Community Child & Adolescent Mental Health Service Project

6th Quarterly Report
January – March 2016

Dept. of Child & Adolescent Psychiatry,
NIMHANS

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

A. Project Objectives

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

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

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

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

B. Project Implementation: Activities and Progress

During this quarterly period, from January to March 2016, the Project has reached out to: 243 children and 30 teachers in schools, through mental health and remedial education services; 397 children and 23 teachers in anganwadis and 127 children in PHCs; 298 children in child care institutions, including children in care and protection, children in trafficking, children in conflict with the law and children with disability; 35 child care service providers were reached through training and capacity building programs. In total, 1,065 children received some level of mental health care through the Project i.e. through screening, individual assessment/ first level responses and/or group interventions; and 88 child care service providers, including teachers received capacity building inputs.

The pilot initiative to work with PHCs and anganwadis has been completed and this report summarizes our learning and experiences from a year's child mental health work in these two settings. Work was also initiated in a new context: at the Observation Home, with children in conflict with the law—the report provides a detailed analysis of this very controversial segment of vulnerable children, including pathways to vulnerability, consequences, first level interventions for these children and systemic challenges experienced whilst working in this area.

1. Mental Health Services in Schools

1.1. Individual Intervention in Schools

The project continued to provide school mental health services, during this quarterly period, in those schools that specifically requested them at the time of the symposium (August 2015). A total of 6 schools, 5 government schools and 1 aided school were reached out to and individual assessments (for emotional/ behaviour/ learning problems) and first level psychosocial and mental healthcare responses were provided to children identified by teachers.

Amongst the 6 schools was Gottigere School, which is supported by an NGO called Vidya, and the Rotary Club. Upon request from Vidya and Rotary club, mental health services were initiated in the high school. As a preparation for services, the Project organized an orientation workshop for the school teachers and the NGO staff who work directly with children (described in the Training & Capacity Building section). The NGOs and school are keen for the Project to continue services in Gottigere Government High School, as well as primary school. Thus, when school re-opens in June, the Project will continue its individual counselling work there, as well as plans to expand its interventions to providing life skills sessions for adolescents and teacher training programs.

In all, a total number of 78 children were assessed (see table 1(a) for demographic details) and provided with first level responses. Amongst these children (taking into account that some children met the criteria for more than one mental health disorder), 99 cases of child & adolescent psychiatric problems were identified: 30(30%) cases of emotional disorder, 27(27%) cases of behaviour problems, 29(29%) cases of learning difficulties, 2 (2%) cases of developmental disabilities and the remaining 11(11%) cases of other issues, namely, serious mental issues, medical problems/ life skills issues and child sexual abuse (see table 1 (b) for child mental health disorders).

Table 1(a): Total No. of Consultations Disaggregated by Age & Sex in Schools, January- March 2016

Age Groups	January		February		March		No. of Children
	Male	Female	Male	Female	Male	Female	
6 to 12 yrs	2	0	0	14	0	15	31
13 to 17 yrs	11	6	14	8	0	8	47
Total	**13**	**6**	**14**	**22**	**0**	**23**	**78**

Of the 78 children, 11 children (14%) 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 backgrounds as well as having complex family issues.

Table 1(b): Child & Adolescent Disorders Identified in Schools, January- March 2016

Child & Adolescent Mental Health Issues		No. of Children			Total
		January	February	March	
Emotional Problems	Dissociative and Somatic symptoms	0	2	0	2
	Other Anxiety Issues	4	4	9	17
	Dysphoria/Depression/Adjustment Disorder	1	4	3	8
	Self-harm	0	2	1	3
Sub-Total		5	12	13	30
Behaviour Problems	Conduct Symptoms : Anger/ Aggression	1	5	3	9
	Truancy	0	0	2	2
	Conduct Disorder (Lying and Stealing)	0	1	0	1
	Conduct Disorder (Most Symptoms)	0	1	1	2
	Attention Deficit Hyperactivity Disorder	2	6	5	13
	Runaway behaviour	0	1	0	1
	Substance Abuse	0	2	0	2
Sub-Total		3	16	11	30

Learning Issues	Specific Learning Disability	2	6	5	13
	Other Learning Problems	6	3	7	16
Sub-Total		8	9	12	29
Developmental Disability	Intellectual Disability	2	0	0	2
Sub-Total		2	0	0	2
Other Issues	Life Skill Issues(Sexuality, bullying)	0	5	0	5
	Other Health/Medical Problems	0	1	1	2
	Child Sexual Abuse*	0	0	1	1
Sub-Total		0	6	2	8
Total		**18**	**43**	**38**	**99**

*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, January- March 2016

Child & Adolescent Mental Health Disorders		No. of Children			Total
		January	February	March	
Emotional Problems	Dissociative and Somatic Symptoms	0	2	0	2
	Self-harm	0	2	1	3
Sub-Total		0	4	1	5
Behavior Problems	Conduct Disorder (Most Symptoms)	0	1	0	1
	Attention Deficit Hyperactivity Disorder	0	1	0	1
Sub-Total		0	2	0	2
Other Issues	Substance abuse	0	2	0	2
	Runaway Behaviour	0	1	0	1
	Child Sexual Abuse*	0	0	1	1
Sub-Total		0	3	1	4
Total		**0**	**9**	**2**	**11**

During the Project's services in the schools, it was observed that after our initial work and awareness creation through the symposium and subsequent discussions with school staff, both teachers and more so the heads of schools were keen for children to receive psychosocial and mental health services. It was also noted that this time around, teachers had greater knowledge of individual children's issues and were successfully able to identify (and refer) children in need of mental health services.

