Community Child & Adolescent Mental Health Service Project

5th Quarterly Report
October to December 2015

Date of Submission:

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

1. Mental Health Services in Schools

1.1. First Level Responses to Emotional, Behaviour and Developmental Problems

The Project continued to provide school mental health services throughout this quarterly period, except in the month of October 2015 when no services were delivered as most schools had *Dasara* vacation and examinations. The project reached out to 9 schools, in keeping with requests made by school staff and authorities during the Kalikeya Kale symposium in August 2015. At least 2 visits were made to each school every month; however, some schools were visited more frequently due to larger numbers of children and more problems reported by teachers. First level responses, including assessment, provisional diagnosis and interventions to children and teachers, were providedfor children identified by teachers as having emotional, behavioural, developmental and learning problems.

In all, 74 children were assessed and provided with first level responses. Amongst these children, a total number of 85 child and adolescent psychiatric problems were identified: 20 (23.5%) cases of emotional disorder, 31(36.4%) cases of behaviour problems, 24 (28.2%) cases of learning difficulties, 2 (2.3%) cases of developmental disabilities and the remaining 8 (9.4%) cases of other issues, namely, serious mental issues, medical problems/ life skills issues and child sexual abuse. *(Refer to Table 1 (a) and (b)).*

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

Age Groups	November		December		No. of Children
	Male	Female	Male	Female	
6 to 12 yrs	10	2	8	3	23
13 to 17 yrs	25	7	14	5	51
Total	**35**	**9**	**22**	**8**	**74**

Table 1(b): Child & Adolescent Disorders Identified in Schools, October – December 2015

Child & Adolescent Mental Health Issues		No. of Children		Total
		November	December	
Emotional Problems	Other Anxiety Issues	8	10	18
	Dysphoria/Depression/Adjustment Disorder	0	1	1
	Post-Traumatic Stress Disorder	0	1	1
Sub-Total		8	12	20
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	4	3	7
	Truancy	2	1	3
	Conduct Disorder (Most Symptoms)	6	3	9
	Substance Abuse	5	0	5
	Attention Deficit Hyperactivity Disorder	5	2	7
Sub-Total		22	9	31
Learning Issues	Specific Learning Disability	8	5	13
	Other Learning Problems	7	4	11
Sub-Total		15	9	24
Developmental Disability	Intellectual Disability	1	1	2
Sub-Total		1	1	2
Other Issues	Life Skill Issues(Sexuality, bullying)	4	3	7
	Other Health/Medical Problems	0	0	0
	Child Sexual Abuse*	1	0	1
Sub-Total		5	3	8
Total		**51**	**34**	**85**

*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, October – December 2015

Child & Adolescent Mental Health Disorders		No. of Children		Total
		November	December	
Emotional Problems	Post-Traumatic Stress Disorder (PTSD)	0	1	1
Sub-Total		0	1	1
Behavior Problems	Conduct Disorder (Most Symptoms)	1	1	2
	Attention Deficit Hyperactivity Disorder	0	2	2
Sub-Total		1	3	4
Other Issues	Substance abuse	1	0	1
Sub-Total		1	0	1
Total		**2**	**4**	**6**

Of the 74 children, children (8%) were referred to tertiary care facilities for medication and psychotherapy. The largest proportion of referrals was made for Behavioural Problems that required medication and depth inputs, the other portion of referrals had been made for emotional problems and for substance abuse as many of these children come from difficult as well as complex family issues. (Refer to Table 1 (c)).

During our services, it was observed that in many schools, after the *Kalikeya Kale*symposium, teachers and heads of schools appeared to beable to identify children in need of mental health services more easily than before, thus indicating an increased awareness and understanding of child mental health problems.

However,in some schools, lack of awareness and sensitivity about children's mental health problems continues to exist. Teachers' comments '*You cannot achieve anything'* and *'You won't be able to pass your 9th standard exam'*directed atindividual children caused them to report loss of motivation and interest in studies and indeed in attending school. Since comments such as these are in the realm of emotional abuse, as per the NCPCR guidelines, the Project team, unequivocal in their support of children's rights, has, in certain schools taken strong measures: meetings have been held with the concerned school heads and teachers, bringing to their notice the implications of remarks such as these, with an insistence to stop such engagements with children, failing which the team would report the teacher and school to the Dept. of Education and other child welfare authorities.

1.2. Remedial Education Services

In August 2015, the Project team conducted a symposium *Kalikeya Kale*-- on responding to children with learning difficultiesin August, 2015, for government school heads and teachers. Participants from 10 of the schools subsequently approached the NIMHANS team to help them implement remedial education in their respective schools. Remedial education has, so far, largely been implemented in resource rooms in private schools, which have space as well as specialized personnel to assist children with special learning needs. Government schools, given low resource availability,do not have such facilities. They conduct extra classes and bridge courses (as described in the previous quarterly report), however, these are not equivalent to remedial teaching programs—which entail use of differential methodologies to address the learning needs/ problems of individual children rather than a mere extension of teaching time and assistance as is currently being done by government school teachers.

Given the socio-economic strata that most children in government schools are drawn from, many are first-generation learners coming from home environments of severe under-stimulation, others are children of migration labor and therefore constantly shifting schools and mediums of instruction; and then there are those children who actually have mild intellectual disabilities, specific learning disabilities and/or ADHD. Most of the 10 schools selected for intervention are high schools which are Kannada/Urdu medium schools. The children who come into them are from primary/middle schools which are Tamil/Urdu Medium Schools. The change in language of instruction creates many learning difficulties for the children, thus resulting in 8th and 9th grade children not having age or grade appropriate reading and writing skills.Thus, in any government school the proportion of children requiring remedial inputs, for one or other reason, is usually high.

In the light of this, and given the resource constraints, both in terms of personnel and space, the Project has undertaken to introduce classroom remedial techniques. This classroom-based approach is different from the individual remediation techniques usually used in resource rooms by special educators—wherein the teacher works one-one with a child—and which would be difficult to implement in government schools due to the time constraints of teachers. So, the idea is to adapt special education/ resource room remedial techniques to a classroom setting in a low-resource context, namely government schools.

Members of the project team visited each of the 10 schools and interviewed the school heads and some of the teachersin order to gain a better understanding of the teaching-learning challenges faced in these schools, and the specific areas of engagement expected from the project team. Based on the information thus gathered, the project team is now in the process of conducting orientation workshops for the teachers, in the school premises. 5 such orientation workshops have been completed (Arundhati Nagar, Tank Garden, BaretanaAgrahara, Begur and New Fort) to reach 50 teachers. The remaining workshops will be conducted over the month of January, 2016.

Simultaneously, the next phase will be implemented. The project team members will work in collaboration with the teachers in demonstrating group remediation strategies in the classrooms to achieve reading, writing and math readiness levels to facilitate learning. Various alternative methods targeting different learning objectives will be discussed and demonstrated. A trial period of 6 weeks will be demarcated for the teachers to independently use the methods in the classrooms, following which; another set of workshops will be conducted to analyze the feedback from the teachers. Moreover, in schools where a resource room/ space is feasible, appropriate enablement and training will be provided to set up and utilize such spaces.

Introduction of Remedial Education in Government Schools: Orienting Teachers

Objectives:

- To achieve a basic understanding of the range of learning difficulties faced by students, and the underlying reasons for these difficulties.
- An experiential orientation of 3 major components of Learning Difficulties - Learning Disability, ADHD/ADD, socio-emotional and behavioral disorders
- Creating a platform and readiness for implementation of remedial strategies.

Each workshop was conducted over duration of 2 hours, divided into 4 sections, followed by question and answers time at the end.The team was introduced to the teachers and a brief introduction of the scope of the workshop session was given.

Activity 1: The first activity attempted to provide experiential insight into the challenges students with Learning Disability face. A set of handouts comprising brief write-ups in English on different topics was distributed to the participants. They were given time to read the papers and to answer the questions that follow each. (The printouts had many deliberate errors, but the participants were unaware of that.) Then they are asked to list the difficulties they faced in doing the task. Their responses included punctuation errors, spelling errors, irregular spacing and font size, new words, high level of the language used etc. Subsequently, they were given another set of handouts, with no errors. They were asked again if earlier problems still persist and most responded that this time the reading and comprehending was much easier without the errors. It was then explained that for students with Learning Disability, most print appears as did the ones with the errors.

Activity 2: In the next section a brief explanation was offered to throw light on the neurological processes that are involved in the activity of reading.For the second activity the participants were asked to perform some physical activity on the cue of a clap from the facilitator. On the next clap they were asked to think of something that is not related to their present engagement. On the next cue they had to change both the physical activity and the thought. As they are thus engaged, they were also asked to read some story books that are given to them. The facilitator clapped frequently and at random intervals. At the end of the designated time, they were asked how much each one was able to read. It was then explained that the activity could be interpreted as an attempt to simulate the challenges faced by students with ADHD/ADD.

Activity 3: The facilitator distributed a few pictures to the participants. The pictures showed different children in various distressing situations. Each participant was asked to identify herself or himself with the child in the picture and build an autobiographical narrative. They were asked to be as specific and detailed about the distress portrayed in the picture. Then, as the facilitator broached an academic discussion they were asked to evaluate their own abilities to fruitfully participate in the discussion, given the preoccupation of their minds with their stressful life situations. It was then explained that although this did not strictly adhere to the definition of socio-emotional disorders, the activity attempted to acknowledge the learning challenges a student may face when preoccupied with socio-emotional issues.

The session was then opened for comments / Q&A. There were requests for more sessions from some of the participants; others had specific queries about management of such difficulties. The facilitator responded with suggestions and a brief on the next phase that would help the teachers take the suggestions into the classrooms.

Observations:

- An open acknowledgement of the unique teaching challenges faced by the teachers of Government schools helps to establish rapport.
- Most of the teachers are keen to cooperate and open to an objective trial of the group remediation measures.
- Some of the perceptions of students' bad behavior in class could now be attributed by the teachers to the learning difficulties

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

During this quarterly, 13 visits were made to 10 PHCs as part of integrating child mental health services into primary healthcare. Despite feedback to the medical officer responsible for targeted PHCs, challenges reported in the previous quarterly of lack of involvement of the PHC staff continues, namely those of lack of community mobilization, or identification/ referral/ follow-up of children in need of mental health care i.e. the PHC is still unable to perceive the importance of integration of child mental health services into primary healthcare, nor take ownership of any such initiative started in the clinic.

2.1. Community Mobilization and Screening Services

Initially, following screening processes the children identified with emotional, behavioural ordevelopmental problems are referred to the PHC itself but to come on a designated day to avail of services from the NIMHANS project team, including detailed assessment and interventions. However, due to poor community mobilization and lack of follow up by the PHC staff,and despite repeated (telephonic) reminders to the parents by the project staff parents often do not bring the children to the PHC on the designated day. As a result, the Project team modified its approach to conducting screening as well as the detailed assessment and interventionson the same day—usually on immunization day, to ensure thatchildren and their families receive assistance, since they are at the PHC.

During this quarterly,a total number of 537 children were screened, out of which 493(92%) were between the age of 0-6yrs and 42(8%) were between the age of 7-12yrs. (Refer to demographic details in Table 2(a)). As the screening services were conducted on the immunization day, a majority of the children were between the ages of 0-6yrs. However, often the young children at the PHC for immunization are accompanied by their elder siblings, whom also we screen for mental health issues; in addition, the screening process also includes discussing the mental health of all her children with the mother—to check if any of her children, including the older ones not present, have emotional, behaviour, developmental and learning problems. Therefore, the Project extends screening activities beyond those young children present at the PHC to others in their familiesand neighbourhood, thus also creating awareness about child mental health issues and service availability.

During immunization days, as most of the children screened were between the age of 0-6yrs the project staff also conducted awareness programsfor parents about early child development and the importance of early stimulation using the Flip chart developed by the project.

Table 2 (a): Screening Services: Demographic Profile, PHC Services, October-December 2015

Age Groups	No. of Children Screened						
	October		November		December		Total
	Male	Female	Male	Female	Male	Female	
0 to 6 yrs	108	100	83	65	69	68	493
7 to 12 yrs	13	7	2	3	9	8	42
13 to 17 yrs	1	0	0	0	0	1	2
Total	**122**	**107**	**85**	**68**	**78**	**77**	**537**

Of the 537 children screened, 42 children (8%) were found to emotional/ behavioural/ learning problems or developmental disabilities and were provided with assessments and interventions at the PHC.

