficult family or social situations such as those with experiences of loss/grief/trauma, physical and sexual abuse were also referred.

a) Child and Adolescent Mental Health Disorders Identified

376 consultations (including first consultation and follow up) were provided to 283 children over this quarterly period. Amongst them, 347 cases of child and adolescent mental health disorders were identified (one child may have more than one disorder). Of these cases, nearly 69 cases or 20% had emotional disorders relating to anxiety and adjustment disorders/ depression; 112 cases or 32% had behavioural issues such as ADHD and conduct issues; 94 cases or 27% were identified with learning problems; 62 cases or 18% were identified with developmental disabilities.

Table 1: Total No. of (New) Consultations Disaggregated by Age & Sex, January-February 2015

Age Groups	January		February		Total
	Male	Female	Male	Female	
7 to 12 yrs	65	31	43	28	167
13 to 17 yrs	40	25	37	14	116
Total	105	56	80	42	283

Emotional and Behaviour Problems: The major part of emotional problems pertained to anxiety occurring due to social anxiety or marital conflicts/ family issues in children's homes; another common cause for anxiety is learning problems and the fear children experience in the classroom due to the teacher's expectations (thus, many children with specific learning disabilities also reported anxiety). While the number of behaviour problems were higher than emotional problems, ADHD alone accounts for about half the behaviour disorders reported consisted of ADHD. Of the remaining, anger and aggression issues were the most frequently occurring conduct symptoms.

Most anger issues and other conduct symptoms were related to neglect and punitive and/or emotionally rejecting parenting; children are also exposed to a great deal of aggression and violence at home, often the only method of problem-solving or conflict-resolution modelled by parents. Aggressive behaviour was also found to be reinforced in the context of peer group interactions.

The common causes underlying children's anxiety problems were alcohol abuse by parents and parental marital conflicts, including experiences of domestic violence. Bullying at school, fear of being teased by other children, fear of teachers especially in case of children with learning disabilities formed other reasons for anxiety. Social anxiety was found to be quite common and may be attributed to hostile home environment at home, lack of stimulation and exposure to social situations, over-protectiveness by parents, and sub-optimum parent-child relationships.

Table 2: Child & Adolescent Disorders Identified, January-February 2015

Child & Adolescent Mental Health Issues		No. of Cases		
		January	February	Total
Emotional Problems	Selective Mutism	1	0	1
	Dissociative/Somatic	4	1	5
	Bed Wetting	2	1	3
	School Refusal	4	0	4
	Other Anxiety Issues	26	11	37
	Dysphoria/Depression/Adjustment Disorder	9	8	17
	Post-Traumatic Stress Disorder	2	0	2
Sub-Total		48	21	69
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	18	18	36
	ODD	1	0	1
	Conduct Disorder Symptoms: (Lying and Stealing)	6	6	11
	Truancy	1	6	7
	Attention Deficit Hyperactivity Disorder	35	21	56
Sub-Total		61	51	112
Learning Issues	Specific Learning Disability	29	22	51
	Other Learning Problems	19	24	43
Sub-Total		48	46	94
Developmental Disability	Intellectual Disability	26	15	41
	Speech Problem	11	8	19
	Motor Disability	2	0	2
	Autism	----	----	0
Sub-Total		39	23	62
Life Skill Issues(Sexuality)		3	3	6
Other Health/Medical Problems		2	2	4
Total		**201**	**146**	**347**

Of the various mental health disorders identified and teacher's understanding of and empathy towards children with specific learning disabilities and of emotional problems was perhaps the lowest. Teachers' expressed viewpoints such as 'they are lazy'—they do not

participate in class…', frequently labelling children and stating the belief that such children 'will never change'. Even following psychoeducation, teachers found it difficult to understand that there was almost always an emotional basis to children's behaviour problems. As a result, their receptivity to inputs was also found to be relatively low (as evident by their limited execution of interventions—see section on Follow Up).

Developmental Disabilities and Learning Problems:
Given the existence of the Right to Education Act, schools admit several children with mild intellectual disability (but only one or two with moderate intellectual disability). During the course of school counselling work, it was found that many children have learning difficulties in the areas of reading, writing and mathematics. The nature and reasons for this are varied:

i) There are children whose problems are due to specific learning disabilities (SLD);
ii) There are those whose learning issues arise from mild (to moderate) intellectual disabilities;
iii) Mild to moderate Attention Deficit Hyperactivity Disorder (ADHD) is common amongst school age children. Some children have a combination of ADHD and SLD while others have only ADHD. In the latter group, inattentiveness and hyperactivity result in hindering children from participating fully in learning processes, thereby creating a context of learning problems.
iv) Many children, due to their difficult home environments, suffer from severe under-stimulation and lack of educational inputs;
v) Children from migratory families have tended to start school late or had intermittent or interruptive schooling opportunities thereby affecting their basic foundations in language and math; these children have also had learning difficulties due to changes in the medium of instruction;
vi) Finally, there is a group of children whose learning difficulties have a basis in emotional problems—children with issues such as anxiety and depression tend to be pre-occupied with family/ social/ individual experiences that have caused these emotional issues; consequently, they are unable to concentrate on academics and participate in learning processes and/or are not motivated to study, thereby creating barriers for learning.

Whatever the underlying cause of children's learning problems, whether they result from specific learning disabilities, intellectual disabilities or indirect causes (reasons (iii) to (vi)), the problems tend to present themselves as poor academic performance. When schools and teachers are unable to identify or do not understand the nature and context of an individual child's learning disability, it is also difficult for them to provide appropriate responses and special assistance to the child. A vicious cycle is then created of the teacher's expectations not being met and the child's anxiety and subsequent de-motivation, both of which cause his/ her academic performance to further deteriorate. Thus, while children who have emotional problems have learning difficulties, the converse is also true—children with specific learning disabilities and other types of learning problems also present with a range of emotional and behaviour problems such as anxiety, depression, poor self-esteem, lack of motivation and poor social skills.