On subsequent visits to the schools, some of the children - especially those with conduct disorder, wherein children attributed their improvement to first level response in terms of the discussion that took place in the session with the counsellor and to the interventions suggested by the counsellor. For children with learning problems, while major advances in their academic abilities would require time and intensive remedial inputs, it was found that the first level interventions suggested (such as making charts of difficult words/ taking help from friends for reading/making flashcards of difficult words for reading) were followed; children reported that they now felt more confident (less anxious) and motivated to take the upcoming exams.

"*Nobody used to understand my problem. What you said that day helped me*" was a common response of the children--it refers to the counsellor's first level response following detailed assessment, when the project staff suggest activities and interventions for children to experiment with, in dealing with their problems. Interestingly, some of the improvements in children with problems are also acknowledged by other children. One child, who was a classmate of another child with conduct disorder (X), reported to the Project team: "X was a very bad boy...no girl ever spoke to him. But now he has 3 girl friends!" When his classmate asked how X had managed to change, he had told her "when I spoke to them [Project team], I realized many things...and what is important...now I have understood...so I changed."

In some of the schools, children came forward voluntarily and expressed their desire to talk with the project staff. When asked why, the children's responses were: "My friend told me that if I speak to you about my problem, you might help me solve it" and "My classmate who used to get punished everyday is a good boy now, after he talked to you".

The above self-reports by children clearly reflects that listening, empathy and acknowledgement of children's problems and emotions, and insight facilitation techniques have a positive effect on the children's problems, motivating them to attempt to change behaviour. It shows, once again, the impact that first level responses can have i.e. even brief inputs given, short durations with the child can be meaningful and beneficial to him/her.

1.2. Remedial Education Services in Government Schools

Continuation of Orientation Workshops for Teachers:

Orientation workshops on children's learning problems were conducted for 5 schools, in the previous quarterly period. During this quarterly, 2 more schools were covered. A convenient date for the workshop could not be agreed upon for the remaining 3 schools due to teacher commitments of examinations, school functions and external duties. However, the heads of these schools have committed to the workshop being conducted in June 2016, with the commencement of the new academic session.

Table 1 (d): Orientation Workshops on Children's Learning Problems, January to March 2016

Name of School	**No. of Teachers Reached**
Govt. Higher Primary School, Chamrajpete	8
Govt. High School -Sarakki	11
Total	**19**

The workshops were attended by 19 teachers from 2 schools. Each workshop lasted about 2 hours, divided into 4 sections, followed by question and answers. Sections 1 to 3 aimed at an experiential orientation of the major components of learning difficulties, i.e, specific learning disability, ADHD/ADD and socio-emotional disorders, and section 4 aimed at providing a basic understanding of the neurological processes involved in the activity of reading.

Following a brief introduction of the scope of the workshop session, the first activity attempted to provide experiential insight into the challenges that students with learning disability face. A set of hand-outs comprising of brief write-ups (in English) on different topics is distributed to the participants. They are given time to read the papers and answer the questions that followed each. (The printouts have many deliberate errors, but the participants are unaware of that.) Then they were 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 are given another set of handouts, this time with no errors. They were asked again if their earlier problems still persisted, and most responded that this time the reading and comprehension was much easier without the errors. It is then explained how for students with learning disability, most print appears as did the ones with the errors. 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 had to think of something that is not related to their present engagement. On the next cue, they were asked to change both the physical activity and the thought. Thus engaged, they were also asked to read some story books that are given to them (simultaneously). The facilitator clapped frequently and at random intervals. At the end of the designated time, they were asked how much each one has been 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.

Next, 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/himself with the child in the picture and build an autobiographical narrative. They were asked to be 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 and questions. 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, (demonstration of group remediation word and number activities) 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 behaviour in class could now be attributed by the teachers to the learning difficulties
- Most of the teachers evinced interest in the workshop experience and some asked for additional workshops to gain a larger awareness about the teaching-learning process.
- However, most teachers wanted a formula-based management technique as a quick solution for learning difficulties in children, especially in the context of examination performance.
- Some teachers were sceptical about the connection between the word and number activities suggested by the facilitator and enhancement of learning abilities.

Classroom Demonstration of word Activities

As noted in previous quarterly reports, the children in Government schools largely come from socio-economically deprived family backgrounds and many of them are first generation learners. As a result most of them are under stimulated for typical vocabulary development. The formal schooling process that they enter into also engages them in a rote learning system that does not offer opportunities to the children to explore letter-sound combinations to form meaningful words. Moreover, there is fear of performance and the threat of being reprimanded. All this combines to render the vocabulary learning process meaningless and fearful thus causing learning difficulties. The regular and brief practice of the word games in the classroom serves many purposes. The brief duration and play/game methods remove the tediousness, fear and stress of learning. The regular opportunity to explore sound-letter association to form meaningful words in a stress-free environment is conducive to vocabulary learning. Sustained practice of the same would, over a period of time help to address many of the learning difficulties of the children in the area of vocabulary learning. This would be the first step towards enhancement of reading skills.

Following the orientation workshops, classroom demonstrations were carried out in 4 schools. 10 teachers witnessed the demonstration. 80 children were addressed through a 'Make a Word' activity.