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

No. of Children	No. of Children Screened and Referred to PHC			
	October	November	December	**Total**
Screened	229	153	155	**537**
without Problem	204	149	142	**495**
Referred to PHC	25	4	13	**42**

2.2. Assessment & First Level Response Services

42 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 as well as other children identified and referred by PHC staff. More than half the children identified with problems were 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, October-December 2015

Age Groups	October		November		December		Total
	Male	Female	Male	Female	Male	Female	
0 to 6 yrs	10	9	0	3	5	3	30
7 to 12 yrs	3	2	1	0	4	1	11
13 to 17 yrs	1	0	0	0	0	0	1
Total	**14**	**11**	**1**	**3**	**9**	**4**	**42**

Amongst 42 children, 45 cases of child and adolescent disorders were diagnosed and the project staff provided services (refer to Table 2(d)). At PHC level, services included provision of detailed assessment of the child's issues, psycho-education and inputs to the child's family, first level responses to the child (wherever appropriate) and psychiatric medication as required.

Of the 42 children assessed at the PHC, 9 (21%) were referred to tertiary care facilities (refer to Table 2(e)). 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, October-December 2015

Child & Adolescent Mental Health Issues		No. of Cases			
		October	November	December	Total
Emotional Problems	Other Anxiety Issues	1	0	0	1
Sub-Total		1	0	0	1
Behaviour Problems	Conduct Symptoms : Anger/ Aggression/Temper Tantrums	3	0	0	3
	Attention Deficit Hyperactivity Disorders	1	0	1	2
Sub-Total		4	0	1	5
Learning Issues	Specific Learning Disability	1	0	0	1
	Other Learning Problems (incl. under-stimulation)	1	1	1	3
Sub-Total		2	1	1	4
Developmental Disability	Intellectual Disability	2	2	1	5
	Speech Problem	6	1	3	10
	Motor Disability	7	1	5	13
Sub-Total		15	4	9	28
Life Skill Issues(Sexuality, Bullying)		1	0	0	1
Speech and Hearing		0	0	1	1
Other Health/Medical Problems*		2	0	3	5
Sub-Total		3	0	4	7
Total		**25**	**5**	**15**	**45**

*Medical problems as seen in children having psychosocial problems—such as congenital diseases/seizures/HIV etc.

Table 2(e): PHC Referrals to Tertiary Care Mental Healthcare Facility,October-December 2015

Child & Adolescent Mental Health Issues		No. of Cases			
		October	November	December	Total
Developmental Disability	Intellectual Disability	1	1	1	3
	Speech Problem	1	0	0	1
	Motor Disability	1	0	2	3
Sub-Total		3	1	3	7
Speech and Hearing		0	0	1	1
Other Health/Medical Problems		0	0	1	1
Sub-Total		0	0	2	2
Total		**3**	**1**	**5**	**9**

Please note that the relatively low numbers provided with services at the PHC were due to absence of community mobilization services in the community by the PHC staff and community health workers, Thus, child mental health services are dependent only on community awareness/ mobilization activities provided through the screening services of the Project.

3. Anganwadi Services

During this quarterly there were no direct pre-schoolservices provided in the Anganawadis. The reasons were as follows:

i) During the month of October, due Dasara vacations, the strength of the children in the anganawadi was very low and teachers were on leave.

ii) The services were scheduled to be initiated in the month of November, for which the project staff attended the anganwadi teachers monthly meeting-- to provide the schedule. But many issues/concerns were raised by the anganawadi teachers—namely those relating to the Project not factoring in the time-table/ content of the non-formal education program in anganwadis. Given this feedback, the Project felt that it would be critical to clearly understand the issues and concerns of the teachers before continuing with the services. Therefore, the Project scheduled meetings with CDPO andSupervisor on the one hand, and with individual anganwadi teachers on the other, to come to a consensus on what services the Project was mandated to provide in the anganwadis and how.

Based on individual meetings and discussions with anganwadi teachers, we learnt that the teachers are not able to implement activities located within conceptual frameworks of child development because of:

- Their heavy the workload and other responsibilities (aside from non-formal education).
- Their experiencing difficulties in implementing the activities incorporated in their (Department) curriculum.
- Having a different curriculum to follow: the topics in the activities developed by the project were not in sync with the curriculum developed by the Department and hence they find it difficult to implement the activities demonstrated by the Project.The Anganwadi teachers thus requested the Project to incorporate the 5 domains of development into the curriculum.
- The methods, skills and demeanour of the designated Project staff was found to be unsuitable/ unacceptable to many teachers. (The challenge of finding qualified and skilled staff for the Project and how this adversely impacts Project operationshas been reported in previous quarterlies)

In response to the concerns voiced by the anganwadi teachers, the project acted upon their feedback in the following ways:

The Project conducted a round of visits to the anganwadis,explaining to the teachers that one of the objectives of the project was to collaborate with the teachers to explore how best to deliver their/departmental curriculum such that the 5 developmental domains are addressed. Further discussions were held on the domains of child development as a refresher:

- Physical - structure, growth, gross and fine motor skills - important also as readiness levels for subsequent years
- Speech - sound, articulation, vocabulary, coherent communication - important also as readiness for formal reading
- Cognitive - thinking, application, reasoning - important also as readiness for formal school learning
- Social - adjusting in an unfamiliar environment, interaction with people who are not family members, playing together, following norms - important also as readiness for formal schooling
- Emotional - ability to identify and name appropriately some basic feelings in themselves, ability to report feelings, ability to identify similar feelings in others - important also for suitable emotion management in the formal school environment.

Subsequently, using the relevant topic for the week, namely, ‘Household Items’, ‘Touch, Taste, Smell’ and ‘Shape, Size and Measurement’, the following suggestions were offered -

- Physical games like making formations in different shapes, fetch and keep objects, count and keep, push and pull actions with objects and people, colour within outlines (physical, social)
- Naming and sorting activities, identifying similar objects at home and in other familiar environments, talking about how they are used at home, feeling the difference in shapes , for example, between a ball and a cube (speech, cognitive)
- Reciting and singing activities, free movement of arms and legs, raising, lowering, stretching and bending activities (speech, physical)
- Using classroom situations, like a crying child/ children fighting/ children happy, to identify and label feelings and their causes (social, emotional)
- Using the school meals, talking about smell, hot/cold, taste, quantity of servings, likes and dislikes in food, helping to serve, waiting for turn, feeding skills (physical, speech, cognitive, social, emotional)

The other measures that could be followed by the teachers are as follows:

- Alternating activities to be done sitting at one place and standing or moving around
- Preparing children for the shift in activities by first announcing what was going to happen and then, when the activity is over, announcing the closure of that and only then introducing the next.
- Following practices that children learn to associate with specific activities and know what is expected of them
- Noting lags in any of the developmental domains
- Earmarking 2 or 3 children for each day to be given special individual attention, such that the entire group receives such attention turn by turn
- Gradually increasing the school time for the new children.

Observations made during the Anganwadi Visits are as follows:

- Lack of basic amenities like toilets and drinking water pose a huge challenge
- Lack of space restricts teacher initiatives sometimes.
- Other demands on the teachers such as food distribution distract them.
- There seems to be a gap in the State Education Department’s vision as seen in the design of the curriculum and the teachers’ capacity building in enabling them to deliver the content.
- Most teachers, though they acknowledge developmental requirements, are yet not open to modifying delivery styles.

4. Services in Child Care Agencies

4.1. Children in Care and Protection

a) Individual Services

During this quarterly, the project continued to provide individual services in child care institutions. A total of 41 children were provided with detailed assessments and first-level inputs, including referral to tertiary care facilities/ NIMHANS, as required. Amongst these children, 38 child psychiatric problems were identified[8], 44.7 %(17) of which were emotional problems or internalizing disorders and 44.7 %(17) were behaviour problems or externalizing disorders. Despite this categorization (which is more for convenience), for children in institutions, most behaviour problems actually have a strong emotional basis, also related to their difficult and traumatic experiences in the home/family context.

Table 4 (a): Total No. of (New) Consultations Disaggregated by Age & Sex, in Children's Institutions for Care and Protection October-December 2015

Age Groups	No. of Children						
	October		November		December		Total
	Male	Female	Male	Female	Male	Female	
5 to 12 yrs	1	1	0	7	3	4	**16**
13 to 17 yrs	6	6	5	2	2	4	**25**
Total	7	7	5	9	5	8	41

In addition to assessing and addressing the psychiatric problem that each child has, the project is also addressing the psychosocial contexts in which these problems occur because the psychosocial context, including how children experiences and internalizes it, is often what causes or determines the (nature of) emotional and behavioural issues as they occur in children. As the 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.

Table 4(b): Child & Adolescent Disorders Identified in Child Care Institutions for Care and Protection, October- December 2015

Problems/ Disorders		No. of Issues Identified			
		October	November	December	Total
Emotional Problems	Other Anxiety Issues (incl. separation anxiety)	0	2	1	3
	Dysphoria/Depression/Adjustment Disorder	2	3	5	10
	PTSD	2	0	0	2
	Self-Harm Behaviours	0	0	2	2
Sub-Total		4	5	8	17
Behavioural Problems	Conduct Symptoms : Anger/Aggression	3	3	2	8
	Conduct Disorder	1	1	0	2
	Runway Behaviour*	4	0	2	6
	Attention Deficit Hyperactivity Disorder	0	1	0	1

Sub-Total		8	5	4	17
Developmental Disability	Intellectual Disability	1	1	0	2
Sub-Total		1	1	0	2
Other Issues, incl. serious mental health issues and life skills issues	Life Skill Issues(sexuality, bullying etc)	1	0	0	1
	Psychotic Symptoms	0	1	0	1
Sub-Total		1	1	0	2
Total		**14**	**12**	**12**	**38**

Table 4 (c): Psychosocial Contexts of Emotional/ Behavioural Disorders

Contexts	**No. of Contexts**			
Psychosocial Context	**October**	**November**	**December**	**Total**
Single Parents/Abandoned	2	4	4	10 (26%)
Marital Conflict/Domestic Violence	3	3	1	7 (18%)
Physical Abuse	6	2	6	14 (36%)
Emotional Abuse	4	1	1	6 (16%)
Child Sexual Abuse	2	0	1	3 (8%)
Rescued from Trafficking (incl. Child Labour)	1	1	3	5 (13%)
Loss & Grief (Death of Parents and/or other Attachment Figures)	3	1	3	7 (18%)
Alcohol dependency in parents	3	3	3	9 (23%)
Parent involved in Crime	0	0	1	1 (3%)
Parent with mental illness/ disability	0	0	0	0
Children in Conflict with law	0	0	0	0
Family Engaged in Sex Work	**0**	**2**	**0**	**2 (5%)**

Of the 41 children assessed at theinstitution, 7 (17%) were referred to tertiary care facilities (refer to Table 4 (d)). 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). All children were referred to the Dept. of Child and Adolescent Psychiatry.

Table 4(d):Referrals to Tertiary Care Mental Healthcare Facility in October, November and December 2015

Child & Adolescent Mental Health Issues		**No. of Children**			**Total**
		October	**November**	**December**	
Emotional Problems	Dysphoria/Depression/Adjustment Disorder	1	0	1	2
	Post-Traumatic Stress Disorder	2	0	0	2
Subtotal		3	0	1	4
Behavioural Problems	Conduct Symptoms : Anger/ Aggression	1	0	0	1
	Conduct Disorder	0	1	0	1
Subtotal		1	1	0	2
Other Problems (including medical issues	Psychotic symptoms	0	1	0	1

and serious mental illness)					
Sub-Total		0	1	0	1
Total		**4**	**2**	**1**	**7**

*The table shows causes of referral which is important from a clinical point of view. 7 children had been referred during this quarterly.

b) Depth Therapeutic Work

In this quarterly, 3 children had been seen for in-depth therapies in order to address emotional and behavioural problems. These are children referred to Dept. of Child and Adolescent Psychiatry, NIMHANS, for severe emotional and behavioural problems arising from child sexual abuse experiences, after which both pharmacological treatment as well as psychotherapy was started. During their weekly visits to child care institutions, project staff also carried outdepth psychotherapy sessions to assist these children. Various methods, as outlined in the child sexual abuseworkbook[1], were used in combination with other creative and cognitive behaviour therapy methods to help children with healing and coping with difficult and traumatic experiences.

c) Group Interventions

During this quarterly, the Project has reached 296 children through 46 group sessions conducted in 8child care agencies (See table 4(e) for details). As described in the previous quarterly report, life skills modules have been developed to address issues on emotional development, sex and sexuality, motivation, gender and violence. The Project continued to roll out these sessions on a weekly basis, with groups of children.

