Community Child & Adolescent Mental Health Service Project

3rd Quarterly Report
April to June 2015

Date of Submission: 31st July 2015

Dept. of Child & Adolescent Psychiatry, NIMHANS

**Supported by Dept. of Women & Child Development,
Government of Karnataka**

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

During this quarterly, in addition to the school and primary healthcare centre services, the project initiated services in anganwadis, to reach pre-schoolers, and in governmental and non-governmental child care institutions working with children in need of care and protection. Further, school services were conducted in collaboration with the Rashtriya Bal Swasthya Karyakram (RBSK) teams to integrate child mental healthcare into school health team services. In all, the project provided direct services to 701 children[1] through individual and group interventions in 15 PHCs, 7 schools, 24 anganwadis and 7 child care institutions.

The project also continued its capacity building activities, reaching a total of 311 child care service providers through orientation and training programs. A considerable amount of material development in the form of pre-school teacher activity book and flip-chart on early stimulation, for parent/ caregiver education, was developed as part of training and capacity building components of the project. Preparations for two large symposiums, one for government school teachers (on learning difficulties in children) and the other for anganwadi teachers (on early stimulation and child development) were also initiated.

<u>Note:</u> With regard to individual services (as provided in schools, primary healthcare centres and child care institutions), while a primary psychiatric diagnosis is made for each child, the categorization of disorders is done with a view to developing interventions. There are children in child care institutions for whom it is the psychosocial context that is the target for intervention. In other instances, in schools and primary healthcare centres, some children do not meet criteria for a full disorder. Thus, the data is recorded for the major focus/behaviour in question. Hence, the primary diagnosis is based on standard ICD10 classificatory system with the necessary flexibility (as described).

[1] This is the number receiving individual services (first level responses) and group session activities; it does NOT include the 285 children screened in the PHCs (because some of these children were received/ served at the PHC and the project data wanted to avoid any double-counting issues).

1. Mental Health Services in Schools

In the previous quarterly, 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. During this quarterly, no school services were provided in April/May 2015 due to summer vacation. Services were resumed in June 2015. However, this time around, the project staff visited schools along with the Rashtriya Bal Swasthya Karyakram (RBSK) school health teams, providing child mental health services alongside the RBSK staff.

The RBSK is an important national (central government/ Dept. of Health) initiative aiming at early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Deficiencies, Diseases, Development delays including disability.

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.

Assessment and screening forms that had already been developed and piloted in schools/ anganwadis by the project continued to be used in the services with RBSK.

The NIMHANS team have been accompanying RBSK teams to schools and demonstrate to/ assist the RBSK teams to assess and provide first level responses to children identified by teachers, with emotional/ behaviour/ learning/ disability problems. Responses included basic counselling to children, and inputs to teachers on how to manage children with problems. Mild to moderate problems were managed at school level, as described, while more severe problems (requiring depth work/ medication) were referred to tertiary facilities, namely NIMHANS's Dept. of Child & Adolescent Psychiatry.

Currently, services/ support for the initial 3 months are being provided to Bangalore South Zone, to RBSK teams A, B and C. The project will provide support to RBSK services on a daily basis from **1st June to 31st August 2015.** By the end of the three month period, it is anticipated that the RBSK teams would have acquired the learning and skill to continue basic child and adolescent mental health services as part of their health services in schools/ anganwadis.

Table 1(a): Total No. of Consultations Disaggregated by Age & Sex in Schools, June 2015

Age Groups	June 2015		No. of Children
	Male	Female	
6 to 12 yrs	28	14	42
13 to 17 yrs	42	8	50
Total	70	22	92

Table 1 (a) and 1 (b) present the new cases identified (refer to Table 1 for demographic details and table 2 for Child & Adolescent Disorders Identified) and provided with consultation. Table 1 (c) shows the numbers of children In June 2015, 6 schools government and aided schools were reached and 92 children provided with services. *(See annex 1 for list of schools reached along with RBSK teams).*

Table 1(b): Child & Adolescent Disorders Identified in Schools, June 2015

Child & Adolescent Mental Health Issues		No. of Cases
Emotional Problems	Selective Mutism	0
	Dissociative/Somatic	0
	Bed Wetting	1
	School Refusal	1
	Other Anxiety Issues	13
	Dysphoria/Depression/Adjustment Disorder	5
	Post-Traumatic Stress Disorder	1
Sub-Total		21
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	7
	ODD	1
	Conduct Disorder Symptoms: (Lying and Stealing)	2
	Truancy	1
	Conduct Disorder (Most Symptoms)	1
	Attention Deficit Hyperactivity Disorder	15
Sub-Total		27
Learning Issues	Specific Learning Disability	34
	Other Learning Problems	13
Sub-Total		47
Developmental Disability	Intellectual Disability	6
	Speech Problem	10
	Motor Disability	1
	Autism	----
Sub-Total		17
Other Issues	Life Skill Issues(Sexuality)	2
	Other Health/Medical Problems	1
	Child Sexual Abuse*	1
Sub-Total		4
Total		**116**

*Child Sexual Abuse is not a psychiatric disorder. However, it has been coded as it is a major issue of concern needing specialized responses including medical, psychiatric and psychosocial interventions.

Table 1 (c): Referrals to Tertiary Care Mental Healthcare Facility from Schools, June 2015

Child & Adolescent Mental Health Disorders		Reasons for Referral
Emotional Problems	Other Anxiety Issues	4
	Dysphoria/Depression/Adjustment Disorder	2
	PTSD	1
Sub-Total		7
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	1
	Truancy	1
	Attention Deficit Hyperactivity Disorder	1
Sub-Total		3
Developmental Disability	Speech Problem	3
Sub-Total		3
Other Issues	Child Sexual Abuse	1
Sub-Total		1
Total		14

In all, 92 children were assessed and provided with first level responses. Amongst these children, a total number of 116 cases of child & adolescent psychiatric problems were identified: 21 (18%) cases of emotional disorder, 27 (23%) cases of behaviour problems, 47 (41%) cases of learning difficulties, 17 (15 %)cases of developmental disabilities and the remaining 4 (3%) cases of medical problems/ life skills issues and child sexual abuse.

Of the 92 children, 15 children (16%) were referred to tertiary care facilities for medication and psychotherapy. The largest proportion of referrals was made for emotional disorders that required psychotherapy and depth inputs; this is because many children from these schools come from difficult home environments with complex family issues.