Table 1 (e) Classroom Demonstration of Remedial Education January to March 2016

School Name	No. of Students Reached	No. of Teachers Reached
Govt. Urdu High School- Tank Garden	70	3
Govt. Urdu Higher Primary School Arundhati nagar	55	3
Govt. Higher Primary School, Chamrajpete	25	4
Govt. High School New Fort, Chamrajpete	15	2
Total	**165**	**12**

'Make a word' Activity:

The facilitator announced to the class that they would play a word game for 5 minutes. Their teacher would observe and would play the game with them every day for the first 5 minutes of her period. The children were asked to keep their books and pens away. The facilitator asked any one child from the class to give her a vowel (a/e/i/o/u). As one child gave it, the facilitator wrote it at the top-centre of the board and circled it. Now she asked the children, one by one to name any word that had the circled letter in its spelling. The facilitator pointed at individual children to ensure participation. As the words were said, the facilitator wrote them on the board, reading them out loudly. No word was rejected. When an incorrect answer was given, the facilitator wrote the word on the board and pointed out why it couldn't be accepted. Children who couldn't answer were asked to take a later turn. At the end of 3 minutes, the facilitator announced that the children should try to use the words on the board in their own sentences. The activity was stopped at the end of 5 minutes.

The teachers were given a hand-out describing the activity with a note mentioning the instructions to be given by the teacher and the measures to be observed. The rationale of the activity was explained to the teacher as that established the connection between the activity and enhancement of learning ability in the children.

Observations: The children enjoyed the activity demonstration in all the schools. They wanted more games and participated enthusiastically. A set of 8 word games and 5 number games have been devised for this practice. Each of these activities will be demonstrated in the classrooms. The teachers will need persistent persuasion to follow the practice regularly. Most of them appreciated the ease and feasibility of following the practice as it did not increase their work load in any way. To further facilitate the teachers' understanding of effective teaching-learning practices, a second workshop is planned for the months of June-July, 2016, on 'How we Learn' that would help the participants explore the roles of 'fear' and 'practice' in learning.

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

2.1. Screening, Assessment and 1st level responses Services

During this quarter, the Project provided child mental health services in PHCs only in the month of January 2016, wherein visits were made to 4PHCs. (Section 2.2. discusses the closure of Project services in PHCs).

Unlike before, when screening was done on one day and detailed assessments/ inputs were provided on another day (as agreed with the family), this time, screening and assessments/interventions were provided on the same day (usually on immunization day), to circumvent challenges of poor community mobilization and follow up by PHC staff and risks of the family not returning to avail of depth services. A total number of 127 children were screened, out of which 123(97%) were between the age of 0-6yrs and 4(3%) were between the age of 7-12yrs. Refer to demographic details in Table 2(b), 2(c). Amongst 127 children, 7 children were identified with mental health issues, out of which 9 Mental health issues were identified [refer to Table 2 (d) and 2(e)]. 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.

As the screening services were conducted on the immunization day, majority of the children were between the ages of 0-6yrs. During immunization days, as most of the children coming to the PHC are between the ages 0-6yrs, awareness programs for parents, on early child development and the importance of early stimulation, were conducted using the "Home-based Early Stimulation Flipchart" developed by the Project.

Table2 (b): Screening Services: Demographic Profile, PHC Services, January 2016

Age Groups	No. of Children Screened		
	January		Total
	Male	Female	
0 to 6 yrs	52	71	123
7 to 12 yrs	1	3	4
13 to 17 yrs	0	0	0
Total	53	74	127

Table2 (c): Screening Services: Children Identified for Assessment and Interventions, January 2016

Screening Results	No. of Children Screened and Referred to PHC	
	January	Total
No. of Children Screened	127	127
No. of Children without Problem	120	120
No. of Children Identified with Problems	7	7

Table 2(d): Total No. of Consultations Disaggregated by Age & Sex in PHCs, January 2016

Age Groups	January		Total
	Male	Female	
0 to 6 yrs	2	4	6
7 to 12 yrs	1	0	1
13 to 17 yrs	0	0	0
Total	3	4	7

Table 2(e): Child & Adolescent Disorders Identified in PHCs, January 2016

Child & Adolescent Mental Health Issues		No. of Cases	
		January	Total
Emotional Problems	Other Anxiety Issues	1	1
Sub-Total		1	1
Learning Issues	Other learning issues including under stimulation	3	3
Sub-Total		3	3
Developmental Disability	Speech Problem	1	1
	Motor Disability	2	2
Sub-Total		3	3
Other Health/Medical Problems		2	2
Sub-Total		2	2
Total		9	9

* Note: The 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, and because services were provided only for a period of 1 month (4 visits/ PHCs).

2.2. An Overview: Integrating Child and Adolescent Mental Healthcare into Primary Healthcare Services from February 2015 to January 2016

The project initiated Child and Adolescent mental health services in primary health care centres in February 2015.The objectives of integrating child and adolescent mental healthcare into primary healthcare services were as follows:

- Increasing community awareness on child mental health issues.

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

Over a period of 1 year, the project staff made 61 visits to 16 PHCs (refer table 2 (a) for further details). The following services were provided in the PHC's during by the Project:

i. Development and use of screening tools for use with children seeking various types of health services in the PHC to enable MOs and ANMs could screen children who might be presenting with medical complaints for child mental health disorders.
ii. Provision of depth assessment and first level responses to children screened/ identified in PHCs (through periodic/ scheduled visits to PHCs) with behavioural/ emotional problems and developmental disabilities.
iii. Referral of severe and acute child mental health issues to the Dept. of Child & Adolescent Psychiatry, NIMHANS.
iv. On-the- job training and support PHC staff in the clinic and community, during awareness sessions/ home visits, including working with them to demonstrate use of screening/ identification tools and first-level responses.