Table4 (e): Group Interventions Provided to Institutionalized Children, October to December 2015

Institution	Session Content	No. of Children	Age Group
MakkalaJeevodaya	Anxiety Management	15	6 to 13 years
	Making Magic Kites	15	
	Story about sending wishes and thoughts through magic kites	15	
	Connecting to people through kites	15	
Total No. of Children Reached		15	
Total No. of Sessions		4	
APSA	Dealing with Traumatic Memories	15	
	Coping with fears and Worries	14	
	Relaxation Techniques	16	13 to 16 years
	Who am I ?	16	
	Movie screening- Children of Heaven	16	
	Empathy building	14	
Total No. of Children Reached		16	
Total No. of Sessions		6	

[1]Karp, C.L, Butler, T.L (1996). Activity Book for Treatment Strategies for Abused Children, From Victim to Survivor. Sage Publications. New Delhi

Government Boys' Home- Group 1 (Kannada group)	Formation of group	23	12 - 16years
	Rapport Building (Getting to know each other)	12	
	Insight Building	15	
Total No. of Children Reached		23	
Total No. of Sessions		3	
Government Boys' Home- Group 2 (Hindi group)	Bonding and trust building with in the group	31	12- 16 years
	Bonding and trust building with in the group	29	
	Identity building	31	
	Identity building	36	
	Monster and Balloon Game	38	
	Games to build Social Skills	35	
Total No. of Children Reached		38	
Total No. of Sessions		6	
Vijayanagar School Residential Facility	Story about Sharing and Greed	21	6- 13 years
	Story about cleanliness and Hygiene	25	
	Story about cleanliness and Hygiene	25	
	Story about Environmental Care	23	
Total No. of Children Reached		25	
Total No. of Sessions		4	
BOSCO Rainbow Home – Wilson Garden	Rapport Building	22	13 -16 years
	Identifying and Reporting Feelings	17	
	Movie Screening – Stanley kaDabba	68*	
Total No. of Children Reached		22	
Total No. of Sessions		3	
ANC Navajeevana Rainbow School-Chamarajpete	Getting to know each other – Rapport Building	16	11- 14 years
	Identifying and Reporting Feelings	16	
	Talking about difficult and Traumatic Experiences	16	
	Talking about difficult and Traumatic Experiences	16	
	Recap and Trust building	16	
	Movie Screening – Stanley kaDabba	75*	
	Games to build Social Skills	11	
	Dealing with traumatic Memories	16	
	Empathy building	16	
Total No. of Children Reached		16	
Total No. of Sessions		9	
ANC Navajeevana -J.J.R.Nagar	Rapport Building and Story Telling	21	6- 13 years
	Empathy Building	21	
Total No. of Children Reached		21	
Total No. of Sessions		2	
BOSCO VatsalyaBhavan-	Getting to know each other – Rapport Building	15	14-17 years
	Identifying and Reporting Feelings	12	

Chamarajpete	Talking about difficult and Traumatic Experiences	12	
	Dealing with traumatic Memories	12	
	Coping with Fears and Worries	12	
	Who am I? Identity Building	12	
	When I get angry	12	
	Analysing Anger	9	
	Monster and Balloon Game	9	
Total Number Of Children Reached		15	
Total Number Of Sessions		9	
Grand Total Number of Children Reached		**296**	
Grand Total Number Of Sessions		**46**	

Observations and Experiences from Care and Protection Institutions

i) In some shelter homes, children who do not go to school or are in transit homes have no structured activities for the day. So, they are left to their own devices for much of the time, which could otherwise be utilized to do some learning and recreational activities.

ii) In other shelter homes, children have a standard time-table to be followed daily, and these daily activities do not seem to have a clear rationale; and children's interests are not taken into consideration while planning these time-tables. For example, if vocational training has been offered, the only option offered is tailoring, and many children may not be interested in this. Life skills group sessions which are conducted by agency staff have no structure or content, so the children are not keen to attend them, nor benefit from them.As a result, children feel de-motivated, and that their stay in the institution is of no use and frequently express a desire to leave or run away.Children with psychiatric issues find it particularly difficult to adjust to such daily schedules which cater to their needs even less than others.

iii) During our services in the institutions it was observed that the self -harm behaviour is a common behaviour and also one of the major concerns of the institution staff. This behaviour may be attributed to:a) emotional problems and adjustment disorder; b)a means for children to negotiate with institution staff and get their demands met, including seeking their attention and affection; c) a learnt behaviour as children observe each other and learn that it is a way to get their needs met. Institution staff thus frequently see these as children 'being manipulative'. But the Project has made efforts to explain this behaviour as a survival strategy developed due to the exceedingly difficult circumstances that these children have been in; and that this behaviour also needs to be viewed through a life skills deficit lens i.e. as having difficulty with problem solving, conflict resolution and creative thinking.

iv) It was observed that agencies were more cooperative and flexible about timings, keen for the Project to hold sessions for the children, as they really felt the usefulness of the sessions.

v) Following group sessions, children who were erstwhile not referred for individual assessments by agency staff, approached Project staff on their own initiative, requesting to share their problems and concerns. Thus, it appears that group work sessions have enabled the development of a sense of trust and comfort in children and has paved the way for addressing their emotional problems through individual/ in-depth work (erstwhile sometimes challenging as some children were unwilling to engage in conversations with the Project staff/ facilitators).

vi) One of the early objectives of group sessions, with adolescents, was toaddress difficult/traumatic experiences—to share and express them and how to cope with them. As children got comfortable

with sharing their narratives, it was also observed that they became increasingly empathetic and helpful towards each other.

vii) During group work sessionson coping with trauma, although children had difficult experiences within their families, these did not mar the happy memories they had about their family. This reiterated the feeling that their families always came first, and werethe most precious thing to them—all the more reason for agencies to help children maintain family connections rather than encouraging them to erase them, so that children have a sense of security and belonging, knowing that their families continue to exist in whatever manner possible, for them.

viii) Contrary to the institution staff's opinion that children do not wish to talk about their difficult experiences (as it would re-traumatize them and lead to emotional/behavioural issues), sessions on trauma showed that children were not only comfortable sharing their traumatic experiences but that they wanted more sessions than originally planned to be able to talk about them and share their narratives. Validation of difficult experiences and emotions, relaxation techniques and perspective-taking were found to be useful ways of enabling children to move beyond their traumatic experiences (in contrast to getting them to suppress these experiences).

ix) Children appeared to be reflective about the issues and activities discussed even days after the group session on a particular issue was completed. For example,following the session on anger management, children in one institution returned some days later with narratives on their experiences of physical and verbal abuse in the family—now stating that they had tolerated abuse for a long time without voicing their anger about it, realizing now that one day they had finally shown their anger through their decision to leave home; they were also able to consider their anger decisions in terms of the positive and negative consequences i.e. family reactions of not letting them back into the house, currently being in hostel, undergoing vocational training, learning English etc. They also reflected and reported that there are situations in which decisions taken in anger have helped them have the will power to achieve something in life by challenging those who constantly criticized or abused them i.e. conversion or channeling of anger.

x) It is observed that most of the children in institutions have worries and concerns about their future. Most of these worries and concerns were not addressed by the institution and children also do not have a platform to voice out these worries and concerns. However, during the group sessions the project staff addressed these issues and concerns to looking at probable options and alternatives available to them.

d) Medical Protocol in the Child Care Institutions

It was observed that each child care agency follows its own medical protocol and that at times some of the decisions made for testing and treatment are not entirely systematic or as per any set criteria. This somewhat random approach was found to be problematic especially in case of children who were rescued from trafficking/ sex work and contexts of child sexual abuse—wherein emergency health issues such as HIV testing and decisions around pregnancy become critical concerns. An assessment of the content of medical protocols followed by each agency served by the Project was therefore undertaken. Our findings were:

- All institutions have a medical check-up done within 4 days of a child being admitted.
- A general health check-up or physical examination including checking for vital signs, BMI, and per-abdomen, physical signs/symptoms for any abnormalities is conducted when the child is admitted to the institution, and is repeated periodically (every 3 to 6 months).
- Any further laboratory investigations are carried out only if the examining doctor asks for them to be done.

- None of the institutions conduct testing for HIV and other sexually transmitted diseases—unless the child is brought through CWC with a history of child sexual abuse or trafficking. Usually these tests are done by the Police or CWC while the child is still in the transit home.
- Pregnancy tests are not considered by the institution—thatagain; relies on the Police/ CWC to do these tests.

The issue with not making STD/ HIV tests routine or mandatory may be problematic as many of these children i) come from difficult family experiences and backgrounds or may be street children; ii) not all who have been abused may report it at the CWC/ to the police; iii) HIV transmission can occur through routes other than sexual contact—such as mother-to child, and the institution may not have the complete family/ parental health history of every child; or HIV transmission also occurs (as reported in subsequent sections of this report) through blood transfusion/ during medical procedures which a child may have undergone prior to coming to the institution. In all these instances, the detection of HIV and other STDs may be missed unless we routinely rest for these infections. This poses the risk of delayed treatment for the child as well as transmission risks to other children living in the institution. Similarly, not knowing about sexual abuse, because children may not always report it to the Police or CWC, creates issues around early detection of pregnancy and delays decisions around abortion and other issues.

The project team is therefore working towards developing on Medical Protocol for child care institutions that will include SOPs (Standard Operating Procedures) to be followed for all children at the time of admission to the agency.

From the Field Worker's Diary…Enabling Institutionalized Children to Cope with Loss and Trauma

Session 6: Dealing with Traumatic Memories **Date: 3rd October, 2015**

Objectives:

- To help children express and cope with personal loss, grief and trauma experiences.
- To enable children to acquire life skills relating to emotional regulation, interpersonal relations and empathy.

Methods: Visualization, art, narrative

Materials: Paper and crayons/colours

Process:

- All the children were greeted and asked to sit in a circle.
- Asked the children how were they all these days and to share what all they had been doing. I shared the same about myself.
- I asked if anybody can recall what we did in our previous sessions; all the children were given opportunities to respond. Most of the children were able to recall.
- I summarised thus: "Last time we discussed and shared about difficult and traumatic situations in general and the impact it has on our feelings and behaviours. We also talked about how and why it is important to express our feelings about these issues."
- I briefed them about today's session - "Today, we will talk a little about experiences of loss and grief and try to understand our feelings better—so that we also move on to finding ways to deal with these feeling so that we can leave behind the difficult feelings and cope better.
- Rules of the group such as respect, confidentiality and trust were reiterated.
- Also reassured the children that if anybody is not comfortable to share some of their experiences, that's alright — we know that they relate to them in their own minds as we talk.

Activity A:

- All the children were asked to close their eyes and think of a traumatic time/event in their lives.
- They were told to imagine the event/ time as an image (not a narrative/ not in words); like a still photograph and to draw it.
- Children were reassured that their drawing skills will not be judged by us and no one will make fun of each other's drawings.
- 15minutes time was given for children to draw.
- Later all the children were asked to describe it to the person next to them.
- Most of the children had drawn pictures depicting death and some depicting fights.
- All the children were thanked for drawing and sharing their difficult experiences, acknowledged that it would have been difficult for them to revisit the traumatic experience.
- Further discussed with the children on the following topics:
  - What sort of images and feelings came back to them?
  - Asked the children:'was it easy to express the emotions they felt?'
    - They responded it was difficult but could share as they were among friends.

      Further elaborating, I appreciated the children's insight and acknowledged the difficulty they would have felt in sharing traumatic experiences, concluding that though it may be painful to recall, when we share such experiences with the person we trust and consider friend, it's easy and we feel comforted after doing so.