The project's mandate does not actually include aided schools i.e. the focus is government schools and some aided schools may be included as an exception, in case they are located in extremely vulnerable communities. However, services were provided in several aided schools this time around because those were the schools the RBSK team were working in during the month of June.

A somewhat puzzling observation was that some of the aided schools were less cooperative than the government schools i.e. they (the aided schools) were reluctant to allow the project team to work with the children, saying 'our school has no such children [no children with emotional/ behaviour/ learning problems]. The level of awareness on child mental health issues is identical in government schools and aided schools i.e. they are low in both. While the reason for poor receptivity on the part of the aided schools versus government schools is unclear, the project team postulates the following: the numbers of children in aided schools can be very large (much larger than in government schools); therefore, the teachers do not have adequate knowledge of individual children's abilities and problems. Consequently, when the project team approaches the school to provide services, asking the school/ teachers to refer children that they have identified with emotional/behaviour/learning problems, the teachers have difficulty in doing so; as a result, the school denies having any problems at all and refuses the services of the project team.

Another reason attributed to denial of children's problems on the part of aided schools is that they have concerns about their 'reputation' i.e. if they are seen as having children with problems, it might jeopardize the reputation of the school (in their perception). However, this reason is anecdotal and the project cannot confirm it.

Government school teachers, on the other hand, may have smaller numbers of children to deal with and therefore have a greater knowledge of individual children's issues. Further, government school teachers are required, by the Dept. of Education, to work on school enrolment/ attendance issues; as part of this, they are better acquainted with the community, including the family issues of individual children. Therefore, they have less difficulty identifying children in need of mental health services. This might account, in part at least, for their receptivity of school mental health services.

'Kalikeya Kale' Symposium for School Teachers: The project plans to implement a two-day symposium, 'Kalikeya Kale' on Responding to Learning Difficulties in School Children. The symposium seeks to reach 200 teachers from about 50 government schools, and is scheduled for 3rd and 4th August 2015. The objective of the symposium is to orient government school teachers to issues of learning difficulties in school children, including

identification of children with learning problems, emotional and behavioural issues in children with learning problems, remedial education techniques, resource rooms, and alternative education opportunities such as inclusive education, open schooling and vocational training. Preparations for the symposium are already underway, by way of obtaining permissions from the Block Education Officers, giving invitation letters to selected schools and locating and briefing resource persons for the symposium.

Child Sexual Abuse (CSA): The Challenge of Working with Schools

In recent months, the issue of child sexual abuse has received much attention, especially as it occurred in schools with perpetrators being teachers and other school staff. The outrage of parent and civil society groups prompted various actions on the part of schools and education systems, ranging from 'good touch-bad touch' child sexual abuse prevention programs in schools to policy documents on school safety, released by the Dept. of Education and by the Dept. of Women and Child Development. Despite all such efforts, working with school system on the issue of CSA continues to be very challenging.

In June 2015, during the course of the project's routine school mental health service provision, the teacher brought the child to the project team, expressing concerns about his 'sexual' behaviour in his interactions with other children, in particular a 7 year old whom he had tried to engage in physical intimacy. Enquiry by the project team revealed that the child was being abused in the family context by his 14 year old cousin.

Upon obtaining consent from the child, the team proceeded to inform the teacher and school headmistress including providing extensive information on child sexual abuse, its complexities and consequences, ways of treatment. Initially, the school staff were exceedingly understanding, cooperative and supportive, making every effort to convince the child's mother to seek assistance at the Dept. of Child Psychiatry, NIMHANS. Following their efforts, the child and his family visited NIMHANS and an initial counselling session was held, wherein the child and the family were requested to get admitted in the children's in-patient facility in order to better facilitate the child's treatment/ healing.

After this, the child and family did not return for admission and further treatment. When the project team contacted the school, the teachers were irate and uncooperative, saying that they had expected the child to 'be briefly counselled and sent home…and there is no need for admission and the hospital has gone the wrong route…after all, the child did not have any major problem'; the class teacher who had identified the child as having behavioural issues attempted to retract her earlier complaints about him. It was also discussed with the concerned teacher and headmistress that this problem might entail a sexualization process wherein perhaps even the 14 year old cousin had been abused. Their response was one of minimizing the importance of working with the concerned 11 year old and indeed the 7 year old target of his sexual behaviours. Instead, they demanded that we work with the 14 year old cousin (not in their school) and with the adult possibly abusing him (identity not known).

The issue was then reported to the concerned Block Education Officer (BEO) for necessary action i.e. to dialogue with and convince the school of the need to assist the child. However, no action was taken by the BEO, who was evasive when the project team tried to reach him in subsequent days. Eventually, the project called Childline (1098) to track the child and his family and provide the necessary assistance or to convince them to return to NIMHANS for treatment (work-in-progress).

This experience shows that despite the Dept. of Child & Adolescent Psychiatry's vast experience in assisting children and families with child sexual abuse issues, the problem continues to be an extremely complex one to address. The dilemmas of what and how much to communicate to the family in the initial interview remain i.e. to provide adequate information to convince them to get the child treated versus some general information (so as to not alarm them or violate the child's confidentiality) but which might not convince them to avail of treatment and assistance.

What this experience reflects about the schools is that the teachers are not geared to assist children in the issue of sexual abuse—poor understanding of child sexual abuse issues, lack of clear systemic reporting systems (or lack of knowledge on these), attitudinal issues, social stigma and taboos are some of the reasons that continue to be barriers for schools to report and help children avail of assistance for abuse issues. Not the least of the problem is still that schools believe that abuse that happens outside school/ at home is not their responsibility; and this problem is compounded by the apathy of the Dept. of Education, whose officers' interests do not extend to serious assistance to children through serious support and/or disciplinary actions to schools that do not assist children with safety issues.

And so, child sexual abuse prevention programs are mere tokenisms, for, a system that engages in prevention programs without having a sound response strategy will never achieve its objective of child safety. Further, unless schools and systems understand that child sexual abuse prevention and response, any place, any time, whoever the perpetrator may be, is everybody's business versus being 'somebody else's business', policies, posters and programs are of little use.