Table2(a): Child & Adolescent Mental Health Services in PHCs, February 2015 to January 2016

No. of PHCs visited	16
No. of Visits	61
No. of Children Screened	1350
No. of Children Assessed/ Provided with First Level Responses	208
No. of Child & Adolescent Mental health Cases identified	266
No. of Children Referred to Tertiary Facility (NIMHANS)	49

The project had planned to provide services in the PHCs also based on the cooperation and interest of the PHC staff. As observed and described in the previous quarterly reports, they were many challenges such as:

- Lack of involvement of the PHC staff, namely lack of community mobilization, lack of identification/ referral/ follow-up of children in need of mental health care—as a result of which it was difficult to reach children in need.
- The link workers, despite having attended orientation workshops and being repeatedly instructed to inform the community about the nature and time of the child mental health services at the PHC seemed unable to do so. The reasons for this range from lack of timely and adequate payment to link workers to the wards/ communities being 'extremely far away from the PHC' making it hard for the link workers to access their communities and hard for the families to bring their children to the PHC. Link workers being over-burdened with other programs and tasks and therefore too busy to take on 'additional tasks' was another reason proffered—however, the project teams observed that the link workers were often absent in the PHC during the service visits and/or did not appear to 'be busy engaged in data entry and other tasks'; many of them showed little interest in participating in the services and learning about child mental health issues, even when they were present in the PHCs.

- The introduction of ASHA workers in accordance with the NUHM scheme was not in place for most of the Project duration; even if it had been, the functioning of the ASHA workers, which is incentive-based, would not have worked for mobilizing children with mental health issues (since this is not a vertical programs with resources for providing incentives).
- Medical Officers were frequently absent in the afternoons and therefore not available for on-the-job training or medical prescriptions in case any child need them. The lack of interest and animation by MOs may also account for the lackadaisical attitude of the link workers, for the PHCs where community mobilization was much greater than the rest, also had interested MOs.
- NUHM constructions and re-modeling work in most PHCs interrupted routine health work in these centers. Sometimes Thursday morning immunizations were not conducted in the PHCs and were done instead in Anganwadis, in ways that were unplanned and impromptu, so that the Project was unable to coordinate with the staff to be part of the services.
- In sum, tasked with running many other (vertical) health programs, the PHC was neither 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. Also, there was a general disinterest and a perception that the service was to be run by the NIMHANS project team i.e. a lack of understanding of the objectives of integrating child mental health into primary healthcare services, and therefore an attitude that the PHC did not need to participate or learn.

Thus, it became increasingly challenging to meet the Project objective of integration of child mental health. Given the above challenges, it became very difficult to continue to continue child mental health services in the PHCs for the remaining period of the project, as intended. Hence, the Project decided to withdraw its services in PHCs.

However, the year's pilot work in the PHCs has enabled us to understand the tremendous need in communities for child and mental health services. Coming to tertiary care facilities to avail of these services has many barriers for the community—ranging from awareness to financial constraints and stigma and discrimination issues (of accessing services in a 'mental' hospital). Also, the Project still believes that despite the many difficulties such as infrastructure, attitude of the PHC staff, lack of community mobilization etc., there is no doubt about the potential for integrating child mental health care into primary healthcare services. The advantages of community-based child mental health services as provided through primary healthcare settings, like for other health issues, are:

- Accessibility (proximity of the PHC to the community).
- Avoidance of the social stigma attached to availing mental health services in NIMHANS (since many types of health services are provided at the PHC and people need not go to 'mental health' hospitals/ centres).
- Lower costs for communities (no Transportation charges/ free services/ less time spent away from work due to proximity of centre)

3.Anganwadi Services

3.1. Direct Services in Anganwadis

Following the meetings with the Child Development Program Officer (CDPO), the anganwadi supervisors and teachers, and taking into account their feedback and inputs on the services, during this quarterly period, the Project provided direct services to 17 anganwadis in Bapujinagar Ward.

Table 3: Anganwadi Service Coverage, January 2016- March 2016

Anganwadi Services	No. of Children Reached			
	January	February	March	Total
No. of Children Participating in Early Stimulation Activities	240	274	397	397
No. of Anganwadi Teachers Reached with Pre-School Inputs	22	23	17	23
No. of Anganwadis Reached	24	24	19	24

Note: In order to avoid double-counting, the totals are calculated by taking the highest numbers reached (of children/ teacher/ anganwadis) because the work was done in the same group of anganwadis.

First, a round of visits were made to the anganwadis, explaining to the teachers that one of the objectives of the Project was to collaborate with the teachers and explore how best to deliver their departmental curriculum such that the 5 developmental domains are addressed. Further, a brief re-cap about the 5 domains of child development and the other methods that could be followed by the teachers. Next, group activities were demonstrated to teachers, with children. These activities are designed to promote early stimulation and optimum development in the 5 key areas of child development--physical/ social/ speech &language/cognitive/ emotional development—and this conceptual framework is explained to the anganwadi workers. This time, the activities were done in accordance with the (departmental) anganawadi curriculum i.e. using the topics and themes listed in the curriculum.

Child Development Activities for Learning Theme on Seasons

Physical development: children asked to stand in a circle and when teacher says 'summer', children asked to run in a certain direction; similarly, the calling out of each season's name is a cue for them to perform some physical action (whilst familiarizing themselves with the subject vocabulary)

Speech and Language: Teacher mimes different words or situations related to the topic, such as fanning herself/ carrying an umbrella—and the children guess/describe what she is doing. Children are also encouraged to share what they did on a rainy day.

Cognitive Development: The standing rule was the use of the word 'why'—'why use an umbrella?' or 'Why wear warm clothes?' To enable children to understand cause-effect relationships and associations using a given theme.