- What or who helped them at the time? What else could have they done to seek help?

- All children's responses were used to generate coping mechanisms—by pointing out how they got help by sharing it to someone they trust, how their family and friends supported them, and now they have also learnt many things today from other's experiences which they can use to cope with their issues.
- All the children were thanked for sharing their views and experiences;
- Summarized the session by stating different coping strategies, and explained to the children how much we have all learnt about ways to cope with difficult feelings and traumatic experiences.
- Then we played a game called "Make me laugh"

Observations:

- Children were hesitant in the beginning but later, as a few of them began to share, they were emboldened,&started to draw… after reassurances that no one will laugh at their drawing, the others followed suit.
- Some of the children were upset and were able to get comforted when their friends sat with them and reassured them.
- Children were empathetic towards each other.
- After the game they were normal and playful.

Session 7: Dealing with Traumatic Memories- (Continued) **Date: 17th October,2015**

Objectives:

- To help children express and cope with personal loss, grief and trauma experiences.
- To enable children to acquire life skills relating to emotional regulation, interpersonal relations and empathy.

Methods: Visualization, art, narrative

Materials: Paper and crayons/colours

Process: Activity B

- All the children were asked to sit in the circle and then enquired how were they doing all these days and to share what all they had been doing.
- They saw my file which contained crayons and sketch pens and asked me if we are going to draw today also. When I asked them whether they would like to most of them said "No".
- So I decided against the use of art for the session.
- All the children were asked to think about the happiest memory and asked to share/ describe to all of us.
- Discussed how we can use these positive memories to feel comforted and to be stronger: By Visualizing happy memories when we feel very sad and upset with memories of loss and trauma.
- Above concept was explained as follows :

  If we fill our mind only with sad memories, they become bigger and bigger and occupy the entire mind space. Like when we blow a balloon—the air fills the balloon and occupies the entire space. So, instead, if we try to fill our mind with happy memoriesthen it will occupy the greater space in our mind.
- Also discussed how Happy memories help to counter difficult memories—if we focus on happy memories when we are sad, then it will help us to get rid of sadness/sorrowfromour mind.
- Also discussed about maintaining a balance of memories and emotions: No one is saying one must never feel sad or think of the difficult memories; some experiences are very hard and they are bound to come back to us from time to time and it is okay to feel sad about them.
- But we should always try to make a balance and think about how we wish to spend our time thinking about the traumatic memories; we should also think whether we want these traumatic memories to spoil our daily activities such as our Studies, our dreams and ambitions, our relationship and friendship.
- Later we played a game Called -**Chain Reaction**

Chain Reaction Game

How to Play: The children form small groups, and each group stands ina circle, facing the centre. The leader then points to one child in each group,who then begins the game by making a random motion; for example, turningher head from left to right. The player on her right repeats the first motion andthen adds a new one; for example, snapping his fingers. The player on his right,Player number three, turns her head, then snaps her fingers, then wiggles her elbows, in order. The game continues until a player finally forgets one of the motions ormixes up the order in which they occur. That player drops out of the game, andthe others continue until one winner emerges. The winners of each group thencome together for a final match, or the children can be regrouped so each getsanother chance to become a winner.

Observations:

- Most of the Children were reluctant to depict their experiences in a drawing and wanted to discuss or talk about them instead.
- They were very comfortable to share their experiences.
- Most of the children wanted share more than one happy memory, which was encouraged.
- Most of the Happy Memories shared were related to family and the experiences in their Institution (APSA).
- This group of children don't enjoy art/drawing- Other methods such as drama, Role play can be introduced.
- Even though all the children had difficult experiences in their family, thesedid not eclipse the happy memories they had about their family. This reiterated the feeling that their families always came first, and it was the most precious thing to them.

Session 8: Coping with Fears and Worries Date: 24th October, 2015

Objectives:

- Enabling children to express their fears and worries.
- Helping children identify the degree of fear and worry they experience and to distinguish between issues that cause more or less fear/worry.

Methods: Mask-Making

Materials: cardboard paper, scissors,crayons/ colours thread or ribbon

Process:

- All the children were asked to sit in a circle.
- As one of the group members was admitted in NIMHANS for her treatment, all the children wanted to know how she was doing and whether she was having food regularly. They asked me to give her their regards.
- I asked the children how they were doing and then asked them if they could do a recap of the last session – to which afew children did.I continued – "In the last session we had discussed about our most traumatic experiences and the happiest experiences. Today we will be talking about our fears and worries."
- I Explained to the children that everyone of us has our own fears and worries and each one of ours have different intensities—for Example, we may feel terrified (extremely fearful) about some things like a cockroach, we may feel quite afraid about other things like a cow/ buffalo; at the same time, there are also some things we feel confident about like a dog/cat.
- I explained that each of our fears might be different from our friends'. In this session, we will discuss our worries/fears and also some initial ways to manage them.

<u>Activity A</u>:

- Children were asked to imagine how they would like to 'wear their fears and worries outside'—what they would look like if they were
    i) Terrified

ii) Worried
iii) Confident

- Children were provided with the 3 round cardboard cut outs and markers and asked to create a mask to wear for each of the three feelings.
- 15mins time was given to them to create the masks.
- When the children were ready with their masks, asked each child to share their feelings about being terrified/ worried/ confident:
  I. "I feel terrified when…"
  II. "I feel worried when…"
  III. "I feel confident when…"
- All the children were appreciated and thanked for sharing their fears,worries and the things they are confident at.
- Later asked the children to list out the things/activities that they are unable to do when they are worried. A few of the children also demonstrated
  -Cannot Study or do any kind of work/cannot concentrate.
  - Cannot play/do any kind of fun activity.
  - Don't feel hungry or cannot eat properly.
  - Cannot sleep/have disturbed sleep.
  - Won't be able to sit in one place.
- Then asked the children to list the physical symptoms of pain/discomfortthat we feel in our bodies when we are anxious/worried/upset:
  - Body/Stomach/Head Ache
  - Feeling tired/discomfort
  - Giddiness
- Summarised by telling them that when people feel anxious/worried and if they are not able to deal/cope with the situation, they may feel like they are not able to do anything. They may even runaway.
- Discussed about the mind body relationship - how they are interconnected and if either of them is affected, the other also gets affected. For example:
  - During exams when we are tensed and anxious, our hands shake. We feel nauseous. We sweat. These physical symptoms do not occur because of any physical ailment and it does not mean we are sick. They are occurring because we are worried, stressed and anxious.
- Further explained what will happenif we overload our head with thoughts by giving the below example:
  - What will happen if I give you Rs.500 and take you to a food street where you get all sorts of delicious food and told you can buy anythingto eat? If you eat Pani-puri, Masala Dosa, Kabab, juice, and then ice-cream, all together, one after another?
    - Children replied they will get sick and have loose motions.
- Ended the session by telling the children that in the next class we will be learning few techniques and methods to cope with our anxiety and our issues.

Observations:

- All the children enjoyed the mask making. They had lot of fun.
- Children were quick to understand the mind body relationship and to relate to their experiences.

- They also wanted to demonstrate how they feel when they are upset and what kind of Physical symptoms of pain/ discomfort that they feel in their bodies when they are anxious /worried/upset.
- Role play and drama techniques can be used in the future activities as the children enjoyed and demonstrated active participation and involvement (especially when they do not enjoy art much).

Session 9: Relaxation Techniques **Date: 31st October, 2015**

Objective:

- To teach the children ways in which they can manage their worries and anxieties by demonstrating techniques such as Deep breathing, and Guided Imagery.

Materials: None

Methods: Relaxation techniques

Process:

- All the children were asked to sit in a circle and told them that today, as informed in the previous class, we will be learning a few techniques and methods to cope with our anxiety and our issues.
- Explained that there are some simple ways in which we can manage our anxiety and worrieswhich will help us to reduce our feelings of anxiety and to calm ourselves. And today, I will teach some of those techniques and the children will be practicing the same.

Relaxation Technique 1:Deep Breathing

- All the children were asked to close their eyes, sit up straight and place their hands on their abdomen.
- They were asked to breathe deeply through their nose taking in lots of air - as much as they possibly can - and feel their hands moving outwards as their abdomen expanded and to slowly breathe out through their mouth.
- Children were asked to initially repeat the same for 5mins.Then; they weresuggested to try and practice this technique until they begin to feel calmer and relaxed.
- Finally, explained to the children how it will help them as in addition to its calming physical effects, the relaxation response also increases energy and focus. The relaxation response puts the brakes on stress and brings your body and mind back into a state of equilibrium.

Relaxation Technique 2:Guided Imagery

- Asked the children to lie down comfortably on their back.
- Explained to the children that I will now be taking them on an imaginary journey. And that as I speak, they all just need to focus on their bodies as I take them to another place. They must try to imagine all the things that I am going to describe.
- An imaginary narrative was used to demonstrate to the children.
- By the time guided imagery narrative was complete, a few of the children were fast asleep.
- Later when asked how they felt – whether the activity was relaxing - Children said it was a wonderful experience and wanted me to repeat it again.
- Discussed about the use of relaxation techniques from which they can feel relaxed calmer and better and also suggested few instances when they can use Slow Breathing Exercise and Guided Imagery Techniques.

Observation:

- All the children enjoyed the Guided Imagery Activity.
- Post activity, the children felt very relaxed and calm.
- As the children themselves agreed that the activity was calm, it can be practiced on a regular basis and also be used by the Institution staff when the children are anxious or upset to make them feel better and calmer.

Session 10: Who am I? **Date: 7th November 2015**

Objectives:

- To develop a perspective on anxiety in relation to themselves.
- To understand that 'I am much more than just my anxiety'.

Methods: Art

Materials: Paper cut-outs in the shape of a Girl (separately cut into Heads, torso and limbs)

Process:

- As there was a meeting going on at the regular place we use to conduct our sessions, we had to shift to a different place where the children usually sleep. They all wanted to show me the places they sleep and introduced me to their friends.
- All of us gathered and the children were asked to sit in a circle.
- Introduced to the children that in our previous session we talked about our fears and anxieties and how we can respond to them.Today, we will try to understand more about our fears, worries and anxieties and how much space they occupy in our lives& how to cope with them.
- Further explained the Idea of Identity – Identity is nothing but how each one of us think about ourselvesand most of the times it is based on what people tell us.Today we shall try to understand our identities better and learn to make our identities stronger.
- All the children were given paper cut outs in the shape of a girl divided into Head, torso and limbs.
- They were asked to write down
    - i) The various roles they play, on the head part (eg. a student, a daughter, sister, citizen of the country, friend etc.)
    - ii) Their good qualities and talents,on the trunk part(things they are good at. Dancing, studying, singing, playing cleaning, being a good friend, helping others etc.)
    - Their fears and worries,on the limb part. (Fear of darkness/dogs, worried about family issues/studies etc.)
- 15mins time was given to the children after which they were asked to present each of their pictures and share their Roles, Qualities/Strengths, Fears/ Worries.
- When all the children had finished sharing, they were firstly thanked for doing so.
- Later explained to them that they are complete only when they combine all their Strengths, Roles, and Worries/Fears together. Fears and worries only occupy small part of them and they should not allow worries and fears to grow bigger and bigger, if they allow it then it will occupy more of our Identity and will not allow us to be so many other things we can do or be.
- Further explained the need to balance out and counter our fears and worries using our confident thoughts and our positive identity i.e. our strengths, roles, talents etc.

Observations:

- Children during the session while discussing the roles which they are carrying at present, they also wanted to add the roles which they wish to take up in future- children were encouraged to add their future ambition and goals.
- It was observed that children were enthusiastic about their future rather than their present roles and talents, and they said they have no much talents that they can write down now and have not achieved much now and they wish to develop more talents; responding to this I said "even if we have not achieved many of our goals and wishes it's OK, there is still time and we can plan and prepare for it in order to achieve our goals. During our sessions we will discuss more about your dreams and goals and I will help to plan and prepare.