It has also been observed, during project service provision activities, that schools and teachers are unable to identify and appropriately respond to different children's learning issues. This lack of understanding extends beyond schools and individual teachers to the

education system as a whole, for, the schools report that they are under tremendous pressure from the Dept. of Education to 'achieve 100% pass results in Xth standard exams'.

b) Referrals

52 referrals or 18% of the children (new consultations) were referred to tertiary care mental health facilities, namely Dept. of Child & Adolescent Psychiatry, NIMHANS. Of these, a major part of them i.e. 37% of them were referred for emotional issues. They were referred for depth therapy interventions for issues such as physical abuse, trauma, loss and grief. About 21% were referred for behavioural disorders, mainly severe conduct issues; very few were referred for ADHD—because mild to moderate ADHD can be addressed through behaviour training methods (provided in the first level response) and only severe ADHD requires medication, and was therefore referred.

Table 3: Referrals to Tertiary Care Mental Healthcare Facility, January-February 2015

Child & Adolescent Mental Health Disorders		No. of Children Referred		
		January	February	Total
Emotional Problems	Selective Mutism	1	0	1
	Dissociative/Somatic	2	1	3
	Bed Wetting	1	1	2
	School Refusal	2	0	2
	Other Anxiety Issues	6	0	6
	Dysphoria/Depression/Adjustment Disorder	1	2	3
	PTSD	2	0	2
Sub-Total		15	4	19
Behaviour Problems	Conduct Disorder Symptoms: (Lying and Stealing)	2	5	7
	Conduct Disorder (Most Symptoms)	1	0	1
	ADHD	2	1	3
Sub-Total		5	6	11
Learning Issues	SLD	2	0	2
	Other Learning Problems	1	0	1
Sub-Total		3	0	3
Developmental Disability	Intellectual Disability	5	0	5
	Speech Problem	5	3	8
	Motor Disability	1	0	1
Sub-Total		11	3	14
Other Health/Medical Problems		3	2	5
Total		**37**	**15**	**52**

While some referrals for Specific Learning Disability were made at the start of the service, this was stopped at a later stage when a large number of children were identified with various learning problems. Due to the large numbers of learning problems, the project is considering having a special educator to visit the schools in order to provide assessment, certification and remedial education to the children/ support to teachers at school.

Similarly, referral for developmental disabilities were made only when specific/ additional therapeutic interventions for speech and loco-motor problems were required—other inputs for managing children with intellectual disability were provided to teachers/ caregivers in school. While information was provided to teacher/ caregivers on where to obtain disability

certification for these children, these were not recorded as referrals. Other than the Dept. of Child and Adolescent Psychiatry, NIMHANS, the project has a tie up with the Dept. of Psychiatry at Victoria Hospital to also provide disability certification to those in need.

While some of the children referred came to the NIMHANS Child & Adolescent Psychiatry Department for treatment and some are still expected over the summer vacations, it is observed that there are many barriers to seeking care at a tertiary healthcare facility, namely: i) Parents have low motivation to help their children—although they feel the detrimental effect of poor child mental health, it is still not a priority for action (and indeed child neglect is one of the commonly reported problems in vulnerable urban communities) ; ii) Many parents are drawn from poor socio-economic groups and work as day labourers—they are therefore unable to forfeit a day's work and income to bring children to the hospital for treatment; iii) Despite treatment at NIMHANS being free for these children[1], many still quote financial problems as reasons for not following up with referral recommendations; iv) some parents deny that their children have any problems; v) the stigma associated with taking children to a 'mental hospital' continues-- the project staff dispel these biases by explaining the nature of the hospital now and the many types of services provided both in the hospital and by the Dept. of Child & Adolescent Psychiatry.

c) Follow-Up

Of the 283 children identified in January and February 2015, 113 children were followed up to track progress made, based on the first level response provided. Children with learning issues (94) and those referred (52) were not included in the follow-up. This is because children with learning problems have not yet received remedial education inputs (for which the project has a plan) and those referred were not provided with detailed first level inputs (since they were to avail of treatment at NIMHANS). Thus, about 137 children were targeted for follow-up. Of these 113 children were followed up as the remaining were not available/ not in school on the days of the follow up visits. Schools also had exams in the month of March, making it difficult to access children for follow-up; Xth grade children were already unavailable due to public exams.

Table 4: Follow Up Services

No. of Children Identified with Child Mental Health Disorders	283
No. of Children Not Included in Follow Up Services (94 cases of learning problems and 52 referrals)	146
No. of Children Targeted for Follow Up Services	137
No. of Children Followed Up	113

The parameters for follow-up of children with emotional and behaviour problems (Table 6) are different from those with intellectual disability (Table 5). This is because the objectives of intervention for each of these groups is different—while interventions for the first group aim at achieving a reduction in a given emotional problem (such as anxiety/ anger) or changes in behaviour, the interventions for the latter group aim at promoting child development, more specifically at disabled children acquiring age-appropriate developmental abilities and skills. Also, while there might be variations in time for individual children's emotional and behaviour

[1] The Department of Child & Adolescent Psychiatry has waived even the nominal registration and service charges for children referred through this Community Child & Adolescent Mental Health Service Project. This is in recognition of the fact that these children are drawn from socially and financially vulnerable families and communities and that their health seeking behaviour (particularly with regard to mental health services) is poor.

problems to improve, in general, some improvements are possible in a short time; however, children with developmental disability may take many months to wholly or partially acquire new skills. Therefore, for disabled children, the evaluation of progress needs to be on process versus outcomes (which will only occur in the longer term) i.e. the extent to which teachers and caregivers carry out the interventions, knowing that change could take a long time.

i) Follow Up of Children with Intellectual Disabilities

Over this quarterly, 20 children with intellectual disability were followed up. It was found that while all teachers claimed to be providing psychoeducation to parents (based on inputs provided to teachers by the project team), the teachers themselves did not seem to be willing to/ think it possible to implement special interventions for children with disabilities—a majority of them did not carry out the suggested interventions with children at school. The project services had also provided information on disability certification (about which many parents were unaware), in NIMHANS and Victoria Hospital; however, only 25% of the families had it done for their children.