Social and Emotional Development: Situations in the classroom were used and children asked to help each other out—such as 'It is hot in this room and there is only one fan. How do we all share it?' or 'It is hot and someone comes home. What can we offer them? (a glass of cold water)

The project services have therefore tended to focus more on capacity building of the teachers. The anganwadi teachers were requested to use the materials available in the anganwadi and do the activities erstwhile demonstrated. Thus, the service approach is one of on-the-job training through demonstration and discussion according to the curriculum of the Anganwadis. These activities were developed taking into consideration the limited space and materials available in the anganwadi.

3.1. An Overview: Child Developmental and Mental Health Work in Anganwadis, April 2015 to March 2016

Over the past year, the Project provided services in 671 children in 50 anganwadis, through 200 visits, with the objective of promoting early stimulation and optimum development in the 5 key areas of child development--physical/ social/ speech & language/cognitive/ emotional development to pre-schoolers, and building the capacity of anganwadi teachers to do that same. The following services were provided:

- Direct work/ group activities with children to promote early stimulation and optimum development in the 5 key areas of child development (physical/ social/ speech & language/cognitive/ emotional development);
- On-the-job training/ demonstration of early child education and development techniques to the anganwadi teachers, including inputs on child development alongside the activities to enhance teachers' conceptual and theoretical understanding of early stimulation and child development.
- Capacity building of anganwadi teachers through symposium on early childhood development and the importance of early stimulation/ early intervention.
- Screening and early identification of children with developmental disabilities—for such children, referrals were made to the PHC services and inputs were provided to anganwadi teachers to support children with special needs.
- Material development including:
    - Development of a few simple low cost aids (to complement, not substitute the already available play materials in anganwadis), mainly using old newspapers, paper cups etc. This kit was taken to the anganwadis daily and teachers were also told how they could, very simply, create their own aids.
    - 'Arambhikeya Arambha', a book of 35 simple pre-school activities has been developed for the use of anganwadi teachers.
    - A Flip-Chart for Parents & Caregivers on home-based stimulation for young children, for use by anganwadi workers during mothers' meetings/ parent education sessions to provide community education on early childcare and development.

Table2 (a): Child Development & Mental Health Services in Anganwadis, April 2015 to March 2016

Total Number of Anganwadis reached	50
Total Number of Teachers Reached	50
Total Number of Children reached	671
Total Number of Visits	200

Like the PHC services, there have been challenges in providing services in the Anganwadis, not only because of remuneration dissatisfaction and burdens of multi-tasking (i.e. having to contend with other maternal and child health responsibilities) but also because of lack of motivation on the part of anganwadi teachers to learn and practice new methods or indeed to conduct any non-formal education/pre-school activities at all. Very few make the effort to implement pre-school activities; the rest say [to the project team]: 'you are coming, so you do the activities.' There is a perception that the pre-school education activities are not their responsibility, especially when the project team visits. Anganwadi teachers still feel that early childcare/ child health is only about adequate nutrition i.e. they

find it difficult to perceive the role that early stimulation and pre-school education plays in child development and health.

The Project made several efforts to understand challenges and take feedback—for example, following the development of the pre-school activity book and initial services, we learnt that all non-formal education activities need to be work in accordance with the department curriculum, or rather that the anganwadi teachers' perceived the interventions suggested by the Project to be 'extra' work since they were unable to make the connections to child development concepts/ activities; at the time, the Project revised its approaches to ensure that suggested activities were directly linked to the department curriculum, to make the 'connections' evident for the teachers. Despite such efforts, it was increasingly observed that despite many discussions and demonstrations, very few teachers were actually doing any work with the children.

The Project has therefore decided to discontinue work in the anganwadis as there appears to be little impact. One of the key reasons for discontinuing services due to poor impact was that unlike other child care settings (schools/institutions), where individual and group sessions can be conducted at regular intervals (according to life skills themes etc), in anganwadis, early child development work needs to be done daily. If it is not done every day, these activities will not have the desired impact on children's learning and development. The Project visits to the anganwadis every week or so were not expected to have a direct impact on children's development—for this, we were dependent on the teachers to continue the activities as per the demonstration; and given the teachers' lack of initiative and motivation, the interventions were not being implemented every day.

Again, as discussed about primary health care services and their potential to affect community child and adolescent mental health services, anganwadis/ anganwadi teachers have tremendous potential to impact child mental health and development, not least because they are key players in community child health. Giving children a head start through intensive pre-school activities that are conducted with clear child developmental objectives will provide a strong foundation for children's learning and development. This is evidenced by the fact that the Project has frequently observed the links between pre-school development and education or the lack of it, and learning problems in school age children.

Embedding mental health interventions in early childhood care and education systems cannot be emphasized enough. Exposure to risk factors as well as the presence of developmental and clinical disorders can derail the developmental trajectories of preschoolers, and problems may persist if left untreated. Anganwadis provide essential care to young children, especially those living in vulnerable urban (and rural) contexts; and the multi-disciplinary (health-nutrition-education) approach adopted by the Integrated Child Development Scheme (ICDS) provide perfect platforms to integrate developmental and mental health care for pre-schoolers. However, our experience shows that the deep-rooted systemic problems within the ICDS system create many barriers to early childhood care and education, in particular to non-formal education, which in the hierarchy of child development needs, receives lowest priority.

Health and nutrition receive greater attention and rightly so if viewed from a child survival perspective. However, unless child development is viewed through the lens of holistic development, with due inclusion of mental health and educational needs of young children, there will be no practical translation of the value added by health and nutrition interventions. In other words, the ICDS program needs to

examine its non-formal/ pre-school education component and place it at par with its other components and provide staffing and resources accordingly. Else, no amount of training by the Job Training Centre (JTC) and other institutions to build anganwadi teacher capacity in pre-school education is of any use, for, without the necessary systemic changes, this component cannot be implemented.