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

Despite feedback to the Medical Health Officers responsible for the targeted PHCs, the challenges reported in the previous quarterly, of the absence and/or disinterest or lack of involvement of the PHC Medical Officers continue as does the perception among PHC staff that the service was to be run by the NIMHANS project team versus their learning about child mental health issues to integrate into primary healthcare services.

As a result, one of the targeted PHCs, in Tavrekere area, was dropped from the service—the medical officer there was never present and community/ neighbourhood reports corroborated the project team's experiences of the PHC staff being absent or completely unprepared/ uncooperative in matters of service delivery. Instead, the Yarabnagar PHC has been added to the targeted list of PHCs—this PHC was selected because it serves an extremely large vulnerable slum population, where many children are in need of mental health services --as evident when the project team provided services in the Yarabnagar Urdu School, during the previous quarterly. *(See annex 1 for list of PHCs where child mental health services were provided).*

Community Mobilization: Screening Services

A new development that has occurred in the last three months, in the PHC system, is the change in the community health worker system. Now, most PHCs have done away with link workers and under the National Urban Health Mission, are in the process of appointing ASHA workers. Unlike link workers, ASHA workers will not be paid a monthly salary; instead they will work on an incentive basis, wherein they get paid a certain amount for identifying and bringing patients to the health centre. Currently, the PHCs are in the process of transitioning from the link worker to the ASHA worker system and therefore, there are no community health workers. This has implications for the project which has relied on link workers to refer children with mental health problems to the PHCs; many PHCs now have no one to carry out this community mobilization function.

The project makes no provision to directly undertake community mobilization—since the objective is to integrate child mental health care into primary healthcare services, including community health work. However, given the current scenario where PHCs are having difficulty with their community mobilization function, the project team has been using the immunization campaigns (and other health campaigns) as well as routine immunization days (weekly) to screen children for mental health issues and developmental disabilities and refer them to PHC services. Brief and simple early screening tools are used during these days/campaigns to screen children for disability and emotional/ behaviour/ learning problems. Not only are the children present at the campaign/ service screened (usually young children who come for immunization), but their parents/ caregivers are asked about siblings who might have problems. Those found to have mental health/ developmental problems are then asked to return to the PHC on a pre-set date when the children are assessed in detail and provided with first response and referral inputs as necessary.

A total of 285 children were screened. Since the screening services were provided mostly as part of immunization services, a majority of children, 244 (86%) were between the ages of 0 and 6 years (Refer to Table 2 (a)). Of those screened, 46 children (16%) were found to emotional/ behavioural/ learning problems or developmental disabilities and referred to return to the PHC for detailed assessment and interventions (Refer to Table 2 (b)).

Table 2 (a): Screening Services: Demographic Profile, PHC Services, April- June 2015

Age Groups	No. of Children Screened						
	April		May		June		Total
	Male	Female	Male	Female	Male	Female	
0 to 6 yrs	62	51	14	13	50	54	244
7 to 12 yrs	2	2	10	11	5	6	36
13 to 17 yrs	0	0	2	1	1	1	5
Total	**64**	**53**	**26**	**25**	**56**	**61**	**285**

Table 2 (b): Screening Services: Referral to PHC for Assessment and Interventions

	No. of Children Screened and Referred to PHC			
	April	May	June	Total
No. of Children Screened	117	51	117	285
No. of Children without Problem	95	40	104	239 (84%)
No. of Children Referred to PHC	22	11	13	46 (16%)

Assessment & First Level Response Services

Despite the challenges of having no community mobilization services, 63 children, between the ages 0 and 17 years, availed of child mental health services at the PHC(refer to Table 2 (c)). These include most of the children identified during the screening services (described above) as well as other children identified and referred by PHC staff. Over half are young children, below 6 years—again because the children screened were mostly younger age groups that avail of immunization services at the PHC.

Table 2 (c): Total No. of Consultations Disaggregated by Age & Sex in PHCs, April- June 2015

Age Groups	April		May		June		Total
	Male	Female	Male	Female	Male	Female	
0 to 6 yrs	13	6	7	3	3	3	35
7 to 12 yrs	4	4	4	5	1	0	18
13 to 17 yrs	3	3	1	1	1	1	10
Total	**20**	**13**	**12**	**9**	**5**	**4**	**63**

Amongst 63 children, 80 cases of child and adolescent disorders were diagnosed and provided with treatment (refer to Table 2 (d)). 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.

Of the 63 children assessed at the PHC, 17 (27%) 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 2 (d): Child & Adolescent Disorders Identified in PHCs, April- June 2015

Child & Adolescent Mental Health Issues		No. of Cases			
		April	May	June	Total
Emotional Problems	Selective Mutism	0	0	0	0
	Dissociative/Somatic	0	0	0	0
	Bed Wetting	3	1	4	8
	Pica	0	1	0	1
	School Refusal	0	0	1	1
	Other Anxiety Issues	1	1	4	6
	Dysphoria/Depression/Adjustment Disorder	0	1	0	1
	Post-Traumatic Stress Disorder	0	0	0	0
Sub-Total		4	4	9	17
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	2	2	1	5
	ODD	0	1	0	1
	Conduct Disorder Symptoms: (Lying and Stealing)	0	0	0	0
	Truancy	0	0	0	0
	Conduct Disorder (Most Symptoms)	0	0	0	0
	Attention Deficit Hyperactivity Disorders	9	3	0	12
Sub-Total		11	6	1	18
Learning Issues	Specific Learning Disability	7	2	0	9
	Other Learning Problems	2	1	2	5
Sub-Total		9	3	2	14
Developmental Disability	Intellectual Disability	5	4	0	9
	Speech Problem	5	6	3	14
	Motor Disability	2	2	2	6
	Autism	0	3	0	3
Sub-Total		12	15	5	32
Life Skill Issues(Sexuality)		0	0	0	0
Other Health/Medical Problems		1	2	0	3
Total		**37**	**30**	**17**	**84**

Table 2 (e): Referrals to Tertiary Care Mental Healthcare Facility from PHCs, April- June 2015 2

Child & Adolescent Mental Health Disorders		No. of Children Referred			
		April	May	June	Total
Behaviour Problems	Conduct Disorder Symptoms: (Lying and Stealing)	1	0	0	1
	Conduct Disorder (Most Symptoms)	0	0	0	0
	ADHD	0	1	0	1
Sub-Total		1	1	0	2
Learning Issues	SLD	3	1	0	4
	Other Learning Problems	0	0	0	0
Sub-Total		3	1	0	4
Developmental Disability	Intellectual Disability	0	1	0	1
	Speech Problem	1	3	2	6
	Motor Disability	0	2	2	4
Sub-Total		1	6	4	12
Total					**17**

3. Anganwadi Services

Anganwadi services were initiated during this quarterly, and the 24 anganwadis (located within the selected PHC catchments) randomly selected and targeted *(see Annex 1 for list of Anganwadis)* were provided with pre-school services. Due to summer vacations, services were provided during 2 out of the three months this quarterly i.e. in April and June 2015; no services were provided in the month of May due to holidays.