Table 5: Follow Up on School Children Identified with Developmental Disabilities, March 2015

% Activities Implemented by Teachers	0-25%	90% (18)
	26-50%	10% (2)
	>51%	0
No. & % of Children Acquiring New Skills	Full	0
	Partial	25% (5)
	None	75% (15)
No. & % of Teachers Providing Psychoeducation to Parents/ Families		100% (20)
No. & % of Children Obtaining Disability Certification		25% (5)
Total No. of Children		20

In general, it was observed that in most schools, teachers' knowledge on child development is poor. While they are able to identify children with mild to moderate disability, those who are on the dull-normal (borderline) usually go undetected. Consequently, such children, because they are perceived to be normal, are under pressure to perform; unable to meet the regular standards for performance, they are often at higher risk of emotional problems such as anxiety. Even where teachers are aware of children's disability, they have not the skills to work with these children.

Unfortunately the premise of the Right to Education (RTE) Act is geographic location and socio-economic status, not inclusive education. The RTE mandates that old children living within a certain radius of the school have to be admitted in that school; the RTE also has a social mandate, which is to get all children, especially those from underprivileged backgrounds to go to school or to not be rejected for school admission. Thus, mandatory admission of children with disability is part of the geographic and social mandate of RTE and while normal children may benefit from this, children with special learning needs only get further marginalized. These children are admitted to schools in which there is no spirit of inclusive education and teachers have no skills to cater to their special needs; teachers are frequently resentful of such children because they are 'the reason the school cannot get 100% results'. Thus, the RTE, well-intentioned as it may be, does not make provisions based the learning needs of children, especially children with disabilities, thereby also reflecting how narrowly its social inclusion mandate is defined.

Table 6: Follow Up on Children Identified with Emotional and Behavioural Disorders, March 2015

Child & Adolescent Disorders	No. of Cases Followed Up	No. & % of Cases implementing Interventions*	No. & % of Cases reporting improvement**			Reasons Attributed by Children for Improvement in problem***				No. & % of Teachers implementing interventions	No. & % of teachers reporting improvement in Child		
			0-25%	26-50%	>51%	First level response at school	Interventions suggested in first level response	Teacher's intervention	Other Reasons		0-25%	26-50%	>51%
Anxiety	23	**87%** (20)	**39%** (9)	**13%** (3)	**47%** (11)	**15%** (3)	**50%** (10)	**25%** (5)	**10%** (2)	**44%** (**10**)	**30%** (7)	**39%** (9)	**30%** (7)
Adjustment Disorder/ Depression	5	**60%** (3)	**8.6%** (2)	**4%** (1)	**9%** (2)	**25%** (1)	0	2	1	**60%** (3)	**4%** (1)	**13%** (3)	**4%** (1)
Anger/ Aggression	21	**90%** (19)	**13%** (3)	**39%** (9)	**39%** (9)	**41%** (9)	**45.4%** (10)	**9%** (2)	**5%** (1)	**42%** (9)	**22%** (5)	**43%** (10)	**26%** (6)
Conduct Symptoms	9	**56%** (5)	0	**13%** (3)	**26%** (6)	**38%** (3)	**38%** (3)	**25%** (2)	0	33% (3)	0	**9%** (2)	**30%** (7)
ADHD	32	**69%** (22)	**60%** (14)	**52%** (12)	**26%** (6)	**38%** (12)	**25%** (8)	**34%** (11)	**3%** (1)	**50%** (16)	**65%** (15)	**61%** (14)	**13%** (3)
Life Skill Issues	3	**67%** (2)	**4%** (1)	**4%** (1)	**4%** (1)	**100%** (1)	0	0	0	**67%** (2)	**4%** (1)	**8 %** (2)	0
Total	93	**76%** (71)	**31%** (29)	**31%** (29)	**38%** (35)	**34%** (29)	**36%** (31)	**26%** (22)	**5%** (4)	**43** (46%)	**37%** (29)	**32%** (25)	**31%** (24)

ii) Follow Up of Children with Emotional and Behaviour Problems

Children's Perception of Issues that Improved and the Extent of Improvement:

Anxiety: 87% of children with various anxiety problems reported that they were (partially or wholly) implementing the interventions suggested in the first level response. Nearly half these children reported greater than 51% improvement, while a third of them reported some minimal levels of improvement. Reasons for anxiety issues showing the maximum improvement amongst all disorders are that: first level response is often successful in providing the child with clarity on the sources of his/her anxiety and thus able to enable the child to gain insight and take a perspective on the issue; the onus of implementing anxiety management techniques lies with the child (rather than being dependent on the unpredictable support of teachers/ caregivers), so where the child implements these techniques, it is effective.

Adjustment Disorder/ Depression: Although much fewer in number, children with adjustment disorder or depressive symptoms do not appear to have benefitted greatly from first level response and interventions (only 9% report higher levels of improvement). This is probably because feelings of sadness, hopelessness and low self-esteem require to be expressed and validated at length, for the child to feel comforted enough to move on to problem-solving and recovery. The service may have to consider referral and/or greater involvement of the teacher in order to address this.

Anger/ Aggression Problems and Conduct Disorder Symptoms: 90% of children with anger/ aggression implemented interventions and nearly 40% of them reported high levels of improvement. Of the 56% of children implementing interventions for conduct symptoms, only 26% reported high levels of improvement. It is probable that children with higher levels of insight and motivation, particularly important for conduct issues, are able to feel greater improvement. While first level response appears to have benefitted children with just anger problems, children with more complicated conduct symptoms such as lying and stealing and intense aggression (property destruction and serious physical aggression) require more work on gaining insight into their problem, including its negative consequences (a process in itself) in order to gain motivation for change. Also, greater support from teachers in terms of cues and reminders might also be required for the children to implement anger management techniques in a more sustained manner. Further, reducing conduct symptoms such as severe and long-standing anger and aggression, lying and stealing behaviours are not just a matter of control—they also entail development of certain other life skills such as problem-solving and empathy. The learning of such life skills usually require more time and work than sometimes possible in a first level response—and could therefore be an agenda for life skills sessions and group work in schools.