4. Services in Child Care Agencies

4.1. Interventions in Children's Agencies for Care and Protection

a) Individual Services:

During this quarterly, the project provided individual services in 7 child care institutions. A total of 38 children (identified through group work sessions or by child care staff) were provided with detailed assessments and first-level inputs including referral to tertiary care facilities/ NIMHANS as required. Amongst these children, 56 child psychiatric problems were identified, 12 (21%) of which were emotional problems or internalizing disorders and 21 (37%) were behaviour problems or externalizing disorders (refer table 4 (b**))**. Despite this categorization (which is more for intervention/ convenience purposes), 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 January- March 2016

Age Groups	January		February		March		No. of Children
	Male	Female	Male	Female	Male	Female	
5 to 12 yrs	5	4	1	8	4	2	24
13 to 17 yrs	1	3	0	3	6	1	14
Total	**6**	**7**	**1**	**11**	**10**	**3**	**38**

Emotional and Behaviour Problems in Children

The major part of emotional problems pertained to anxiety occurring in a social context (social anxiety) and due to family issues in children's homes; the common causes underlying children's emotional and behavioural problems were alcohol abuse by parents and parental marital conflicts, including experiences of domestic violence, lack of stimulation and exposure to social situations. A majority of institutionalized children's problems stem from attachment issues and neglect that occur in families and home environments that are ridden with marital problems, domestic violence, and alcohol dependence; single-parenting and lack of time on the part of the parent to care for the child (due to financial constraints and long hours of daily labour) also result in emotional neglect of children. As a result, children's early experiences of the world, represented by his/her caregivers are often hostile; and so children's emotional regulation is poor. As these children then continue to grow in these difficult home environments, their mistrust and anxieties are aggravated by the often difficult, violent and always unpredictable nature of the home environment—and this worsens their abilities to control and manage difficult emotions.

The number of behaviour problems is higher than emotional problems, with conduct disorder alone accounting for about 38% of the behaviour disorders. Of the remaining behaviour problems, substance

abuse was the most frequently occurring behaviour problem. Most anger issues and other conduct symptoms were related to neglect and punitive and/or emotionally rejecting parenting; children are also exposed to a great deal of aggression and violence at home, often the only method of problem-solving or conflict-resolution modelled by parents. Substance abuse was also found to be initiated and reinforced in the context of peer group interactions. As discussed in detail in section 4.3 on children in conflict with the law, children from vulnerable family contexts are at higher risk of conduct issues, including substance abuse.

Table 4(b): Child & Adolescent Disorders Identified in Children's Institutions in Care and Protection, January- March 2016

Problems/ Disorders		No of Issues Identified			
		January	February	March	Total
Emotional Problems	Other Anxiety Issues (incl. separation anxiety)	3	1	3	7
	Dysphoria/Depression/ Adjustment Disorder	4	1	0	5
Sub-Total		7	2	3	12
Behavioural Problems	Conduct Symptoms : Anger/Aggression	1	4	3	8
	Conduct Disorder – Lying and stealing	1	1	0	2
	Runway Behaviour	0	0	1	1
	Substance abuse	1	0	3	4
	Attention Deficit Hyperactivity Disorder	2	3	1	6
Sub-Total		5	8	8	21
Learning disability	SLD	8	2	4	14
	Other learning issues	2	0	3	5
Sub-Total		10	2	7	19
Other Issues, incl. serious mental health issues and life skills issues	Life Skill Issues(sexuality, bullying etc)	1	2	1	4
Sub-Total		1	2	1	4
Total		23	14	19	56

All children in institutions have vulnerabilities due to psychosocial events that, in turn, lead to poor emotional regulation mechanisms, of which difficult behaviours are a consequence. These psychosocial contexts are important in order to understand children's experience while addressing their psychiatric problems. Thus, assessing and addressing the psychiatric problems of children, in accordance with the psychosocial contexts in which these problems occur is children who come from difficult circumstances. Table 4(c) shows the psychosocial contexts of institutionalized children's emotional and behaviour problems.

Of the children assessed at the institution, 3 were referred to tertiary care facilities, for more severe emotional and behaviour problems, namely anxiety, substance abuse and run away behaviours. These were children who required further assessments in multiple areas of behaviour and development,

psychiatric medication and longer term in-depth psychotherapy. All children were referred to the Dept. of Child and Adolescent Psychiatry, NIMHANS.

Table 4 (c): Psychosocial Contexts of Emotional/ Behavioural Disorders, January- March 2016

	No. of Children with Difficult Contexts			
Psychosocial Context	January	February	March	Total
Single Parents/Abandoned	4	4	1	9
Marital Conflict/Domestic Violence	2	2	4	8
Child Sexual Abuse	0	1	0	1
Rescued from Trafficking (incl. Child Labour)	0	0	2	2
Loss & Grief (Death of Parents and/or other Attachment Figures)	3	2	0	5
Alcohol dependency in parents	1	3	2	6
Parent with mental illness/ disability/ health issues	1	1	0	2
Children in Conflict with law	0	0	1	1

Note: All children are from a low socio-economic background whose parents are daily labourers or have no fixed income.

b) Group Interventions:

During this quarterly, the project reached 183 children through 73 group sessions held in 9 child care agencies. As described in the previous quarterly report, life skills modules have been developed to address issues concerning emotional development, sex and sexuality, motivation, gender and violence. The project is conducting these sessions on a weekly basis, as per the availability of children in institutions. Table 4 (e) below shows the session content for each institution/group of children.