4.2. Interventions in HIV/AIDS Infected and Affected Children's Institutions

As part of the Project's objective to assist children in difficult circumstances, including children infected/affected by HIV, the Project worked in collaboration over a 2 month period with the Paediatric ART Centre atIndira Gandhi Institute of Child Health (IGICH). The objective of our support and services was to obtain a clear understanding not only of children's issues but also of counsellor roles and functions, the feasibility and logistics of integrating mental health issues into HIV counselling with children, and the needs and challenges thereof—and based on this, to develop materials for direct work with HIV infected/affected children as well as for training ART counsellors.

During the course of two months, the Project team made 2 to 3 visits per week tothe ART Centre (a total of 16 visits). The following support and services were provided by the project:

- Direct service provision to children visiting the ART centre with a view to integrating child and adolescent mental health concerns into paediatric HIV services.
- Development of a child mental health screening protocol for children/adolescents & parents in order to identify and address children's psychosocial and mental health concerns.
- On-the-job training, through discussion and demonstration, for the two counsellors/ social workers on:
    - How to interview children and parents/caretakers.
    - Provide inputs on early stimulation.
    - Providing detailed assessment and first level responses for the Psychiatric issues (Emotional & behavioural issues) identified.
    - How to address psychosocial context specific to HIV infected children such as Disclosure, Adherence, Stigma and Discrimination, Placement issues/Social Intervention, Concerns about future, stigma & discrimination and disclosure issues with parents and children.
- About 15 hours of classroom/ theory training forthe 2 counsellors on communication techniques with children and other child mental health issues, including those specific to HIV. (The ART counsellors were also included in the 3-day training organized by KHPT—see sub-section on 'Training and Capacity Building' for details).

Children who visit the centrefor ART treatment also avail of counselling services through 2 social workers appointed for this purpose. Before initiating our services, we found that the counsellor's focused mainly on ART medication (pill counting and dispensing) and adherence issues. Disclosure was mentioned mainly as an instruction to care-givers to 'tell the child' but care-giver concerns (barriers to disclosure) on how this needs to be done, why, and at what age were not part of the counselling process.

Children's emotional and behaviour issues and concerns about illness, loss and mortality were not addressed, nor were child psychiatric issues identified.This was why the Project developed a screening tool for the use of the ART counsellors—to enable them to identify children's (and care-givers') concerns and do more detailed assessments to provide first level responses and referrals. Also, no inputs were provided at all to care-givers for very young children (pre-schoolers) infected/ affected by HIV in terms of the need for play and stimulation activities to optimize brain development which tends to be adversely affected by pre-natal acquisition of HIV infection and exacerbated by HIV.

Screening for Child and Adolescent Mental Health Issues
***(For Children)**
For Dept. of Pediatrics, ART Centre, Indira Gandhi Institute for Child Health (IGICH)

Developed by Community Child & Adolescent Mental Health Service Project,
Dept of Child & Adolescent Psychiatry, NIMHANS

Name of Child: **Date:**

Age: **Sex:**

Explain to Children: *'Hello, my name is……I work here with the team in the hospital, to help children in whatever ways possible. You have been coming here for a while, to see the doctor and collect your medicines. Sometimes children have worries and confusions about things that happen at school or at home or even in the hospital; it is not always easy to talk about these problems. But if we do, then it might be easier to get some help with them. So, while you come here for medical treatment, we also want to share and understand if you have other worries and difficulties at home/ school and help you.*
I am going to read you a list of worries/ problems—if you have any of them, say 'yes', otherwise, say 'no'.

Issues		Yes	No
1.	You often feel worried or scared.		
2.	You often feel like you don't want to go to school.		
3.	You often get headache/ stomach ache/ body pains.		
4.	You often feel sad and like you want to cry.		
5.	You often like to be alone and don't feel like playing with other children.		
6.	You often feel angry and like you want to shout or hit others.		
7.	You often don't want to or refuse to take your medicines.		
8.	You have questions and worries about coming to the hospital/ taking medications.		

Has anyone at home/ in the institution told you anything about your hospital visits and why you need to take medications? (Yes/ No)

***Referred for Counselling Services (Yes/ No):**

During the Project team's visits to the ART centre, a total of 45 children were assessed and provided with first level responses and assistance.19 child and adolescent mental health issues were identified in this group of children, of which 11 (nearly 58%) were emotional problems, 2 (11%) were behaviour problems, 3 (15%) children with Developmental Disability and 3 (15%) children with other Issues, incl. serious mental health issues and life skills issues. (Refer Table 4(f), (g) and (h)).Only 1 child with Dysphoria and self-harm risk was referred to the Dept. of Child and Adolescent Psychiatry, NIMHANS. Other issues were managed in the ART centre by the Project team and the ART counsellors. Refer to Table 4 (h) for the specific psychosocial contexts of HIV infected/ affected children's mental health problems.

Table 4(f): Total No. of (New) Consultations Disaggregated by Age & Sex, in Children's Institutions for HIV, October-December 2015

Age Groups	No. of Children		**Total**
	Male	Female	
0 to 6 years	4	4	**8**
7 to 12 years	11	5	**16**
13 to 18 years	14	7	**21**
Total	**29**	**16**	**45**

Table 4(g): Child & Adolescent Disorders Identified in Children's Institutions for HIV, October-December 2015

Problems/ Disorders		**Total No. of Children**
Emotional Problems	Other Anxiety Issues (incl. separation anxiety)	6
	Dysphoria/Depression/Adjustment Disorder	5
Sub-Total		11
Behaviour Problems	Conduct Disorder Symptoms: (Lying and Stealing)	1
	Attention Deficit Hyperactivity Disorder	1
Sub-Total		2
Developmental Disability	Intellectual Disability	1
	Speech Problem	2
Sub-Total		3
Other Issues, incl. serious mental health issues and life skills issues	Life Skill Issues(sexuality, bullying etc)	2
	Other Health/Medical Problems	1
Sub-Total		3
Total		19

*Includes many children from the government boys home who have run away from home due to various difficulties and problems with families.

Table 4(h): Psychosocial Contexts of Emotional/ Behavioural Disorders

Psychosocial Context	**No. of Contexts**
Marital Conflict/Domestic Violence	**1**
Emotional Abuse	**1**
Loss & Grief (Death of Parents and/or other Attachment Figures)	**12**
Single Parents/Abandoned	**10**
Disclosure	**29**
Adherence	**0**
Stigma and Discrimination	**4**
Placement issues/Social Intervention	**2**
Concerns about future	**11**
Early stimulation	**9**

Observations and Experiences at IGICH's Paediatric ART Centre

During the services following issues and concerns were observed:

- 11 out of the 19 cases of child mental health issues identified i.e. more than half the children seen, had emotional issues, mainly anxiety. The anxiety pertained to the illness and concerns about the future, some sense of loss of parents/ care-givers and in adolescents, to fears of stigma and discrimination.

- The majority i.e. 29(37%) children identified through screening haddisclosure issues.Most parents and care-givers were not willing to talk to children about the illness. Even after detailed discussions were had with them on the reasons to do disclosure (based on children's right to know, anxieties that could arise out of not knowing or receiving incorrect information from unauthorized sources) and how to provide information about illness in an age-appropriate manner, care-givers were reluctant to tell children about the illness. Their reasons ranged from 'the child is too young' (even when children were above the age of 8 years) to being fearful about how the information would be received by the child and that 'children will not understand all this'. Many were of the opinion that they would tell their children at the age of 18 years. Concerns about when to tell vis-à-vis other life events, when a child may be ready to receive such information and the ability of the child to comprehend information are all common care-giver concerns regarding disclosure.
- Interestingly, none of the children seen (although our sample may not have beenstatistically significant or representative) had medication adherence issues. Considering that almost all ART counselling is directed at adherence, it does not appear that many children have an adherence problem per se. This indicates that adherence issues are not as much of a problem that it is generally perceived to be. This means that one needs to question the notion/ belief that children with HIV come from difficult backgrounds/ temperaments and are bound to have adherence issues. Also, where adherence is a problem, it is likely to be because disclosure processes have not been duly conducted.
- Parental over-protectiveness towards children served as a barrier not only for illness and disclosure issues but also for facilitating normal processes of child development and growth. When inputs were provided regarding the importance of early stimulation and the need for exposure to school/ social situations/ family functions, to develop children's social and emotional skills even at older ages, parents expressed concerns about stigma, discrimination and the child's health. Their greatest fear was 'what if children tell others that they have HIV'. In response to these issues the team explained the importance of early stimulation and the need for developing the child's confidence and life skills to enable the child to grow and develop as normally as possible i.e. so that they are not deprived of opportunities due to their illness—and that in fact, because of the illness, they require increased opportunities for development so that they do not lag behind other children; the team also shared ways in which children may be helped to understand the concept of privacy and that health issues are usually kept private and not shared with outsiders.
- 22 (28%) of children were identified with having single parents or no parents wherein children was in the care of grandparents/other relatives. The concerns and issues raised by the children's relatives included concerns about the child's future—in terms of education, whether children will survive to be able to study and have a career. Grandparents, however, had not planned for the child's future in the event of their own illness and death—and many grandparents had HIV and/or other illnesses. In these instances, the Project provided them with options and ways to plan their child's future, in terms of institutionalization and hostel education i.e. social interventions were provided.
- Institutional children came in large groups, often with staff who did not really know their concerns. While some institutions who met the Project team spoke of the challenges they face in dealing with children's emotional and behaviour problems, others did not see this as a need. Like many ART counsellors, and indeed care nonHIV care and protection shelters, they believed that providing food, shelter, education and ART treatment is adequate for children infected with HIV.

- Most of the parents themselves had emotional and other psychiatric issues which were also addressed during the counselling sessions and where necessary, they were referred to the Dept. of (Adult) Psychiatry, NIMHANS.
- It was also observed that some of the children who were HIV (+) ve but their parents were negative, so the infection was not transmitted from mother to child. These families also reported that they had, at some point, taken these children for treatment of other illnesses, some minor and other major, such as surgeries also requiring blood transfusion, to varioushospitals. Since most of these children were either very young or had not yet been told about the HIV status, parents expressed concerns regarding the child's future (due to HIV) but also about their fears on how the child may respond to knowing the routes of HIV transmission. These families expressed their anger about the injustice of the (health) system- "the system which was responsible for the care and protection of the child's health, due to negligence and inefficiency was responsible for the child's illness". As these families come from a low socio-economic background they frequently perceive themselves to be powerless, especially as they cannot afford legal assistance to fight the system. These issues are likely to lead to complex psychosocial problems in the child, such as complicated anger (justifiably so). The tension and the need for acknowledgement and accountability on part of the concerned hospital system that erred calls for comprehensive support for children and families[2].

4.3. Interventions for Children with Disability

During this quarterly period, the Project carried on work intensively in the area of disability with two child care agencies serving children with disability—Dharithree Trust which is a school for children with special needs and Nirmala Shishu Bhavan, which is a shelter home for disabled children who are orphan and abandoned. (See below for details of our work and learning from these agencies).

a) Dharithree Trust

The Project initiated services and support to Dharithree Trust in the month of July 2015. Group Sessions were conducted once a week, till November 2015, for 20 children, aged 10 years to 18 years. The objective of the sessions was to help the children identify and express their emotions that would facilitate socio-emotional development. The methodologies used in the sessions included story-telling and role-play using masks depicting different emotions. However, based on our experiences so far, we felt that we required a review and a re-assessment of the needs of the agency and children. Therefore, a depth observation-analysis exercise was undertaken with a view to understanding more clearly the needs and what approaches and methods might most effectively meet the needs.

School Structure and Functioning

The Trust operates a day school for students, 6 years to 35 years of age, with Intellectual Disability of mild to profound levels with various co-morbidities like Down's syndrome, Cerebral Palsy, ADHD and Autism among others. The fee is Rs.300 per month and students belonging from families unable to bear this cost are supported through private donations. The staff comprises 12 members, 6 of whom are Special Educators. The others, some of whom are parents, help with sundry duties like cleaning, mobility of the students as well as teaching.

[2]From conversations with IGCHI staff, we learnt that the response of the erring hospitals, upon enquiry is either to produce documents which absolve them of blame or to be unable to trace the necessary documents is what makes legal advocacy in these cases difficult.