Attention Deficit Hyperactivity Disorder: Nearly 80% of ADHD children report improvement—with over half of them reporting between 26 and 50% improvement and nearly a third of them reporting over 51% improvement. This is heartening to note although somewhat surprising too as ADHD is a neurological problem that generally takes a considerable amount of time and training for improvement to occur. There are three reasons that might explain the report on improvement: a) teachers have managed to implement 50% of the suggestions provided to them to assist the children; b) many were mild to moderate cases of ADHD and therefore improved faster than severe ADHD would; c) some over-reporting by

children due to lack of insight (most children identified with ADHD were of a younger age group) and/or due to social desirability on the part of the child.

Overall, across disorders, 76% reported that they were (at least to some extent) implementing the interventions suggested during counselling sessions and 38% of the children reported higher levels of improvement. This indicates that first level response has impact in schools and has considerable potential to provide psychosocial support to children. Interestingly, although the 'complaints' about problems arise largely from the teachers, the children seem to be more motivated than the teachers to implement interventions--only 43% of teachers report that they implement interventions while nearly double that proportion of children report implementing interventions.

Another noteworthy issue is that in case of many disorders, teachers' report on the level of child's improvement has been considerably lower than the child's report on his/ her improvement. However, it appears that with regard to some of the behavioural disorders (anger/ aggression, ADHD and conduct symptoms) children and teachers' views in the 26 to 50% category are in the same range. In other categories such as the >51%, most often the teachers' perception of improvement in the child is lower than that of the child. One possibility is that teachers may be better able to perceive changes relating to externalizing issues through children's behaviours; however, they may be less able to gauge improvements in children with internalizing problems—especially as few teachers appeared to have the skill, ability or interest to engage with children having emotional problems. And this is because teachers' relationship with children is largely based on children's ability to perform academically, be obedient and behave in socially acceptable ways versus on children's individual abilities, talents and personhoods (as observed frequently in the project staff's interactions with the teachers).

Some of the other factors that impact the extent to which disorders improve are:
i) Age of the child—younger children tend to forget discussions had in the counselling session and also find it more difficult to implement interventions on their own without constant reminders and support from teachers and caregivers.
ii) Difficult home environment –A great deal of the requisite support is not easily forthcoming given the home environment these children come from, where there are not only many conflicts and stresses but where parents have no time to spend with their children.
iii) Teachers' interest and motivation to support and assist children—indeed this is a highly variable factor but a very critical one in the light of the difficult home circumstances that many of these children come from. There are individual teachers who are child-friendly and certain schools that have a larger number of such teachers; however, unfortunately, a greater number of teachers tend to be strongly critical and authoritative
iv) It is to be noted that progress is being reported over a very short period-- only two sessions/ interactions per child (and teacher) were completed at the time of this report. As is well known, behaviour change is a process, and one that requires continuous inputs (as will be provided in subsequent follow-up sessions).

Reasons Reported by Children for Improvement:
In general, over a third of children attributed their improvement to first level response in terms of the discussion done that took place in the session with the counsellor and to the interventions suggested by the counsellor. "What you said that day, on the first day" was a

common attribution, referring to the counsellor's response on the day of the assessment and initial discussion with/ response to the child. This is clearly reflective of the fact that listening, empathy and acknowledgement of children's emotions have an immediate positive effect on the psychosocial problems they are experiencing i.e. the counsellor's engagement with the child, however brief, helps the child to feel heard, comforted and supported. That the children report that the interventions they implemented to whatever extent also show that first level responses can help them contain the problem and even reduce it to some extent. This also shows that some of the techniques suggested were doable by the children. In sum, based on the children's opinions, first level response has the desired impact in terms of providing psychosocial support to them.

In terms of specific disorders, the proportion of children attributing improvement to interventions suggested for implementation by the child in first level response, was highest amongst children with anxiety and children with anger/ aggression (45% and 50% respectively), thus indicating that first level interventions can be effective for anxiety and anger management.

Only a third of the ADHD children attributed their improvement to teachers' interventions and about one-fourth of children with anxiety and conduct symptoms attributed their improvement to teachers' interventions. This corroborates the fact that teachers do not make enormous efforts to implement interventions (due to lack of time, as they say, or lack of motivation, as observed by project staff) and that consequently, children do not feel supported by them to any significant extent. This finding raises some critical questions about teachers' involvement in children's psychosocial development and support: while teachers may seem like the best (and often the only) persons to provide first level response and support to children with psychosocial issues, especially children drawn from difficult home and social circumstances, are they really able to do it? While the reasons they provide, about lack of time, burden of administrative tasks may be true and valid to an extent, first level response does not require large amounts of additional work and time on the part of teachers. The findings from the follow up and the project's experience and observations whilst providing the services show that lack of interest and motivation on the part of many teachers (vis-à-vis lack of awareness and knowledge which also exists but is more easily addressed by the project services) appears to be the bigger reason for the difficulty teachers have in supporting children's psychosocial needs. Further, teachers' hierarchical attitudes towards children engender a relationship that is founded largely on instruction, criticality, and expectations of performance and obedience. Such attitudes and relationships do not inspire confidence in the children; in fact they only provoke fear, and that does not lay the foundations for any sort of sharing or counselling relationship. Moving forward, it remains to be seen, during the course of project implementation, if teachers' attitudes can be changed and they can be better involved with supporting children's psychosocial needs.