Table 4(e): Group Interventions for Children in Care and Protection, January- March 2016

Institution	Session Content	No. of Children	Age Group
Makkala Jeevodaya	CSA Prevention and Personal Safety - Getting to know your body	15	9 to 12 years
	CSA Prevention and Personal Safety - General safety	15	
	CSA Prevention and Personal Safety - Physical safety	15	
	CSA Prevention and Personal Safety - People safety	15	
	CSA Prevention and Personal Safety - Understanding safety and Abuse	15	
Total No. of Children Reached		15	
Total No. of Sessions		5	
APSA	Life skill/ Emotional Development: Who am I? Identity work	13	13 to16 years
	Life skill/ Emotional development : When I get angry (Anger management)	13	
	Monster and Balloon game for Conduct Issues	13	
	Life skill/ Emotional Development : Anger Management- Using story stems	13	
	Life skill/ Emotional Development : Anger Management- Assertive Skills	13	
	Life skill/ Emotional Development: Assertive Skills (cont…)	13	
Total No. of Children Reached		13	
Total No. of Sessions		6	
ANC Navajeevana Rainbow School-Chamarajpete	Life skill/ Emotional Development: Who am I? (Identity work)	14	13- 14 years
	Monster and Balloon game for Conduct Issues	14	
	Movie Screening - Hejjegalu	14	
	Life skill/ Emotional Development: Anger management	14	
	Anger management- story stems	14	
	Anger management- story stems (cont…)	14	
	Recap and Games	14	
Total No. of Children Reached		14	
Total No. of Sessions		7	
	Life skill/ Emotional Development: Getting to Know Each Other	8	

GovernmentBoys'Home-Group1 **(Kannada group)**	Life skill/ Emotional Development: Feeling Wheel	8	12 to 16 years
	Life skill/ Emotional Development: Talking about Difficult and Traumatic Experiences	8	
	Life skill/ Emotional Development: Talking about Difficult and Traumatic	7	
	Screening movie- Hejjegalu	7	
	Screening movie- Hejjegalu/ Discussion	7	
	Understanding Group Commitment and Rules	7	
	Understanding Group Commitment and Rules	7	
	Life skill/ Emotional Development: Dealing with Traumatic Memories	7	
	Life skill/ Emotional Development: Coping Mechanisms for Trauma	7	
	Life skill/ Emotional Development: Decision-Making in Difficult Situations	7	
	Trusting Others/ Seeking Help	7	
	Role play on Alternative Thinking	7	
	Movie screening- Stanley ka Dabba	4	
	Stanley ka Dabba Discussion	4	
	Coping with fears and worries	4	
	Coping with fears and worries	3	
	Life skill/ Emotional Development: When I Get Angry (Anger Management)	3	
	Life skill/ Emotional Development: Who am I (Identity)	3	
	Conflict resolution and Problem Solving	3	
	Conflict resolution and Problem Solving (role play)	3	
	Conflict resolution and Problem Solving (role play)	3	
	Conflict resolution and Problem Solving (role play)	3	
	Life skill/ Emotional Development: Anger management	3	
	Life skill/ Emotional Development: Other People's Feelings Matter	3	
Total No. of Children Reached		8	
Total No. of Sessions		25	
GovernmentBoys'Home-Group2	Rapport building	15	
	Story Sessions- Related to Challenges faced by the children	15	

(Hindi-speaking group)	Story Sessions- Related to Decision Making, (2),	15	13 – 15 Years
	Story Sessions- Related to Violence	15	
Total No. of Children Reached		15	
Total No. of Sessions		5	
St Mary's Institution For Girls	Rapport building and Getting to know each other	15	
	Life skill/ Emotional Development: Feelings wheel	15	
	Life skill/ Emotional Development: Movie screening 'Hejjegalu'	15	
	Life skill/ Emotional Development: Dealing with traumatic Memories	15	
	Life skill/ Emotional Development: Dealing with traumatic Memories	15	
	Life skill/ Emotional Development: Relaxation techniques	15	
Total No. of Children Reached		15	
Total No. of Sessions		6	
Ananya Foundation	Life skill/ Conduct & Behaviour: Anger : Cause and Effect	15	13 - 16 years
	Life skill/ Conduct & Behaviour: Rule making process	15	
	Life skill/ Conduct & Behaviour: Rule requirements,	15	
	Life skill/ Conduct & Behaviour: Rule framing	15	
	Life skill/ Conduct & Behaviour: Justifications for Rules	15	
	Life skill/ Conduct & Behaviour: Reflection	15	
	Life skill/ Conduct & Behaviour: Meaning of Consequences	15	
	Life skill/ Conduct & Behaviour: Reformative measures	15	
Total No. of Children Reached		15	
Total No. of Sessions		8	
BOSCO Rainbow Home–Wilson Garden	Movie Screening- Hejjegalu	64	10 -16 years
	Total No .of Children Reached	64	
	Total No. of Sessions	1	
ANC Navajeevana -J.J.R. Nagar	Life skill/ Emotional Development: Role Play- Jealousy	21	7 – 13 years
	Life skill/ Emotional Development: Role Play- Friendship and Trust		
	CSA Prevention and Personal Safety - Getting to know your body	5	7 – 9 years

	CSA Prevention and Personal Safety - General safety	5	
	CSA Prevention and Personal Safety - General safety, Physical safety	5	
	CSA Prevention and Personal Safety- People safety*	16	7 – 13 years
	CSA Prevention and Personal Safety - Understanding safety and Abuse*	21	
Total No. of Children Reached		21	
Total No. of Sessions		7	
BOSCO Vatsalya Bhavan	Life skill/ Emotional Development: Movie Screening- Hejjegalu	9	14 - 17years
	Life skill/ Emotional Development: Assertive skills	9	
	Recap and Rapping of Life skill Emotional development module	9	
Total Number of Children Reached		9	
Total Number 0f Sessions		3	
Grand Total Number of Children Reached		**189**	
Grand Total Number Of Sessions		**73**	

*Table shows 2 sessions which were conducted in half a day workshop mode.