Each Anganwadi has received 3 visits by project staff, who spend about an hour in each centre doing activities with the children and demonstrating the same to the anganwadi teacher. The project has also created some low cost aids (using locally available materials, such as old newspaper and charts freely available in stationary stores) for use in anganwadis. In subsequent visits, the anganwadi teacher was requested to use the materials available in the anganwadi and do the activities erstwhile demonstrated. Thus, the service approach is one of on-the-job training through demonstration and discussion.

The group activities with children are designed to promote early stimulation and optimum development in the 5 key areas of child development--physical/ social/ speech & language/cognitive/ emotional development—and this conceptual framework is explained to the anganwadi workers. However, observations reveal that anganwadi teachers tend to focus heavily on rhymes and rote learning; activities hardly focus on social, emotional and cognitive skills. Further, a major gap was the lack of fine motor activities—as a result, many of the younger school age children have writing problems i.e. since there is little preparation in anganwadis for writing readiness. The project services have therefore tended to focus more on these gaps and do activities in these areas.

Table 3: Anganwadi Services Coverage, April- June 2015

	April	May	June
No. of Children Participating in Early Stimulation Activities	146	-	433
No. of Anganwadi Teachers Reached with Pre-School Inputs	16		21

*Since the same anganwadis were reached in April/ June, there are over-laps in the children reached. Therefore, the numbers reached in June (the highest numbers of children reached in each centre) are reported—since June had the maximum attendance with all the children having returned from summer vacations.

While approximately 20% of the anganwadi teachers have been extremely interested in the services and receptive of new knowledge and methods, in general, and as frequently reported by bureaucrats and officers within the Dept. of Women and Child Development, many anganwadi workers have little motivation to work. Whether the reasons are more to do with inadequate and irregular remuneration or due to attitudinal issues is hard to say; but the end result is that non-formal education or the pre-school education component of the ICDS program is the most neglected. Below are the project staff's observations:

- There appears to be little accountability as many anganwadi workers do not report for work (or are frequently very late).
- Despite the project's interventions, anganwadi teachers still feel that early childcare/ child health is only about adequate nutrition i.e. they find it difficult to perceive the role that early stimulation and pre-school education plays in child development and health.

- Out of 24 anganwadis, only about 5 make the effort to implement pre-school activities; the rest say [to the project team]: 'you are coming, so you do the activities.' There is a perception that the pre-school education activities are not their responsibility, especially when the project team visits.
- Some anganwadis have small numbers of children despite being located in large slums. Parents state their unwillingness to send the children to anganwadis due to the unhygienic conditions there and the risk of illness to their children. (Some also say they are not convinced about what the children really learn in anganwadis).
- Anganwadis have a considerable amount of play materials for pre-school activities but are unwilling to use them—the teachers fear breakage and destruction of materials. As a result, they are seldom used (and this is also why few play and educational activities are done with children in anganwadis). Where teachers allow children to play with the toys and materials, there is no structured use of the play materials i.e. they a randomly emptied onto the floor and the children are left to engage in largely unsupervised free play.
- Anganwadi teachers' ways of engaging with the children are largely in a disciplinary context, generally in a mode that is instructive rather than playing, dialoguing or conversing with the children. There is little evidence of pedagogical practice. Surprisingly, on many occasions, the anganwadi helpers have been found to have greater interest and initiative in doing activities with the children.

The above is a list of initial observations, which require further substantiation through discussions in the field with parents and anganwadi teachers. During the next quarterly, the project plans to conduct a brief process evaluation to understand the utility of the anganwadi service.

Material Development

i) Low cost aids for Use in Anganwadis: In order to specifically gear activities to meet the gaps i.e. mainly social, emotional and cognitive areas and fine motor skills, the project team developed a few simple low cost aids, mainly using old newspapers, paper cups etc. This kit was taken to the anganwadis daily and teachers were also told how they could, very simply, create their own aids. (See pictures of aids below). These aids are meant to complement (not substitute) the already available play materials in anganwadis.

ii) Pre-School Activity Book for Anganwadi Teachers:

'Arambhikeya Arambha', a book of 35 simple pre-school activities has been developed for the use of anganwadi teachers. Currently, in draft stage, the book is being translated into Kannada, and will be made available to anganwadi teachers in August 2015 (distribution will begin during the anganwadi symposium scheduled for this time).

The activities described in this book are categorized into five broad groups--Locomotor Development, Speech and Language Development, Social Development, Cognitive Development, Emotional Development—as per the five key areas of child development. Bearing in mind constraints of time, space and other resources as faced by anganwadi teachers, the project team has attempted to keep the activities simple—all of them require minimal preparation and very few materials. Most activities are developed in accordance with the toys and materials that anganwadis already have as part of their kit; others are low cost aids that can be easily access otherwise or created. Many of these developmental

interventions do not even require aids/ materials— they can be done through playful activity. In fact, the activities have been developed based on the work done in the anganwadis, with the teachers i.e. all these activities have been tested in the anganwadis.

While the project is aware that there other activity books developed for your use by the Job Training Centre (JTC), this book seeks to complement other resources. However, the difference is in the organization of this activity book: the activities have been fitted into a conceptual framework based on abilities and skills in the five areas of child development and the specific opportunities/ activities through which they can be achieved. Also, often the activities suggested require fewer and simpler aids (less preparation) than the activities in the JTC books.

iii) Flip-Chart for Parents & Caregiver

A flip-chart on home-based stimulation for young children has been developed during this quarterly period; it is nearing completion and will also be available in August 2015, along with the pre-school activity book. Like the book, this flip chart is organized according to the five key domains of child development and pictorially depicts abilities and skills that children need to acquire between ages 1 and 6, and simple activities/ methods that parents and caregivers can use to provide early stimulation at home.