2. Child and Adolescent Mental Health Services in Primary Healthcare Centres

Following the PHC medical officers' training conducted by the Dept. of Child & Adolescent Psychiatry, NIMHANS, in the previous quarterly, permissions were obtained from BBMP Health to enable 12 selected PHCs to participate in the project activities. The objectives of integrating child and adolescent mental healthcare into primary healthcare services are as follows:

- Increasing community awareness on child mental health issues.

- Ensuring early and more accurate identification and referral of children with developmental disabilities and other emotional/ behaviour disorders.
- Provision of first level/ primary healthcare and services to children with developmental disabilities and emotional and behaviour problems, including parent and teacher guidance on home-based care and training for children with disability.

Integration of child and adolescent mental healthcare into primary healthcare services has been envisioned as follows, in consultation with the PHC staff (during the needs assessment phase of the project):

- The project develops screening tools for use with children seeking other health assistance in the PHC i.e. so that MOs and ANMs can screen children who might be presenting for other medical complaints and thereby identify mental health issues also.
- The project team provides services in PHCs (through periodic/ scheduled visits to PHCs) to children identified with behavioural/ emotional problems and developmental disabilities, through consultation liaison mode i.e. with intervention planning done by NIMHANS and executed/ followed up by PHC team.
- The project provides training and capacity building support to PHC staff through:
    - Training workshops/ classroom training on child mental health, with emphasis on practical skills (to enable PHC staff to provide first level responses to children with developmental disability and emotional/ behaviour problems).
    - On-the- job training and support PHC staff in the clinic and community, during awareness sessions/ home visits/ consultation liasions, working with them to demonstrate use of screening/ identification tools and first-level response.

Based on the above implementation objectives, 12 PHCs were visited once each, between 2 and 4 pm on Thursday and Friday afternoons through the months of February and March 2015. 7 senior residents from the Dept. of Child & Adolescent Psychiatry, NIMHANS, who are also part of a super-specialty academic program, a DM (super-speciality) program in Child Psychiatry, were deployed to provide these services in conjunction with the PHC staff.

In all, 72 children were received between the ages 0 and 17 years (refer to table 6) and 96 child and adolescent disorders were diagnosed and provided with treatment (refer to table 7). At PHC level, treatment included provision of psychoeducation and inputs to the child's family, first level responses to the child (where appropriate) and psychiatric medication as required.

Table 6: Total No. of (New) Consultations Disaggregated by Age & Sex, February-March 2015

Age Groups	February		March		Total
	Male	Female	Male	Female	
0 to 6 yrs	16	5	6	4	31
7 to 12 yrs	13	5	3	3	24
13 to 17 yrs	5	0	1	1	7
Total	**34**	**10**	**10**	**8**	**62**

Of the 72 children assessed at the PHC, 16 (22%) were referred to tertiary care facilities. As in the case of school mental health services, these were children requiring further in-depth assessments in multiple areas as well as those requiring longer term in-depth psychotherapy (in case of emotional and behavioural disorders) or special inputs for speech and loco-motor disabilities. All children were referred to the Dept. of Child and Adolescent Psychiatry, Dept.

of Speech Pathology and/or Dept. of Neurological Rehabilitation (for physiotherapy) as required.

Table 7: Child & Adolescent Disorders Identified, February-March 2015

Child & Adolescent Mental Health Issues		No. of Cases		
		February	March	Total
Emotional Problems	Selective Mutism	1	0	1
	Dissociative/Somatic	0	0	0
	Bed Wetting	6	1	7
	Tic Disorder	2	0	2
	School Refusal	0	2	2
	Other Anxiety Issues	3	0	3
	Dysphoria/Depression/Adjustment Disorder	1	0	1
	Post-Traumatic Stress Disorder	0	0	0
Sub-Total		13	3	16
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	0	0	0
	ODD	3	0	3
	Conduct Disorder Symptoms: (Lying and Stealing)	0	0	0
	Truancy	0	0	0
	Conduct Disorder (Most Symptoms)	1	0	1
	Attention Deficit Hyperactivity Disorders	12	2	14
Sub-Total		16	2	18
Learning Issues	Specific Learning Disability	5	0	5
	Other Learning Problems	0	2	2
Sub-Total		5	2	7
Developmental Disability	Intellectual Disability	16	11	27
	Speech Problem	7	4	11
	Motor Disability	4	1	5
	Autism	1	1	2
Sub-Total		28	17	45
Life Skill Issues(Sexuality)		0	0	0
Other Health/Medical Problems		7	3	10
Total		**69**	**27**	**96**

The project experienced considerable challenges in delivering services in the PHCs:

- It was found that community mobilization by the link workers is extremely variable; in most cases, community mobilization was extremely poor as was evident in the fact that barely any children/families came to the PHCs to avail of the services.
- The link workers, despite having attended orientation workshops and being repeatedly instructed to inform the community about the nature and time of the child mental health services at the PHC seemed unable to do so. The reasons for this range from lack of timely and adequate payment to link workers to the wards/ communities being 'extremely far away from the PHC' making it hard for the link workers to access their communities and hard for the families to bring their children to the PHC. Link workers being over-burdened with other programs and tasks and therefore too busy to take on 'additional tasks' was another reason proffered—

however, the project teams observed that the link workers were often absent in the PHC during the service visits and/or did not appear to 'be busy engaged in data entry and other tasks'; many of them showed little interest in participating in the services and learning about child mental health issues, even when they were present in the PHCs.

- Medical Officers were frequently absent in the afternoons and therefore not available for on-the-job training or medical prescriptions in case any child need them. The lack of interest and animation by MOs may also account for the lackadaisical attitude of the link workers, for the PHCs where community mobilization was much greater than the rest, also had interested MOs.
- There was a general disinterest and a perception that the service was to be run by the NIMHANS project team i.e. a lack of understanding of the objectives of integrating child mental health into primary healthcare services, and therefore an attitude that the PHC did not need to participate or learn.