Functional assessment of every student is done by the institution's psychologist, in collaboration with the teachers, using the form developed by the NIMH (National Institute for Mentally Handicapped). Based on the assessments, the students are divided into groups – non-educable, educable (primary and higher primary), Pre-Vocational and Vocational.

The day begins with a common yoga session for all the children. Student participation in these sessions, generally conducted by a single teacher, is largely dependent on each student's cognitive ability to follow instructions. Moreover, in the absence of services of trained personnel like physiotherapists, students with physical challenges are also unable to participate in the yoga sessions. For the rest of the school day, smaller groups of students, formed on the basis of their abilities attend sessions with individual teachers.

The students assigned to the pre-primary group are taught basic social communication skills, like greeting with "Hello/Hi/Namsathe" and engaging in simple conversation. They are taught names of fruits, vegetables, other common objects, colours and shapes. Activities that promote eye-hand coordination are practised with the students. This group also includes children with speech and hearing impairment.

The students who comprise the educable group are taught formal academics using the text books for different subjects prescribed for the State syllabus. English as a subject has been recently introduced in this group. It was observed that this group too has students who are speech and hearing impaired.

The students in the Prevocational group are taught several self-help skills along with fine motor skills as preparation for their promotion to the Vocational group. They engage in activities like cutting, sticking and folding paper, buttoning, lacing, using a brush and comb etc. As part of their life-skills learning, the students are taught the difference between coins and notes and some basic elements of engaging in a social conversation. This group too has students who are non-verbal.

The students in the Vocational group are deemed to be in the final course/class. These students are taught various vocational activities like making phenyl, soap, paper bags etc. These products are made and sold as per consumer demand. The students are also taught about banking and post-office processes.

Observations

The teachers are affectionate and caring. However certain additions and modifications would certainly provide significant value addition to the services rendered to the students.

i) Physical infrastructure: Construction of a ramp to access the toilets that are located on the first floor of the same building would benefit the entire school community greatly. This would definitely ease the burden of the teacher's/helper's duties. It was observed that in the absence of this facility the students with loco-motor disability have to use toilet pans. The discriminatory nature of the use of the toilet pans adds to the indignity of the disability status of the student. Management of day-to-day basic needs with dignity and independence to the extent possible is critical for the mental and emotional well-being of the students. Additionally, this could also pose a threat to hygiene.

ii) Teacher Preparedness: The staff members are extremely caring and well-intentioned. However, both for those members of the staff who do not have the necessary qualifications and those with certification in Special Needs Education, some structured in-service training programmes from an

accredited source would help in capacity building for better quality management of the students' conditions. It is important for teaching-learning processes to be planned with developmental objectives. Although certain general methods and techniques could be used, for effective learning, each student's individual education plan needs to be mapped based on the student's developmental requirements and his/her ability levels in the 5 core developmental domains – physical, speech, cognitive, social and emotional. The Individual Education Plan (IEP) describes the student's diagnosis/evaluation, current ability levels in each of the developmental domains, a specific goal to be achieved in each domain and the time period within which these goals would be achieved. The plan also describes the specific activities to be done, the methods to be followed by the teacher and the follow-up that could be done by the parents. For example, it was observed that when pictures depicting numbers were shown to a group of children, a few were able to respond accurately, while others were completely unresponsive. For a student who didn't respond, the IEP could describe different 'count the objects' activities to be done over the month, with the goal that the student will be able to accurately count objects, from 1 to 5 by the end of the month. Within the same group, for a student who currently responds accurately in counting objects from 1 to 5 in number, the IEP could set the goal of accurately counting objects from 1 to 10 by the end of the month. The mapping of the IEPs, empowers the teachers as then they have definite information about each student's specific requirements based on which they can organise their teaching time and activities with the students and help them to learn more productively. Parent involvement in the mapping of the IEPs is recommended. This helps the teachers to understand parental aspirations and also helps the parents to better understand the condition and abilities of their children.

iii) Student Body Composition: One of the greater challenges faced by the teachers here is the diverse disability spectrum from which the student body belongs. As mentioned in the preceding section, it was observed that some of the groups include students with speech and hearing impairments and text-books prescribed by the state board syllabus are being used for their academic learning. Working on the premise that the students have the intellectual ability for such academic learning, these students with speech and hearing impairments would benefit and learn more effectively if specific methodologies like the use of standard sign languages are used to teach them. However, the social and emotional requirements of these students will not be met by academic learning. Enabling and empowering these students to be a part of mainstream society is an urgent requirement. The school must devise and implement experiential learning opportunities for these students that will teach them to communicate effectively and satisfy their requirements. For example, interactions with people in public spaces like markets, public transport etc has to be a part of their regular curriculum. Taking another instance, students with ADHD could learn more effectively if behaviour management procedures were employed along with special needs teaching practices. Here too, a focus on their academic learning will have a limited impact in enhancing the student's life-skills. Students with severe to profound physical disability require physiotherapy protocols that can be provided only by trained physiotherapists.

iv) Gender and Sex education: This is a field of urgent requirement especially with students in the disability sector. Teaching students with intellectual disability about sexual needs and practices is not only critical for their physical and mental well-being but is also extremely important for their safety. This becomes significantly critical in the light of research findings that indicate that a large percentage of the victims of physical and sexual molestation are people with intellectual disability. The students have to be taught to discern proper and improper touch, the boundaries of the physical self, whom to trust, and most importantly, how to and whom to report any case of misconduct they may experience or even fear. It was observed that some of the students handle

their genitals and stimulate themselves sexually. It must be understood that sexual urges constitute physiological, hormonal and psychological aspects and cannot be simplistically seen as acceptable or unacceptable social behaviour. Students with Intellectual Disability need specific training to 'acceptably' manage their sexual requirements. The school needs to collaborate with other professionals like psychologists, to include such training in their curriculum.

v) Socio-emotional education: Students require practical learning opportunities to comprehend and practice social skills and emotional management. For example, it was observed that the teachers use narratives in the class to describe and teach about banking processes. The students however lack the cognitive ability to generalise this learning and transfer this information to real life situations. It would be far more productive for the students if they could get experiential opportunities. For example, sale negotiations for the products made by the vocational group could be done by students. Regular visits to shops, banks, post-office etc, using public transport would offer opportunities to the students to learn from real life situations and give them the confidence to be self-reliant. Such interactions would also help the students to identify, regulate and manage their emotional responses in different situations.

Conclusion

The interaction of the Project team members with the Dharithree Trust staff members and students was productive and enriching. The services rendered by the staff are valuable and definitely beneficial for the students. It is due to the effort of the teachers that the students are achieving various learning targets to some extent in spite of their disabilities. However, many of them are not able to realise their potential, and need specialized management to ensure developmental progress. Most importantly, a school for students in the disability sector needs to prioritise and focus on life-skills as the most critical area of learning.

b) Nirmala Shishu Bhavan

The Need for a School in the Home

Services and support extended to Nirmala Shishu Bhawan, by the Project included assessment and both group and individual therapy. In the course of the interaction with the children it was strongly felt that in spite of the high level of love and care with which the children are looked after, all the developmental domains need urgent address through a process of structured sessions so designed. It was also noticed that some of the children had the ability to attend a school programme and would in fact benefit holistically from such attendance. Apart from the academic learning that a school programme offers, the children would find opportunities for socio-emotional interactions in the school, that for these children are limited only to the other children and adults in the Home. However, discussions with the Home authorities revealed that schooling as a norm for these children had been considered and 4 of the children currently attend the APD School. However, the Home authorities are not entirely satisfied with the schooling the children are receiving; their concern being that the individual learning needs of these children are not being addressed. For the other 5 children, who were deemed to be capable of attending school, the Home authorities' concerns were regarding their physical safety and specific needs like catheterization for passing urine etc. As per their account, an earlier attempt at sending these children to school had resulted in serious fear of injury and health concerns due to which the authorities decided against sending them to school. The children had already been introduced to reading-writing activities and the caregivers continued to teach them.

Interactions with the children indicated that while on the one hand there were fears, on the other hand they had enjoyed the school activities and had aspirations of being educated. Given the interest and abilities of the children, the scope of developmental enhancement that schooling could achieve and every child's right to education, the project team came up with the idea of simulating the school process within the Home premises itself. The Project team felt that the schooling programme could be scientifically structured to suit individual needs and abilities and could be administered in a more systematic manner. The Home authorities were interested and suggested the possibility of training one of the care givers, who has had previous experience as a teacher, in Special Needs Education techniques and delivery. This was the genesis of the idea of a Home School.

Setting up the School

It was suggested to the authorities that a space be designated as a school room and be used only for that purpose. Further, one of the Home staff members was identified by the authorities to be trained by the project team as a Special Needs Educator,who would practice the school routine on a daily basis. The Project team has prepared a step- by-step programme to implement the plan. The Project team visits the Home once a week. Specific training sessions with the Home teacher started in November, 2015. In these sessions the Home teacher was introduced to the theories that describe and explain the impact of different kinds of disability on the learning abilities of children and the theoretical tenets of Special Needs teaching methodologies.

In December 2015 sessions, the project team worked with the teacher and the children towards training her to identify individual requirements and evaluate current levels of each developmental domain and academic skill. The teacher is currently undergoing training in the preparation and implementation of Individual Education Plans (IEPs). The school time has been divided into 4 periods. Activities designated for each period have a specific goal. The four major goals are – enhancement of fine motor skills, oral/speech skills, reading skills and writing skills.

How the School Works

Keeping in mind the 4 goals, the teacher has prepared IEPs with help from the project team member. Each IEP states the child's name, physical age, current level of ability in the specific area, the level to be achieved, the time period within which the goal is to be achieved and a review plus follow-up column, that will be filled after the time period is over.

Each session begins with a brief review of the past week's practice of the IEPs. Then the teacher is helped to conduct each part of the session with each child as per the IEP. For instance, if the session begins with the oral/speech period, the teacher offers a book of rhymes to each child turn by turn. Each child chooses a rhyme and the teacher recites it line by line as a model to be repeated by the children, paying special attention to the children who have a serious lag in oral enunciation skills. After all the children have had their turn, the teacher announces the next period. This maybe the period for fine-motor skill enhancement. The teacher chooses an activity out of a list that has been suggested. The activities include - building with 'Lego' blocks, drawing and colouring, stringing beads, buttoning and lacing, clay dough, cutting and pasting etc. Depending on each IEP the teacher has been guided to set the difficulty level for each child and assist them. So, while one child may be colouring an intricate pattern using thin colour pencils, another maybe filling in a single-outline shape using thick crayons.

This maybe followed by the reading period. As per each IEP, the teacher moves from child to child with the relevant reading material. While she is thus engaged with one child, the other children remain engaged with the activity of the preceding period. For this period too, while one child may be reading 3 and 4 letter words, another is reading the letters of the alphabet.

After all the children have had their turn, it's time for the last period; writing. The teacher chooses a writing activity for each child from a list suggested and mentioned in the IEP - drawing lines and shapes, copying from the board or text, dictation work etc. Each child writes only what has already been covered in the reading period. For example, if the reading goal in the IEP states that the child will be able to accurately read all the 3 letter words in the Grade 2 textbook, by the stated time period, then in the writing period the child writes only 3 letter words. The school session ends with the children going in for lunch.

So far, So good...

The teacher is willing and cooperative. Since she has to execute this responsibility on her own, she needs help in other areas too like organising the school-room more efficiently so as to make all the learning materials easily accessible.

The children are extremely enthusiastic. They have named it as 'Nirmala Shishubhavan School' and want the Head of the Home to be designated as the Principal of the school. They have expressed their desire to wear a uniform during the school time and also want a bell to be rung to denote the beginning and end of each period. Some of them find it difficult to sit on chairs for a prolonged period and it has been suggested to the teacher that each child be allowed to change position from chair to wheelchair as and when required.

The authorities have been fairly positive and cooperative. The idea seems to be taking firmer root with the progress of the sessions. However, a few norms more firmly established would help in better implementation of the programme - more efficient moderation of volunteer activities, identifying relevant learning material for each child and keeping it in the school room.

From the Field Worker's Diary...Developing Socio-Emotional Skills in Children with Disability

7th October 2015

Objectives:

- To provide children with an exposure to the outside world and thus address social development issues.
- To address social anxiety i.e. related to going out of the institution.