The flip chart is for use by anganwadi workers during mothers' meetings/ parent education sessions as well as other community health workers (link workers/ ASHA workers) to provide community education on early childcare and development. Given that the objective is to reach many who may not be literate, the text is minimal and all messages are provided purely pictorially. The flip chart will be piloted in the next quarterly (July 2015) and final corrections made before printing and distribution in anganwadis and primary health centres.

4. Services in Childcare Agencies

During this quarterly, the project initiated services in 7 government and non-government child care institution (CCIs). Most institutions reached cater to children above the age of 6. Children residing in these institutions comprise of those who have run away from home or have been relinquished by their parents due to financial or other family issues. All children have been placed in these homes after due child welfare committee (CWC) processes. Direct service provision to children in these institutions, by the project, is of two types—i) individual assessment and assistance (first level inputs to child and institutional staff/ caregivers) for children that the staff identify as having emotional and behaviour problems or 'being difficult to manage'; ii) group interventions to children to provide life skills education sessions to children on issues such as managing difficult emotions and interpersonal relationships, sex and sexuality issues, and substance abuse. *(See annex 1 for CCIs covered).*

Individual Interventions

Starting June 2015, a total of 18 children were provided with individual assessment and assistance for various emotional and behaviour problems. (Refer to tables 4(a) and (b) for details). Specific anxiety disorders such as bed-wetting and somatic symptoms and adjustment disorder are some of the most commonly seen emotional problems in children in institutions. The majority of behaviour problems constituted runaway behaviour, with children running away (sometimes multiple times) from home due to financial stresses and/or emotional/physical abuse at home. In most instances, emotional problems were the basis of

behaviour problems i.e. most institutionalized children's behaviour problems, such as anger problems are a result of anxiety and sadness usually caused by traumatic experiences. This is why many of them, having a combination of anger and anxiety issues, were diagnosed to have Adjustment Disorder.

Table 4(a): Total No. of Consultations Disaggregated by Age & Sex in CCIs, May/June 2015

Age Groups	No. of Children Served		
	Male	Female	Total
6 to 12 yrs	1	6	7
13 to 17 yrs	7	4	11
Total	8	9	18

Table 4 (b): Child & Adolescent Mental Health Disorders Identified in CCIs, April- June 2015

Child & Adolescent Mental Health Issues		No. of Cases
Emotional Problems	Dissociative/Somatic Symptoms	2
	Bed Wetting	1
	Other Anxiety Issues	1
	Dysphoria/Depression/Adjustment Disorder	5
Sub-Total		9
Behaviour Problems	Runway Behaviour	8
	Conduct Disorder	1
	Attention Deficit Hyperactivity Disorder	2
	Substance Abuse	1
Sub-Total		12
Developmental Disability	Intellectual Disability	1
	Speech Problem	1
Sub-Total		2
Life Skills Issues		3
Mood Disorder		1
Sub-Total		4
Total		**32**

Table 4(c): Psychosocial Contexts of Mental Health Disorders Identified in CCIs, April- June 2015

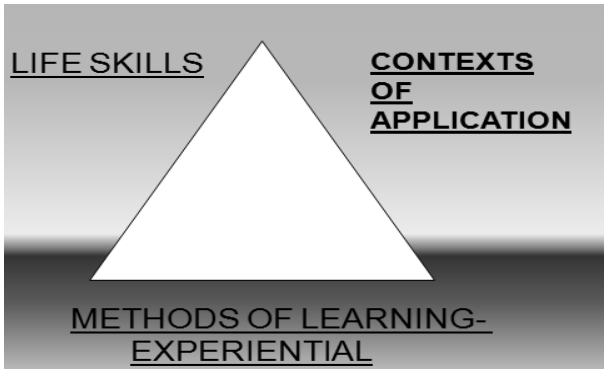
Psychosocial Contexts	No. of Cases (n=27)
Marital Conflict/Domestic Violence	6 (22%)
Physical Abuse	3 (11%)
Emotional Abuse	3 (11%)
Sexual Abuse	6 (22%)
Death of Parents	4 (15%)
Single Parents/Abandoned	5 (19%)

In addition to making and addressing the psychiatric problem that each child has, the project is also developing a list of the psychosocial contexts in which these problems occur. While psychosocial context is important to understanding and treating the psychiatric problems of all children, and the project does so in its work in schools and primary healthcare centres (as per standard operating procedures), the database on CCIs makes special efforts to capture information of psychosocial context along with psychiatric diagnosis. This is because institutionalized children are also commonly categorized as 'children living in difficult circumstances' and it is critical to obtain a depth perspective on how home/ family/ social situations not just contributed to but caused their psychiatric problems. Table 4(c) shows the

psychosocial contexts of institutionalized children's emotional and behaviour problems—this is not an exhaustive list; it is a work-in-progress, that will continue to be developed through individual interventions with these children. The emerging issues will be (and already are being) fed into group interventions sessions (discussed later in this section). 3 children were referred –one child for Conduct Disorder and the other two for substance Abuse and child sexual abuse.

Group Interventions

Development of Materials for Life Skills Sessions



Many manuals and approaches exist for conducting life skills sessions for adolescents. They are all based on the WHO definition and listing of life skills. However, based on our understanding of what various agencies tell us about how life skills sessions are conducted, the content of these sessions are usually very broad and general i.e. they teach skills such as interpersonal relations or communication is a generic sort of way without contextualizing the content to address the needs and daily realities faced by institutionalized children. Further, they do not take into consideration the traumatic nature of many children's experiences—nearly all institutionalized children have experienced some form of trauma in the form of loss, grief and abuse—and these experiences have shaped their emotional and behavioural responses, and resulted in the nature and type of life skills (or survival skills and responses) they have developed (whether positive or negative). The project felt therefore that life skills sessions that either ignore the (present) daily realities or (past) experiences of children would not be effective.