Table 8: Referrals to Tertiary Care Mental Healthcare Facility, January-February 2015

Child & Adolescent Mental Health Disorders		No. of Children Referred		
		February	March	Total
Emotional Problems	Selective Mutism	1	0	1
	Dissociative/Somatic	0	0	0
	Bed Wetting	0	0	0
	School Refusal	2	0	2
	Other Anxiety Issues	0	0	0
	Dysphoria/Depression/Adjustment Disorder	0	0	0
	PTSD	0	0	0
Sub-Total		3	0	3
Behaviour Problems	Conduct Disorder Symptoms: (Lying and Stealing)	0	0	0
	Conduct Disorder (Most Symptoms)	1	0	1
	ADHD	2	0	2
Sub-Total		3	0	3
Learning Issues	SLD	0	1	1
	Other Learning Problems	0	0	0
Sub-Total		0	1	1
Developmental Disability	Intellectual Disability	0	0	0
	Speech Problem	3	3	6
	Motor Disability	0	3	3
Sub-Total		3	6	9
Total		**9**	**7**	**16**

As a result of poor community mobilization and lack of interest and participation by medical officers, the project was able to serve less than 5 children per PHC/ visit. Some PHCs had absolutely no children to avail of the service. Overall, community mobilization appeared to be taking place to some extent in only 2 out of the targeted 12 PHCs, and MOs have been regularly present/ participative in the services in only 2 to 3 PHCs. While the project is cognizant of other programs which are PHC priorities, such as H1N1 awareness/ treatment and immunization campaigns, these and remuneration issues do not seem to account entirely for the general apathy and poor participation of PHC staff.

In response to the above issues, the 3 Medical Health Officers (MHOs) under whose administrative control the targeted PHCs are, were provided with detailed feedback on the nature of engagement and challenges experienced at their clinics. Not keen for the services to be withdrawn as yet (which was one option provided by the project team), the MHOs have requested time to communicate with their PHCs and will revert to the project team.

Meanwhile, the project team also has plans of using the upcoming immunization campaigns as well as routine immunization days to screen children for mental health issues and developmental disabilities and refer them to PHC services. Brief and simple early screening tools have been prepared for the link workers to use during their house-to-house visits to screen children for disability—these will be shared with them in the next quarterly, with a view to improve community mobilization for the purposes of the child mental health services.

3. Preparation for Work with Childcare Agencies

Out of the 25 childcare agencies that responded and/or attended the orientation workshops during the needs assessment and resource mapping phase of the project (June to October 2015), 9 agencies were selected for initiation of services in April 2015. Of these, three are government agencies. During the latter part of this quarterly reporting period, visits were made to these agencies to discuss the types of services that would be useful to the children within them. To begin with, over April and May 2015, the project team will provide individual/ curative services within these agencies, targeting children with chronic emotional and behaviour problems as identified by agency staff. Group work and life skills sessions will be started at a later time when the project team has a better understanding (through individual services) of the particular needs of the children.

4. Preparation for Anganwadi Services

Although initiation of Anganwadi services was planned for this quarterly, the project was unable to achieve this due to human resource constraints. However, now that staff have been identified for the project, this preparations were made for the anganwadi services during this quarterly, and the services are scheduled to begin in April 2015.

A mapping of anganwadis within the targeted PHC catchment areas was implemented during the latter half of this quarterly, in preparation for pre-school psychosocial and mental healthcare services planned by the project. While there are nearly 60 anganwadis within these catchment areas, 24 were randomly selected for initiation of services in April 2015. The rest will be covered later on, during the course of project implementation.

Anganwadi teachers were contacted and informed about the nature of the services, namely direct work/ group activities with children to promote early stimulation and optimum development in the 5 key areas of child development (physical/ social/ speech & language/cognitive/ emotional development); direct work with children will serve as on-the-job training/ demonstration of early child education and development techniques to the anganwadi teachers and the project team will also provide inputs of child development alongside the activities to enhance teachers' conceptual and theoretical understanding of early stimulation and child development. Another objective of the anganwadi services is screening and early identification of children with developmental disabilities—for such children, referrals will be made to the PHC services and inputs will be provided to anganwadi teachers to support children with special needs.

5. Training and Capacity Building

As part of its capacity building objective, the project continues to provide technical support to community-based agencies, more specifically, to field workers based within communities and providing direct assistance to children in need. During this quarterly period, the prokect team facilitated 4 training workshops as detailed below.

1. The project team facilitated two three-day training workshops, for a total of 70 Childline workers, on *'Child Sexual Abuse: A Counselling Perspective'.* Covering a range of basic counselling skills for children who are sexually abused, the workshop covered topics on identification of and first level response to child sexual abuse, including how to do age-appropriate prevention activities on child sexual abuse. (January-February 2015)

2. A three-day workshop was organized and conducted by the project team for 24 ICPS staff. *'Counselling Skills for Child Psychosocial Care and Protection'*, the first of the series of training workshops for the ICPS staff. This is part of the implementation of 'Advanced Capacity Building Initiative for ICPS Staff', for Bangalore Urban and Rural ICPS staff, again a DWCD-NIMHANS project. It is being implemented as a sub-part of the larger Community Child and Adolescent Mental Health Service Project, with the following objectives:

- To enhance the quality of child protection and psychosocial care services available to vulnerable children.
- To provide special interventions to children living in difficult contexts.
- To enable and equip ICPS staff to deliver in-depth child protection and psychosocial care services.
- To develop and standardize advanced training content and materials for ICPS staff in Karnataka.

Through this workshop, additional ICPS staff for training were identified. The DCPO, Bangalore Urban has sent a list of XX ICPS counsellors from the urban area. Training for these staff will be planned in the next quarterly.

3. Upon request from Visthaar, an NGO working in the areas of gender, sexuality and disability, a two-day workshop on *'Gender, Sexuality and Disability: A Child and Adolescent Psychosocial Care Perspective'* was facilitated by the project team. The workshop sought to provide a framework for understanding the relationship between gender, sexuality and disability in children's work, touching on relevant concepts and skills for 25 childcare workers drawn from community-based agencies located in various Asian and African countries, such as Laos, Sri Lanka, Ghana, Zimbabwe etc.