Method: Experiential—field trip

Process:
Preparation: children had been informed about the plan a week before and were very excited; they wore 'special dress' ' to go out. On the morning of the outing, the sequence of activities/the plan for the outing was discussed—where we will go/ what we will do was discussed first (park, shop, ice-cream parlour). And children were instructed to observe all that they could on the way to the places they were going to/ at these places…'what all you see on the way'.

On the Way: Children were taken in their wheel chairs i.e. walking from institution to a nearby park. No transport was used as the idea was to get children to be on the road and overcome their fear of traffic, fear of being bumped in the wheelchair. On the way, children's attention was drawn to various sights on the street-vehicles/ trees/ people/ actions of people…with reassurances to anxious children that they were doing fine, they were safe…we are all being careful about road crossing etc.
At the park: children observed people doing exercises, trees/ squirrels/children play areas… we also allowed for interactions of passers-by with children—helping children give formal introductions of themselves--as to where they were from/ what their names were.

At the shop: children were wheeled through a super-market to observe all the different things on the shelves, naming and pointing these. Each child was permitted to select one packet of biscuits which they would have to take to the counter and pay for (money would be given by the facilitators).

At the ice-cream parlour: a round of tasting was done of different flavours of ice-cream and then each child asked to choose which flavour he/ she would like to eat. A brief discussion was had about which place/ activity children had enjoyed most that morning, different things they saw.

Observations and Analysis:

- Children were very excited and happy to be out.
- One of them, the eldest (14 year old), was exceedingly anxious—very clingy to staff in institution, pleading with her to come with him, slightly panicked at having to leave the institution. He was also excessively anxious to cross the threshold of the shop—where there was a step and his wheel chair had to be lifted over it…he started to cry and throw a tantrum, begging for chair not to be lifted, insisting on being carried as he was used to. However, facilitator gently explained what would happen—he could be lifted, then chair lifted into shop and then he would have to resume his seat in order to go around the shop. At first he resisted, then he finally agreed. Similarly, there was a step at the ice-cream parlour—this time, although he was anxious, he was less so and allowed himself to carried over the step and then wheeled…fear somewhat reduced.

- Children talked about what they had seen but it is still not easy for them to observe their surroundings and report on it—lack of habit/ perhaps their awareness/ observation skills are blunted by being constantly in the same surroundings of the home.
- Children reflect the anxiety and protective responses of caregivers. It is observed that caregivers responses to children's anxieties are: i) laugh it off and tease them (gently) about it; ii) be over-protective and feed into children's fears, agreeing with them. There is no attempt to engage children in a constructive discussion about their fears and how they can overcome them/ reassure them that world is an ok place/ they will be ok.

23rd October 2015

Objectives: To provide children with an exposure to the outside worlds and thus address social development issues; to address anxiety related to going out/ social issues.

Process:

9 children taken to aquarium, followed by picnic in Cubbon Park.

At the aquarium, children spent a while observing all the different kinds of fish with the facilitators drawing their attention to various colours, sizes and textures.

At Cubbon Park, during the picnic, children interacted with some of the public who bought them balloons, shared food and were encouraged to talk about the outing.

Observations and Analysis:

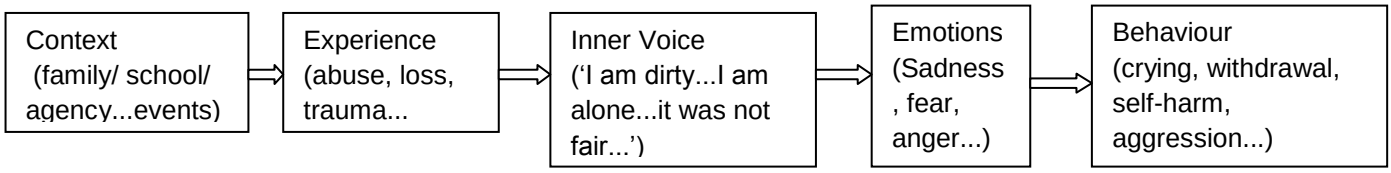
- Some of the children who had been exceedingly anxious on the previous visit were a little less so this time around.
- 3 children who usually go to APD School joined the trip—one has ADHD and another has speech/articulation problems (as a result tends to get easily frustrated & has some impulsivity and over-activity—may also be mild ADHD). The trip served as a social skills development experience for these 3 children also—aimed at following rules, impulsivity control, pro-social skills/ sharing food etc.
- Public response to children with disability: i) people passing by tend to pinch the cheeks of disabled children (in a pitying manner) and greet them—facilitator told them they had no right to touch the children and that they should restrict their interaction to greeting/ conversation with the child; ii) many passers-by watched the group struggle with the wheel chairs in what are essentially disability unfriendly spaces, offering no help at all in lifting the chairs; iii)some younger/ college students offered chocolate to children; iv) one 1 to 2 people helped with wheel chairs; v) some came and tried to talk to the children—asking their names/ where they are from; vi) one lady and her friends bought the children balloons.
- Children's response to public: generally one of indifference; some were very shy and barely greeted people; one child was angry and muttering under her breadth—'I don't want a balloon—I didn't ask…why should they give'.
- The nature of children's social interaction is probably due to the types of social interactions they are exposed to in the home— continuous birthday parties of children they do not know/ pity from visitors/ promises of people returning (they do not know how to interact with children with disability/ how to treat them)—so some children think it is pointless to engage with them (so indifference) and some may be angry/ resentful because—anger may come from a more acutely felt sense of personal dignity and therefore a resentment to anything that appears as pity; furthermore, it could also be based on the experience and knowledge that some of these overtures are temporary and have no long term continuity + possible self-esteem issues due to disability.

5. Training and Capacity Building

5.1. Training for Child Care Institutions and Integrated Child Protection Scheme (ICPS) Staff

As described earlier, the project staffs visit various government and non-government child care institutions on a weekly basis to provide individual counselling and group sessions on life-skills. These sessions are usually conducted along with staff from the agency so that they observe and learn methods to counsel/ support children i.e. a lot of emphasis is placed on on-the-job training. Additionally, the project has implemented classroom learning sessions as follows:

(a) A half-day session on responding to common emotional and behavioural problems in children in institutions was conducted by the team upon request from Navajeevana Rainbow School. 20 child care staff from 8 agencies participated in it. The focus of the session was to enable child care staff to understand the context in which institutionalized children's emotion and behaviour problems occur (see framework below for more specifics) i.e. what we see at the end are the behaviours—which are only a consequence of all the other factors that come together; we need to understand the other factors and how they relate to each other in order to identify the basis on the behaviour—and to develop interventions that address the root causes of the behaviour. Our interventions therefore need to be focussed, not on changing the behaviour but on enabling children to process their experiences (through acknowledgement of emotions and perspective-taking/ generation of alternatives) so as to change the inner voice—which is what leads to certain emotions, which in turn result in certain behaviours.



(b) A 3-day workshop was conducted for child care institution and Integrated Child Protection Scheme (ICPS)[3] Staff on Child Psychosocial Care for Children in Difficult Circumstances. This (level 1) training was focussed on understanding and applying child development basics to counselling, basic communication and counselling techniques with children, and first level responses to loss, death and sexual abuse, which form common themes in psychosocial problems of children in difficult circumstances. 21 staff/ counsellors from 7 child care agencies (where the project provides services), including ICPS, participated in the training workshop. These agencies serve street and working children, orphan and abandoned children as well as those with gender and sexuality vulnerabilities (abuse/ trafficking)[4]. Following this initial training, plans have been made to continue supporting this group of trainees on other child psychosocial issues, on a periodic basis, through one-day workshops/ sessions.

5.2. Training of ART Counsellors, KHPT

In the previous quarterly period,a three-day training workshop was organized for KHPT's Partner Organizations i.e. agencies working with HIV/AIDS infected and affected children, to build first level

[3] The ICPS staff were trained as part of the 'Advanced Capacity Building Initiative for ICPS Staff, Bangalore Urban and Rural'. Although a separate grant from DWCD supports this initiative, it is being implemented as a part of the larger Community Child & Adolescent Mental Health Service Project whose mandate is also to build the psychosocial skills and capacities of government child care staff.

[4]This workshop excluded agencies working with disabled children and HIV infected/ affected children as the needs of these two groups are highly context-specific in terms of certain themes and issues, and do separate trainings were arranged/ planned for them.

(basic) knowledge and skills in providing psychosocial assistance to Children Infected and Affected by HIV. During this quarterly, level 2 of the training, an advanced skills workshop was conducted for the same group—comprising of 20 participants from 22 (KHPT partner) agencies located in 17 districts of Karnataka. Following a refresher on the previous training, this workshop's agenda was to develop skills and capacities in ART counsellors on specialized areas of HIV-related work, namely the trauma of loss and abuse. It covered the impact of trauma on children, the trauma of illness and mortality, loss/grief/death and sexual abuse. As before, a range of participatory and creative methods consisting of case study discussions, role plays, and film viewing/ analysis were used for teaching and training.

5.3. Orientation Workshops for Government School Teachers on Remedial Education

As described elsewhere in this report, one of the Project's pilot efforts is to train government school teachers to address learning difficulties in schools, through classroom remediation techniques. As part of this initiative, 50 teachers (including heads of schools) from 5 schools participated in orientation sessions conducted by the special educator to provide a basic understanding of learning difficulties in children and the need for classroom remedial techniques. Although the schools selected were those who volunteered to be part of this initiative (following the 'Kalikeya Kale' symposium held for school teachers in the previous quarterly), the responses from school teachers, during these orientation workshops, have been mixed. Some are enthusiastic to learn new techniques while others are 'non-believers', essentially holding the view that 'nothing can change these children—they are like that'; some others continue to be reluctant to engage in training workshops saying that 'we are already trained in all this...and we do it anyway' (despite there being no evidence of the practice of such classroom remediation work) because 'we hold extra classes for the children all the time'. The team/ special educator continues to make efforts, focussing on the early adaptors i.e. teachers who are willing to try new methods and who are committed to improving children's performance at all costs, in the hope that some positive results over the coming months might inspire others who have not yet bought into the idea or feasibility of remedial education in government schools.

5.4. Agency Secondments

As previously done, the Project continues to take on staff, in the form of secondments, for a period of 3 to 4 months (per person) from other child care agencies to provide training on child mental health issues. Towards the end of this quarterly, two persons have joined the Project for observation and learning purposes as part of the MoU with Karnataka Health Promotion Trust, and agency working with HIV/AIDS and keen to scale up their psychosocial work with HIV infected/affected children in communities and institutions. One of the trainees works in a KHPT partner agency, namely S.Ammai Hospital and children's institution in Salem for HIV infected/ affected children and their families; the other works in St. Mary's convent, Chamrajpet, Bangalore running school and children's residential institution for orphan and vulnerable children. Classroom learning sessions as well as field exposure is being provided to them.

Summary of Training & Capacity Building Activities, October to December 2015

Time Period	Organizing Agency	Topic	No. of Participants	No. of Agencies Represented	Type/ Profile of Participants	Names/type of Agencies Represented	No. of Districts
October 2015	ANC Navajeevana Rainbow School	Responding to common Emotional and Behavioral Problems in children in institutions	20	8	Child Care Institution Staff	Agencies working with children in difficult circumstances	1
November 2015	NIMHANS (Project)	Child Psychosocial Care for Children in Difficult Circumstances-Level 1	21	7	Counselors and Child care Institution Staff	ICPS Staff and Agencies working with children in difficult circumstances	1
December 2015	KHPT-Karnataka Health Promotion Trust	Child Psychosocial Care for Children in Difficult Circumstances-Level 2	20	22	Profetional councellors of KHPT partner Agencies (HIV AIDS agencies)	Aggencies working with HIV	17
November 2015	NIMHANS (Project)	Learning Disability and Remediation Methodology	10	1	Teachers and HM's	Govt.High School ,New Fort	1
November 2015	NIMHANS (Project)	Learning Disability and Remediation Methodology	6	1	Teachers and HM's	Urdu Higher Primary School,Arundathinagar	1
November 2015	NIMHANS (Project)	Learning Disability and Remediation Methodology	8	1	Teachers and HM's	Urdu High School ,Tank Garden	1
November 2015	NIMHANS (Project)	Learning Disability and Remediation Methodology	16	1	Teachers and HM's	Govt. High School Baretana Agrahara	1
December 2015	NIMHANS (Project)	Learning Disability and Remediation Methodology	10	1	Teachers and HM's	Govt.High School ,Begur	1
Total			**111**	**42**			

6. Advocacy

While it has not been overtly stated that (child mental health/ child rights) advocacy is one of the objectives of this Project, during the course of implementation, several issues promoting systems' work of the nature of advocacy actions, have arisen in the agencies and institutions that we serve. Below are some examples of the advocacy activities that the Project has engaged in.