Life Skills for Emotional Well-Being--A Framework for Module 1 on Life Skills Education

Issues/Contexts	Life Skills Domains	Skill Sets
Loss, Grief and Trauma	• Managing feelings	• Emotional Regulation • Coping with difficult feelings • Relaxation techniques
Anxiety	• Increasing internal locus of control • Managing stress	• Self Identity • Self Efficacy • Self esteem/confidence building skills • Time management • Positive thinking • Self evaluation / Self assessment / Self-monitoring skills
Anger	• Decision making • Problem solving • Conflict Resolution	• Information gathering skills • Evaluating future consequences of present actions for self and others • Determining alternative solutions to problems
Other People's Feelings	• Empathy • Interpersonal Relationships	• Verbal/Nonverbal communication • Active listening • Ability to listen and understand another's needs and circumstances and express that understanding

So, while we acknowledge the usefulness of any life skills inputs given, using various themes and methods, the specific objective of this project is to address the above-described gaps perceived in life skills session content and methodology. Further, our approach locates life skills issues within the larger child development framework. See the box (above) on the initial design of an 8- activity/session module to foster life skills for children's emotional well-being and development. The framework below shows i) issues and contexts—these are drawn from and meant to address children's daily realities and past experiences; ii) life skill domains—the broad areas in which children need to acquire skills in order to address their situations and experiences; iii) skill sets—the specific skills that children acquire through the various activities they do. The idea therefore is to triangulate life skills, contexts of application (situations/ experiences) and methods of learning (experiential activities)—as shown in the figure above.

Group work interventions in some of the CCIs were initiated in June 2015 and the first two activities developed in the above-described life skills modules were implemented, reaching a total of 90 children over 7 sessions (see table 4 (d)). Subsequent modules on substance abuse, sex and sexuality, and on truancy and motivation issues are in progress. They will be rolled out over time. The module on emotional well-being, since it addresses issues of emotional regulation and control, will form the basis of activities in subsequent modules on other issues.

Table 4(d): Group Interventions in CCIs

Name of institutions	No. of Children/ Participants	No. of Sessions	Content of the session
Makkala Jeevodaya*	15	3	Session 1 : Building rapport Session 2: Talking about Feelings
Govt. Girls home**	60	2	Session 1: Building rapport Session 2: Talking about Feelings
Shishu Mandira***	15	2	Early Stimulation Activities
Total	90	7	-

***A group of girls between age 7 and 12 years are reached each time with different sessions.

**2 groups of adolescent girls were reached over 2 sessions. However, this is a floating population; therefore different children were reached at different times.

***An institution for orphaned children between ages 0 and 6 years, who were therefore reached with pre-school/ early stimulation activities.

5. Referrals Received at Tertiary Care Facility

Children assessed in schools, primary healthcare centres and child care institutions, as described above, receive first level inputs. Those requiring depth therapeutic inputs, both in terms of psychological and pharmacological care, based on the nature and severity of psychiatric problems are usually referred to NIMHANS. (See Annex 2 for referral criteria). While some children may be referred to Depts. of Neurology, Physiotherapy & Neuro Rehabilitation and Speech (for various developmental disability), most are referred to the Dept. of Child & Adolescent Psychiatry. Table 5 shows the numbers of children referred by the community project services, and how many actually came to the Dept. of Child & Adolescent Psychiatry to avail of depth services.

(Note: children may have also gone to other departments referred but we do not have the mechanism to track and record these referrals as they are dispersed).

Table 5: Referrals Received at Tertiary Care Facility, April to June 2015

No. of Children	Primary Healthcare Centres	Schools	Child Care Institutions	Total
Referred by Project Team	17	15	3	35
Availing of Tertiary Care Services	4 (24%)	5 (30%)	8 (over 200%)	17 (49%)

One of the challenges faced by the project team is to motivate teachers and families to bring children to tertiary care facilities for depth assistance and services. As noted in previous reports, there are many barriers to referred children availing of mental health services at tertiary care facilities, 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) Despite treatment at NIMHANS being free for these children[2], many still quote financial problems as reasons for not following up with referral recommendations; iii) 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; 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.

These reasons are more applicable to families and communities and to a far lesser degree to child care institutions—which may explain why more children from CCIs have availed of tertiary care services. Even children not (yet) assessed by the project team have been brought by the CCI staff—who during visits by the project team were quick to realize that they had several of their children had either serious or long-standing problems that needed to be addressed; hence, some of them took the initiative to bring them to NIMHANS soon after some awareness-related discussions took place during the project's CCI visits.

Further, the project has, through special requests to the Dept. of Child & Adolescent Psychiatry, developed a system of fast-tracking any referral that comes through the project. This system was devised for the children seen through the project because of the barriers faced by communities to accessing child mental health care. Getting children to be seen on a priority basis and cutting down the long waiting time usually experienced in NIMHANS are some of the measures taken to encourage families that are otherwise reluctant to seek care for their children, to come and do so i.e. there appears to be a difference between families that seek care at the Dept. of Child & Adolescent Psychiatry, NIMHANS of their own accord and those referred by the Community Project—the former, it is hypothesized are likely to be more motivated to seek care for their children while the latter are not, thereby requiring extensive persuasion, follow-up and some incentives (such as shorter waiting time/ immediate assistance) to seek care.

[2] 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.

6. 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 project team facilitated the following training and capacity building sessions/ workshops:

a) Karnataka Health Promotion Trust (KHPT) Staff Secondment

As planned in the previous quarterly, with a view to building KHPT's capacity to address psychosocial needs of children infected/affected by HIV, 2 staff have been seconded to the Project for a period of 4 months (June to September 2015). Over the past month, they have been undergoing intensive classroom and field training in this project. Regular Classroom training has been provided to them (and indeed all project staff participate in in-house learning sessions) on issues such as child development basics, understanding signs and symptoms and intervention methods for internalizing and externalizing problems i.e. the basics of child psychiatry/ child psychiatric disorders and standard methods of identification and intervention were taught to them. Their practical training comprises of daily field visits to schools, anganwadis and child care institutions where they work alongside the project staff to learn and execute assessments and age-appropriate individual and group activities.

b) Training Workshop for RBSK Teams, NIMHANS

A 3-day workshop on "Working with Child & Adolescent Mental Health Issues: First Level Response" was conducted for RBSK functionaries on 11th, 12th and 13th May 2015, as part of the Community Child & Adolescent Mental Health Service Project of the Dept. of Child & Adolescent Psychiatry, NIMHANS. The project, having identified (during the needs assessment phase) tremendous potential in RBSK functionaries, to assist school children, was keen to work with and provide technical support to the RBSK school health program to identify and assist children with emotional and behavior problems and developmental disabilities. The aim of the workshop was to prepare the RBSK staff to integrate child and adolescent mental healthcare interventions into their existing school health services.
The specific objectives of the workshop were:

- Understanding children, childhood and child development.
- Developing skills in first-level/immediate responses to children's mental health and psychosocial concerns in primary care settings, including schools.
- Knowing when to refer children to tertiary level mental health services.