C. Human Resources

During this quarterly, two project officers have been identified to work on the project. A trial period was provided to ascertain the skills and interest of these staff, who were first taken on as resource persons, following which it has been decided that they will continue to serve on the project. Administrative formalities for recruitment will be completed in the next quarterly.

Given the enormous scale and scope of the project (much expanded after the initial submission of the project proposal, wherein it was proposed that only the BTM layout area be served, and following the needs assessment and resource mapping exercise), there is the need for a third project officer. Although not included in the original proposal/ budget, the project plans to recruit a third project officer, at NO extra cost i.e. the existing human resource budget will be used to pay 3 project officers instead of two.

Finally, based on the enormous needs in government schools, with many children having special learning needs and the teachers having poor awareness and skills to address learning disabilities, the project has identified a special educator (to work part-time as a resource person) to provides services in 23 schools, starting June 2015.

D. Collaboration with Other Agencies and Sectors

a) Collaborations with Agencies Providing Care and Protection to Children in Difficult Circumstances

One of the aims of the on-going the Community Child and Adolescent Mental Health Service Project, Dept. of Child & Adolescent Psychiatry, NIMHANS, supported by the Dept. of Women and Child Development, Government of Karnataka, is to provide support to child care agencies assisting children in difficult circumstances (CIDC) through: provision of direct psychosocial and mental health assistance to children and capacity building of agency staff. Thus, it will ensure access to mental health care to CIDC, including psychiatric referral and preventive-promotive care, the development of contextualized intervention packages for various types of CIDC and staff capacity building for continued assistance in mental healthcare. While the project plans to initiate such services, it was felt that more formal agreements with select agencies would be useful in i) ensuring that agencies commit to staff capacity building through methods such as staff secondments to the project; ii) creating greater sustainability of services for children in the community through in-house capacity building of community-based agencies.

The project therefore approached two agencies during this quarterly, namely, Karnataka Health Promotion Trust (KHPT), working in the area of HIV/AIDS and Visthaar, which works with gender, sexuality and disability vulnerabilities. Both agencies were selected for their strong commitment to children and community-based work.

i) Karnataka Health Promotion Trust (KHPT): HIV infected/ affected children form an important sub-group of CIDC, in that they have specific medical and psychosocial needs pertaining to illness and disclosure issues, ART adherence, experiences of loss, grief and trauma, including concerns about mortality. While considerable work has been done in the context of adults, children have been a relatively neglected population in the HIV sphere. However, given that ART has resulted in survival of young children infected by HIV, into adolescence and adulthood, this gap in HIV assistance to children requires to be remedied.

In the light of the above, during this quarterly period, the project has discussed and agreed on collaborations with KHPT, an agency with long-standing experience in the field of HIV, and one that has initiated work with children infected/ affected by HIV. As part of this collaboration, the project will:

- Train KHPT staff seconded to the project in child and adolescent mental health issues, including child psychosocial assessments and methods, age-appropriate interventions for vulnerable children drawn from a variety of difficult contexts; initially, 3 KHPT staff will be seconded to the project for a period of 4 months (each). This is with a view to building KHPT's in-house capacity on child mental health, with a view to sustainability.
- Build KHPT staff capacity through training workshops conducted for KHPT counsellors and outreach workers. These workshops, held at regular intervals of 1 to

3 months, will provide basic and advanced skills on working with children infected/ affected by HIV.
- Develop manuals for staff training and intervention packages for use with children, in collaboration with KHPT.
- Provide any other technical assistance/ advice on child and adolescent psychosocial/ mental healthcare issues pertaining to HIV infected/ affected children.

KHPT's role will be to:
- Second 3 staff to NIMHANS child and adolescent community project for a period of 4 months/ staff.
- Organize training workshops for KHPT staff, in which NIMHANS project staff will provide training on child counselling methods, equipping KHPT staff with basic and advanced skills on working with children infected/ affected by HIV.
- Develop manuals for staff training and intervention packages for use with children, in collaboration with KHPT.
- Enable and facilitate contact/ work with agencies providing care and protection to HIV infected/ affected children.

An MoU has been initiated between the project and KHPT and will be duly signed in the next quarterly, at which time, some of the above mentioned work will be initiated and continued, as required, through the period of project implementation. Staff secondment by KHPT is planned for June 2015.

ii) Visthaar: Discussions were completed and upon the request of Visthaar, a proposal was drafted for the Community Child & Adolescent Mental Health Service Project to work jointly with Visthaar to assist children with gender, sexuality and disability vulnerabilities. More specifically, the objectives of the collaboration would be:
- Provision of direct services to children in difficult circumstances, addressing mental health/ developmental needs, to respond to their social experiences of marginalization and their individual experiences of abuse and trauma.
- Capacity building of childcare staff to:
    - Design their work on rights-based frameworks, to mainstream gender, sexuality and disability issues into interventions with children.
    - Provide first-level psychosocial care responses to children.
- Development of materials for use by childcare agencies including:
    - Service providers' training manuals.
    - Intervention packages for children.

The agency's response and decision is still awaited, as they are required to present the proposal before their Board; the progress will be followed up in the next quarterly period.

b) Support to Rashtriya Bal Swasthya Karyakram (RBSK):
As part of the Project, the objectives of services and support provision to the RBSK school health teams are:
- Early and more accurate identification and referral of children with developmental disabilities and other emotional/ behaviour disorders.
- The extension of the RBSK school health teams' roles in the area of child mental health issues (including disability) in ways that enable them to provide first-level responses to children with emotional and behaviour problems, including parent and teacher guidance on home-based care and training for children with disability.

An implementation plan consisting of the following has been drafted and sent to the RBSK for their approval:

- Training and Capacity Building of RBSK teams—to provide an initial training on screening/ assessment tools and methods and first level responses on various child and adolescent mental health disorders and developmental disabilities in anganwadis and school age children.
- Support through the Project's Direct and Daily Participation in RBSK School Health Services for a 4 month period—to demonstrate to and support RBSK staff in first level provision of mental health services to children.
- Location, Teams and Targeted Schools.