6.1. Child Safety

a) Child Safety Policy, DWCD

Due to the increasingly frequent incidence of child sexual abuse in schools, the Dept. of Women and Child Development developed a child safety protocol which provides guidelines and procedures on implementing child protection, especially in schools. Although the document provides many administrative guidelines on abuse prevention, it does not adequately address the issue of response. The truth is that no matter how extensive the efforts to prevent abuse, a motivated perpetrator will always find a way to commit abuse. In the light of this, the response strategy needs to be exceedingly strong. This would include a standard response protocol consisting of child-friendly/ sensitive approaches that is based on the emotional well-being of the child as a non-negotiable principle. A defined system of enquiry, furthermore, would prevent duplication and unnecessary/ multiple interviewing of the child (thereby re-traumatizing the child). It would also ensure speedy justice processes which are much needed given the low conviction rates under POCSO. A planned and strong response when incidents take place will send a strong message to potential abusers who otherwise take advantage of the weak and fragmented nature of response systems to thus behave with impunity.

In a public meeting organized by the Dept. of Women and Child Development, to share the child safety policy for educational institutions i.e. schools, the above points were tabled on behalf of the Project by the Project PI.

b) Girl Children's Safety

In December 2015, afund-raiser walkathon was organized by some child care institutions that run care and protection shelters for vulnerable girl children on December 5th 2015(Saturday) at the Kanteerva Stadium, Bangalore. The event was open to the public and there was no restriction on the persons entering the stadium to be a part of the event. During the event, each child was asked to walk with one person from among the public attending the event. They were also instructed tohold hands with the public/concerned individual. Our concerns are as follows:

- While the agency staff were around, they were in specific places and it would have been hard for them to monitor children in a space as large as this stadium.
- On speaking with the children,we found that they had not been given a detailed brief on the purpose of the event and had not been part of any safety/ abuse prevention education.
- Given the above scenario and issues, the children were at risk of:
    (i) Being sexually abused (this includes contact and non-contact methods);
    (ii) Being abducted;
    (iii) Given their difficult circumstances and need forcare and attention, making them vulnerable to lure and manipulation;

iv) Given that many of them are adolescent girls, the event exposed them to an on-going engagement with people they met, in an unsupervised manner; the people who they came into contact with would have had the opportunity to provide them with contacts and times/ places to meet in the future as well.

With increasing reports and media attention being directed at child sexual abuse issues, we believe that must be aware of the safety needs and vulnerabilities of the children in your care and protection. As part of our support to your agencies/ children, we are already coming across a great many children who have had experiences of sexual abuse. We therefore believe that as important as your event and its purpose might be, you would see the necessity of ensuring the protection of your children first.

The Project wrote to the organizing agencies, explaining the above issues, including making recommendations and suggestions for future events they might plan, and which must consider child safety issues. These may include:

- giving the children a safety brief
- Encouraging the public to walk separately in a different line/ circle from the children in order that they may avoid direct contact with unknown people.
- Should fund-raising need to be done in a manner in which potential well-wishers and donors are required to interact with the children, this may be done in a planned and supervised manner within the agency.

6.2. Disabled Children's Right to Education

In the course of our work at an institution for children with disability , we found that while 3 to 4 children from this home attend a special school, there are another 4 to 5 children, who could but did not. This latter group of children have loco-motor disabilities but no intellectual disability. We were informed that the fee structure of the special school does not allow these children to attend the school i.e. the agency is unable to pay the requisite amount for all their children to attend the school.

School education is crucial to disabled children's growth and development, not only from an academic point of view but to meet their psychosocial health needs, namely socio-emotional needs. While this is important for all children, for children with disability, especially those who are orphan/ abandoned children, having lived their whole lives in an institution, attending school is not only a need but also a right.

The Project team drafted a letter to the concerned special school, stating the above issues and needs, in an attempt to convince the school to waive the fee and include orphan and abandoned children in need of education and disability services in their program. Following the agreement of the special school to include these children, detailed letters were also provided on the specific and special needs of these children (including their medical issues), especially as they had never been to school before—in order for the school to better accommodate them.

6.3. Vulnerable Children's Right to Healthcare

In our work with child care institutions, we came across situations of vulnerable children who had been in situations of risk. For example, a child with a history of trafficking and multiple

sexual abuse had not been tested for HIV and other STIs even a month after she had been in the institution. This placed her at risk of delayed diagnosis and delayed treatment. On further assessment that reached out to several agencies we work in found that there is no homogeneous medical protocol that is followed across institutions for vulnerable children. The Project thus put together a standard protocol for medical assessment of children in institutions. In addition to standard tests to be administered to all children, it focuses on criteria for certain medical tests, based on what type of risks some children are exposed to. This protocol will be discussed with the administrators of the concerned child care agencies to check for feasibility and consensus on following it.

6.4. Speaking out Against Physical and Emotional Abuse

The NCPCR guideline, on corporal punishment, goes beyond physical abuse issues to also address emotional abuse in school children. While schools seem to have largely understood that physical abuse/ punishment of children is against the law, the understanding that they are equally culpable in case they engage in emotional abuse is missing. In one such school, the Project team, during the course of their services, observed a teacher frequently emotionally abusing the children through negative comments and belittling. As a response to this, and with a view to stopping such abuse from continuing, a report was made to the school principal and a meeting with the concerned teacher was had, raising the issue. Since there was a failure on the part of the teacher, to acknowledge this problem, the Project team conferred with the principal to agree to take the matter further to the Dept. of Education. Finally, there was an admission on the part of the teacher of active emotional abuse and an agreement to change. This was endorsed by the principal.

One of our findings during individual therapy sessions with children in institutions was that a lot of children's problems and upsets, in one of the institutions, were due to certain emotional and physically abusive behaviour by the care-takers. This was brought to the notice of the head of the institution, after which it was ensured that the necessary actions to ensure children's safety.

6.5. Social Interventions for HIV infected Children

Lack of opportunities for children infected with HIV does not arise only from stigma and discrimination issues. Often, families are unable to access appropriate placements. An HIV+ adolescent with a deep interest in the performing arts (film) but currently neither schooling nor in any kind of training was enabled through the Project's networks to find suitable employment with a film crew. In another instance, the grandmother of an HIV+ girl who was facing difficulty in appropriate school placement (due to financial issues) was helped through the Project's networks to find the residential school. Such social interventions are also viewed, by the Project, as being an essential component of the larger mental health services—because, without this kind of advocacy, these children will be further deprived of developmental opportunities, thereby resulting in mental health problems.

6.6. Position on Juvenile Justice Act Amendment December 2015

There has been a fair amount of controversy regarding the latest Juvenile Justice Bill, (December 2015) on the lowering of the age of a juvenile offender to be tried as an adult. There provisions in the existing Juvenile Justice Act [with the amendments made in 2006 and 2011] by

which the juvenile in question can be approached through an individual care plan.The Project recognizes the difference between retributive justice and rehabilitative justice. There is a difference between culpability and accountability, and accountability is part of the therapeutic process and part of the work that we do is to address issues of accountability and reformation.

The Project has represented this view in forums and public meetings and is currently in talks with the Observation Home, Bangalore and ICPS administrators to start work with children in conflict with the law. This would be part of the Project's commitment to assisting children in difficult circumstances.

C. Agency Collaborations

Justice and Care, an agency that rescues and supports victims of trafficking, slavery and other abuses, with a focus on prevention, protection and prosecution, approached the Project to support children in the context of trafficking.Following initial discussions, the Project has agreed to collaborate with the agency to work with children in the context of trafficking, with a focus on the reclamation (the others being raid, rescue, rehabilitation, repatriation and reintegration), which is about providing psychosocial assistance to children to reclaim personhood and affirmative sexuality. Thus, the process will address issues of trauma, sexuality and related psychosocial and mental health issues. The proposed support will be provided in the following ways according to certain (broad) timelines:

- Direct assistance to affected/ vulnerable children in child care institutions where Justice and Care has a presence. This will include first- level counselling responses as well as in-depth therapeutic work as required. (February/ March/ April 2016)
- Preparation of a mandatory mental health assessment as a protocol document to be institutionalised within the state care institutions to address the psycho social needs of the survivors within the state care institutions. (February/ March/ April 2016)
- Implementation of capacity building initiatives and training workshops for child care workers/ service providers as organized/ decided by Justice and Care. (May-August 2016 but extended if required/ feasible and depending on numbers of personnel to be trained).
- Development of psychosocial care manuals (training manuals and counsellor's hand-book).

D. Operational Challenges

In addition to challenges described in previous reports, some specific ones that we faced during this quarterly period are as follows:

i) Environmental and Teacher Motivation Issues in Anganwadis

Anganwadi teachers continue to be difficult to motivate and engage as they are unwilling to change their ways of work despite the Project adapting its methods and content to fit the DWCD curriculum. Also, the anganwadi infrastructure, not only in terms of space, but also non-availability of toilets to pre-schoolers exacerbates the problem of teacher motivation. Learning, including and especially early childhood learning, occurs best in a space that is not restricted and comfortable in terms of basic amenities. Cramped spaces and toilet anxiety are not

congenial as spaces for child development activities. They not only limit learning processes but also compromise (because of lack of amenities) the learning potential in specific social-personal areas of development, for example self-care. The lack of amenities also creates a tension in the child care worker, for fear of toilet accidents, manifesting as angry, threatening outbursts by the anganwadi teachers and helpers; this not only causes anxiety and emotional problems in the child but also vitiates the learning environment.

ii) Inconsistent Criteria for Permission to Work in Child Care Agencies

Despite being located in a central government institution, in the Dept. of Child & Adolescent Psychiatry and supported by the Dept. of Women and Child Development, the Project has continually faced difficulty in obtaining permissions to work in child care agencies, particularly the government-run ones. Further, DWCD-run institutions themselves make it difficult for us, as a DWCD project, to work in their institutions. This is rendered all the more surprising and perhaps disappointing in the light of the fact that these very same agencies grant permissions to (often unknown) NGOs and individuals to provide services to the children, with no background checks, no monitoring of content that is delivered and no accountability in terms of quality of services or reporting. In one of the government schools where the Project is providing services, a private psychiatrist had been allowed into the school to provide 'counselling services' to children, without permission from the Dept. of Education; this individual 'counselled' a child who had recently lost her father, failed to diagnose PTSD and possible psychosis (as later assessed by the Project team) and subsequently, the child also ran away from home. This is an example of the harm that lay/other counsellors other can do, when agencies freely allow them access to children without checking their credentials and affiliations and obtaining formal permissions.

iii) Resistance by Faith-Based Agency to Child Rights' Approaches and Schemes

Some of the existing policies of faith-based children's agencies prevent them from accepting government subsidies. One of the dilemmas of the Project is to balance their mandates with basic child rights issues. This is exemplified by our experience in one such faith-based agency that refused avail of disability subsidies through disability certification that the Project was in process of facilitating for them. Despite the Project team engaging in enabling processes such as organizing for Dept. of Child Psychiatry staff to visit the agency and assess all the children in it, with a view to providing disability certification, and despite considerable requests and discussions to enable rights of diabled children i.e. how children with disability have the right to state assistance and that agency staff should not be making decisions on behalf of the children in terms of rejecting financial benefits, the religious functionaries (also the administrators) of the agency remained unconvinced. While compassion and physical care abound in this agency, the complete lack of understanding of children's rights to education and to availing of financial benefits or empowering them for the future, is exceedingly worrying.

E. Plans for the Next Quarterly Period, January to March 2016

- Continue remedial education interventions and model development in government schools.
- Initiate work in the area of child trafficking.
- Initiate work with children in conflict with the law.