10 RBSK functionaries from Team A, B and C of Bangalore South Zone participated in the training workshop. Since the Community Child Mental Health Service Project is currently located in vulnerable areas in Bangalore South, these teams were selected i.e. in order to prepare these teams to serve government schools in the south zone. In all, 5 medical officers, 3 staff nurses, 2 ophthalmic assistants attended the workshop.

A variety of participatory methods were used: do-and-learn (skills), role plays, case-studies/ examples, short feature films, participatory group activities and discussion. Slides were also used but since the emphasis was on skill training, lecture methods were used minimally. While the materials were in English, the workshop was conducted largely in Kannada.

c) Orientation for RBSK Doctors, RBSK Training Program

As part of the RBSK's training program on 'Re-Orientation Training of RBSK Teams', in May 2015, the project facilitated a session on 'Learning Difficulties in Children' for 40 teams from

Bangalore urban and rural districts. In all, 40 doctors (from 40 teams) attended the session. The orientation encompassed the following topics: basic frameworks for understanding child development, common types of disability in children (including intellectual disability and specific learning disabilities), age-appropriate screening for mats for identification of disability in children (pre-school and school age children), and first level responses to disability (psychoeducation to caregivers on home-based stimulation, schooling issues).

d) Orientation for NGOs working with Children & Disability, Association for People with Disability

In June 2015, the project team was invited by Association for People with Disability (APD) to deliver an orientation session on disability in children. The above-described 'Learning Difficulties in Children' session was therefore done for staff from NGOs working in the area of disability in various parts of Karnataka. The NGO participants were drawn from 6 districts—Kodagu, Mysore, Bangalore, Bijapur, Davangere and Chikkbellapur. The 42 participants represented 28 institutions, including special schools and residential centres for children with disability.

e) Tele-Medicine Learning Session, Indira Gandhi Hospital

Indira Gandhi Hospital (IGI), a tertiary healthcare facility specializing in child health, also runs a paediatric anti-retroviral therapy (ART) centre. The IGI ART centre has recently started a telemedicine learning initiative which they use to reach ART centres/ counsellors across Karnataka State. As part of this, they requested the project to do a session for ART counsellors on working with HIV infected and affected children. Also, an orientation session (since the time is limited to 1.5 hours), the objective of the session was to provide a framework for working with children in the HIV context, and raising issues that are relevant to psychosocial work with children in this context. Starting with a child development framework and why it is important to understand age-appropriate developmental milestones, their relevance to HIV infected/ affected children who are often neuro-compromised and have developmental delays, the presentation moved on to highlighting common emotional and behaviour problems of children with HIV and how these relate to issues of illness and disclosure, experiences of loss, grief and trauma, stigma and discrimination, uncertainty about the future, and mortality concerns. A total number of 157 staff from 34 ART centers, including 1 Centre of Excellence and 1 Paediatric Centre of Excellence in HIV care. *(See Annex 3 for list of districts reached through the session).*

f) Orientation for People Living with HIV/AIDS (PLWAs)

In June 2015, Karnataka Health Promotion Trust organized a State-Level Advocacy Skill Building Workshop for People Living with HIV/AIDS— 'Positive Faces Of Care'. 60 women from 28 districts in Karnataka participated in the workshop, whose objectives were i) to develop an advocacy network for PLWA women; ii) to create an advocacy action plan, along with equipping women with the relevant skills and strategies for advocacy. As part of this workshop, KHPT invited the project team to orient the participants on children and HIV/AIDS issues in order to ensure that their advocacy actions focus on HIV infected and affected children (and their families). An orientation similar to that given in the IGI telemedicine session to ART centre staff (content described above) was provided—and future plans were made to train the participants in more depth work with children and HIV issues.

C. Human Resources

During this quarterly, the two project officers previously identified and working on the project as resource persons were formally recruited through formal institute administrative processes. 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, pending DWCD approval for the creation of a third post for project officer.

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 July 2015. She will in the capacity of a part-time resource person for the project.

Also, an another special educator, with knowledge and experience in a wide range of developmental disability-related issues, such as autism, intellectual disability, and other learning issues has been identified and will join the project in July 2015, to implement project activities in child care agencies working with disabled children.

D. Collaboration with Other Agencies and Sectors

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.

i) Collaborations with Agencies working with Disabled Children

Following training workshop sessions, wherein the project team conducted sessions on learning difficulties in children, *Association for People with Disability* (APD) expressed a keen interest to collaborate with the project on working with agencies that support children with disabilities. Currently, various possibilities are being explored, ranging from designing courses on children and disability to secondments of NGO staff to the project, capacity building workshops for disability-related NGOs based in rural Karnataka, and direct work with disabled children in various agencies. Further discussions are planned for the next quarterly period, so has to have a plan of action for specific work with disabled children—a critical area of work in child mental health, and therefore one that the project is keen to scale up. APD has also facilitated contact between the project and a few NGOs working with children and disability issues, so that the project team may begin with direct service provision and on-the-job training activities in this area.

ii) Collaborations with Agencies working with Gender, Sexuality and Disability Issues: In the last quarterly period, a proposal was submitted to Visthaar, an NGO, for the project to work jointly with Visthaar to assist children with gender, sexuality and disability vulnerabilities. Visthaar has agreed to providing financial concessions and training space to the project whenever capacity building activities require to be conducted. The agency is also keen to

use the project's services in their rural sites, where they work with Devdasi children in community-based and institutional contexts.

E. Operational Challenges

During this quarterly, the problem of obtaining permissions from government departments persisted in the form of obtaining permissions for the school symposium, from the Block Education Officers of South Zone 1, 2 and 3. Repeated visits to the BEO offices were made to try and obtain the requisite letters of permission for submission in the schools, without which the teachers would not be permitted to attend the symposium in August 2015. However, learning from previous experiences of long delays in this process, the project team initiated the permission process well ahead of time i.e. 2 months before the symposium.