The RBSK program's response and formal approval is still awaited (see 'Operational Challenges' for further details).

E. Operational Challenges

During this quarterly, the problem of obtaining permissions from government departments persisted as the project team struggled for several months to obtain approval from the RBSK program which is under the Dept. of Health. The process of communication with various RBSK functionaries such as the Deputy Director, the Mission Director and others has been on-going since August 2014. Permission to support the RBSK program has finally been granted, however, this is still verbal (telephonic); the project has sent on a detailed ToR as per their request and is still expecting a written document to formalize the permission granted. Work planned with the RBSK (outlined above) will start in the next quarterly subject to this formal permission.

One of the major hurdles in project operations has been the Dept. of Women and Child Development itself. Delayed responses to budgetary queries and requests for administrative assistance, and the need for repeated e-mail/ telephone communications with DWCD staff and officials has been difficult and frustrating for the project team. It has taken over 3 months for the project to obtain some response from DWCD on the following issues:

- A letter permitting the project to use other budgetary lines to incur travel costs. This permission is still awaited/ not granted—and is creating problems as transport is a major and critical expenditure for a community service project.(Note: This is only an expenditure permission issue--no additional money is being requested).
- An additional Rs.10 lakhs, over and above the original Rs.60 Lakhs approved for the project for the 3 year period, has been sanctioned by the Executive Committee. The current request is for the first instalment of this i.e. Rs. 3.3. Lakhs be released. All requests made for details of plans for expenditure were met and the project provided the requisite clarifications. However, other than repeated copies of letters that this request has been approved, no details are forthcoming on how and when these additional funds will be released.
- Rs. 1.87 Lakhs already approved and released by the DWCD, for the 'Advanced Training of ICPS staff' project erroneously was sent to the DCPO (Bangalore Urban), instead of to NIMHANS. After repeated follow-ups, over several months, the amount was finally received by NIMHANS at the end of March 2015.
- Following the first ICPS staff training workshop, requests were made to the ICPS/DCPO staff (Bangalore rural and urban) for a list of additional ICPS counselors to be able to plan the next ICPS training workshop. After repeated requests, the

Bangalore Urban DCPO finally sent on a list of staff; however, the Bangalore Rural DCPO has till date not sent on the rural staff list.

Such delays and non-response are creating difficulties for project implementation. It is somewhat surprising and rather unfortunate that the DWCD itself, whose department project this is, has been unhelpful and unresponsive to the project team. One can only hope that this will be remedied, else, in this future, these problems will adversely affect the timely and effective implementation of the project.

F. Plans for the Next Quarterly Period, April to June 2015

- Anganwadi services to be initiated in April 2015.
- Child care agencies services to be initiated in April 2015.
- Special education services to be initiated in the 23 schools served in this quarterly, where children with learning difficulties have been identified.
- Participation in PHC's routine immunization activities (weekly) and immunization campaigns when possible for improved community mobilization to identify children with mental health issues.
- Working with PHC link workers to share screening formats for use in house-to-house visits for them to screen and refer children with disability.
- Building of child and adolescent mental health expertise in KHPT staff who are seconded to the project, as part of the project's objective to reach out to HIV infected/affected children.
- Support to RBSK program, including direct assistance to children through participation in RBSK school health services, and provision of training to RBSK staff on child and adolescent mental health issues/first level counselling responses.
- Implementation of first training workshop for additional Urban ICPS staff as part of the (sub) project on 'Advanced Capacity Building Initiative for ICPS Staff'.

Annexe 1
School Mental Health Service Visits, January to March 2015

	PHC Catchment Area	School Name
1	T.R. Mills	Good Day Govt. School, Shrinagar
2	C.T. Bed	Kamala Nehru Aided School
3	Vidyapeeta	Govt. Kannada Higher Primary School, Itmadu (Banshankri 3rd Stage)
4		Govt. Higher Primary School, Hoskehalli (Banshankri 3rd Stage)
5	Banashankari	Govt. Urdu Primary School, Yarabnagar
6		Govt. Tamil Higher Primary School, Banashankari
7		Govt. Higher Primary School, Sarbandepalaya
8		Govt. Urdu Modern Primary School, Sarbandepalaya
9	Kumaraswamy Layout	Govt. Higher Primary School, 15 F Bus Stop, Kumaraswamy Layout II stage
10		Govt. Lower Primary School, Gowdenpalya
11		Govt. Higher Primary School, Kadrenhalli
12	N.S. Palya	Govt. Primary School, Marenhalli
13	J.P. Nagar	Government High School, Sarakki Layout
14		Government Primary School, Sarakki Layout
15	Bapujinagara	Govt. Higher Primary School
16	Avalhalli	Govt. High School, Batanpura
17		Govt. Primary School
18	Adugodi	Govt. Lower Primary School, Mastripalya
19		Govt. High School, Madiwala (Govt. PU College Madiwala)
20		Govt. Model Primary School, Madiwala (Govt. PU College Madiwala)
21	Tavrekere	Govt. Urdu Higher Primary School, Tavrekere
22		Govt. Urdu Model Primary School, Old Guruappanpalya
23		Govt. Higher Primary School, S.G. Palya
24		S. Janardhan Govt. Kannada Primary School, Guruappanpalya

Annexe 2
PHC Mental Health Service Visits in February-March 2015

PHC visited in February 2015	
1	Tavrekere
2	Avalahalli
3	J.P. Nagar
4	Adugodi
5	C.T. Bed
6	Banashankari
7	Bapujinagar
8	T.R. Mills

PHC visited in March 2015	
1	N.S. Palya
2	Avalahalli
3	J.P. Nagar
4	Koramangala
5	Vidyapeeta
6	Kumaraswamy Layout
7	Bapujinagar
8	T.R. Mills