The second operational challenge this quarterly has been in our attempting to integrate child mental health services into the RBSK school health team services. The following are some of the issues that hinder this integration of services:

- The RBSK teams, it is observed, have little motivation to do child mental health work alongside their regular work. Anecdotal information has it that they 'do not want to do more…if any extra work' as they are dissatisfied with their current remuneration levels.
- The teams have a target that 150 children/ day should receive health check-up; the DPMO has stated that each doctor therefore needs to see about 100 children/ day. Since they need to meet these targets for general check-ups, they are unable to participate in the mental health services.
- The project team's experience with the RBSK teams has frequently been that they do not arrive at schools early enough to begin and finish services efficiently i.e. they tend to arrive at 10:30 or much later. When they arrive, it takes another 45 minutes for them to talk to the school authorities and get the space set up. By this time, little of the morning is left for service provision, as the children's lunch time is at 12:30 pm. The delays in setting up also occur due to the school authorities not being prepared to receive the team's services, at times due to lack of prior information from RBSK and other times despite it i.e. even when prior intimation is provided, they are unprepared.
- It is observed that the RBSK, despite the 3-day training workshop held in May 2015 (and previous orientation sessions in August 2014), are still unable to articulate the child mental health and disability screening agenda to school authorities. They rely heavily on the project team to do so and in schools wherein the authorities have not understood the mental health agenda and have been unwilling for the mental health screening services to be provided, the project team has been helpless—as the RBSK teams are unable to advocate for children to receive mental health and disability services alongside other medical services--this, despite disability being a major part of the RBSK program mandate.
- As a result of all the above, the project team provides the mental health services alongside the RBSK team but in a manner that is parallel and disconnected, rather than integrated. In general, although sometimes the medical doctors enquire or report a child's problem, the two teams work independent of each other.

Post-August 2015, when the project's initial commitment to support the RBSK services comes to an end, a review and feed-back will be planned with the RBSK authorities to

decide next steps i.e. whether to continue support to the RBSK program or to withdraw (in which case, the project will, as before, provide services to schools through the Dept. of Education).

F. Plans for the Next Quarterly Period, July to September 2015

- Special education services to be initiated in the 23 schools served in this quarterly, where children with learning difficulties have been identified.
- Project services to extend to child care agencies working with children and disability issues.
- A two-day symposium, 'Kalikeya Kale' on Responding to Learning Difficulties in School Children, to reach 200 teachers from about 50 government schools, is scheduled for 3rd and 4th August 2015.
- A one-day symposium, 'Arimbhikeya Arambha' on early childhood care and stimulation, to reach 100 anganwadi teachers and their supervisors, is scheduled for 11th August 2015.
- 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, will continue (until 30th September 2015).
- Support to RBSK program will continue, 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 (until 31st August 2015).

Annexe 1
Geographic Coverage: Location of Mental Health Service/ Visits
April to June 2015

A. School Mental Health Service Visits

	PHC Catchment Area	School
1.	Tavrekere	Christa Vidyala
2.	Kumarswamy layout	Sahakari Vidya Kendra
3.	Yedyur	Govt. High School
4.	N.R. Colony	Kamala Nehru Aided School
5.	Yedyur	Govt Kannada Higher Primary School
6.	Banshankri	Kamala Nehru Aided School
7.	J.P.Nagar	Govt Primary school, Sarakki Layout

B. Primary Healthcare Centres Child Mental Health Service Visits,

1	Tavrekere
2	Avalahalli
3	J.P. Nagar
4	Adugodi
5	C.T. Bed
6	Banashankari
7	Bapujinagar
8	T.R. Mills
9	N.S. Palya
10	Avalahalli
11	J.P. Nagar
12	Koramangala
13	Vidyapeeta
14	Kumaraswamy Layout
15	Yarabnagar

C. Anganwadi Service Visits

1.	Kaveri Nagar Anganawadi 1
2.	Kaveri Nagar Anganawadi 2
3.	Kaveri Nagar Anganawadi 3
4.	Kaveri Nagar Anganawadi 4
5.	Ambedkarnagar Anganawadi 1
6.	Ambedkarnagar Anganawadi 2
7.	Sarakki Anganawadi ,
8.	Rajarajeshwari Slum Anganawadi
9.	Maduramma Colony Anganawadi,
10.	Madeena Masjid Anganawadi ,
11.	Old Madiwala Anganawadi,
12.	New Madiwala Anganawadi
13.	E-Stop Anganawadi K.S.Layout
14.	Bovi Colony S.G.Palya Anganawadi
15.	Bismillanagar Anganawadi
16.	Guruappan Palya Slum Anganawadi
17.	Sanjay Nagar Anganawadi 1
18.	Sanjay Nagar Anganawadi 2

19.	Shrinagar Anganawadi 1
20.	Shrinagar Anganawadi 2
21.	Janashakthi Nagar Anganawadi
22.	Indragandhi Slum Anganawadi
23.	Shrinivagilu Anganawadi
24.	Ejipura Anganawadi

D. Child Care Institutions Service Visits

1.	BOSCO Vatsalya Bhavan
2.	APSA
3.	Govt.Boys Home
4.	BOSCO Yuvakendra
5.	Govt. Girls Home
6.	Makkala Jeevodaya
7.	Shishu Mandira

Annexe 2
Definition of Services

- **First Level Response**

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.

- **Referral Criteria:**

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.

Annexe 3
ART Centres Reached through Telemedicine

1.	Mudhol
2.	Chikmagalur
3.	Indi
4.	Gokak
5.	Tumkur
6.	Raichur
7.	Hungund
8.	Hospet
9.	Chamrajnagar
10.	Chitradurga
11.	Hubli
12.	Davangere
13.	Gulbarga
14.	Mysore
15.	Bangalore
16.	Mangalore
17.	Siraguppa
18.	Muddebihal
19.	Bangalore
20.	Mysore
21.	Bagalkot
22.	Koppal
23.	Lingasugur
24.	Bellary
25.	Gangavathi
26.	Belgaum
27.	Saundatti
28.	Jamkhandi
29.	Yadigiri
30.	Sindagi
31.	Vijayapur
32,	Dharwad