Challenges of Psychosocial Services in a Transit Shelter for Boys

Over the last year, the Project has been providing psychosocial care services in the government boys' home, which is a care and protection home for children in transit i.e. these children are usually runaways or child labour rescued by various agencies, and reside in the shelter home until they either return to their homes/ families or are placed in hostels and other children's institutions. While individual assessments and counselling sessions have been done over many months, and some group sessions were conducted (mainly for emotional expression and validation through story-telling and drama games), during this quarterly, the Life Skills Series on Emotional Development was implemented with a groups of adolescents in this Home. Over 25 sessions were implemented, to enable children to reflect on issues of conflict resolution, problem solving, violence, anger and run-away behaviour. Our work shows that concerns and responses of children in this transit home, while in parts similar to children in other institutions, are also very different in many ways. Some of our observations and experiences are as follows:

- Most children said that they ran away from home/ family and did not want to go back because of severe physical abuse by their families, especially their fathers/ brothers (including hitting and burning by candles). They said that they were physically abused because of not going to school, playing with friends, not going home on time and fear of exams ("if I fail, father will hit me badly"). Some also said that they did not want to follow the rules at home—such as study time and other time restrictions. Other said that they like being in the transit shelter (and repeatedly run away from home, even after they are repatriated) because—'we can be with friends all the time and can enjoy'.
- It was observed that nearly all children had poor emotional regulation, especially difficulty controlling anger and aggressive behaviours, and high levels of impulsivity. These problems may be attributed to aggressive role models at home, experiences of severe physical abuse. These experiences of aggression continue when they run away from home and either live on the street or find employment in small businesses; in fact these experiences of physical abuse continue even in the transit shelter wherein the peer group dynamics are exceedingly aggressive, and wherein many caretakers also employ methods of physical abuse to 'control the children' and get them to comply with rules. Thus, their behaviour problems are not only a result of difficult home circumstances and learnt behaviours but also need to be understood as coping strategies and survival skills developed to be able to endure life as a runaway, in the street or as child labour.
- As a result, during life skills sessions, it was observed that these children had immense difficulty with attention tasks, cognitively and emotionally processing experiences and inputs, and in general with creative thinking and alternative strategies for problem solving.
- Other than their difficult family circumstances, there are several factors that increase the risk of conduct issues in these children. The environment of the transit shelter itself is a barrier:
  - As explained, the use of violence daily in the transit shelter by both (older) children and care-takers, makes it hard for children to learn otherwise or break patterns of aggression previously learnt; in fact, the peer dynamics within the shelter make it practically necessary for children to adopt violent methods to contend with the aggression they are confronted with all the time (a survival skill necessary for self-protection within the shelter).
  - The lack of adult supervision and monitoring (there are many children and relatively few staff, who are both under-skilled and disinterested) means that children are left to their own devices most of the time and there is neither correctional nor supportive input nor monitoring for any behaviour change to occur. We have found that in other child care institutions, where there is more intensive monitoring of children by adults/ care-takers, the children are better able to change behaviours or control aggressive behaviours.
  - A major environmental factor that places these children at risk of conduct problems is the inordinate amounts of unstructured time they have on their hands. With very little constructive activity, no systematic daily schedule to follow, children are apt to engage more in fights and aggressive behaviours.
  - The children also have no quality teaching-learning experiences through educational activities. Thus, there is little experience of success and mastery, thereby leading to more aggression. Also, engaging in aggressive behaviours such as bullying are the only avenues through which children achieve a sense of success and mastery, the only contexts in which they are able to exercise power and leadership.

In the wake of the above, the children are up against tremendous odds and it may therefore be difficult to expect them to make behaviour changes solely with life skills sessions/ inputs. It is felt that while these sessions are useful and necessary to prepare children for future situations, their impact is somewhat questionable; the challenges in their present environment make it hard for children to practice any behaviours that are learnt in these sessions. Given the children's difficult family circumstances and individual issues ranging from poor emotional regulation, substance abuse and ADHD, some environmental modification may be necessary to enable children to even attempt to change their (aggressive) learnt behaviours and coping strategies. Moving forward, therefore, the Project is considering more staff sensitization, development of more systematic daily activities/schedules for the children and re-vamping the methods of life skill delivery.

Field Worker's Diary...Life Skills Sessions in the Boys' Transit Home

Activity 3: Talking about Difficult and Traumatic experiences **Date: 9/03/2016**

Objectives:

- To create a space for children to discuss about sadness, hopelessness and other feelings related to loss, grief and trauma issues.
- To enable children to recognize the impact of traumatic events on themselves/ others.
- To help children identify ways to cope with traumatic events and difficult feelings through comfort of self and providing empathic response.

Method: Story building

Time Taken: 1 h 20 min

Process & Discussion:

- Children were asked to sit in a circle, and asked how was their morning and what did they do.
- Children were asked to recall what was done in the previous session and asked if anyone could share about the same.
- The session was introduced as "today, in this session we are going to talk about difficult feelings namely sadness, hopeless, helplessness". As children found it difficult to understand the exact meaning of Hopelessness and Helplessness it was explained using examples.
- Then we discussed about how difficult feelings (like sadness, anger, helplessness, hopelessness) come from difficult and traumatic experiences that many of us have/ had in our life. All these experiences make us feel very sad, helplessness, hopelessness and sometimes very angry. All of us have not been able to express these difficult feelings.
- Then instruction was given to the group like "In this session, we will talk and share our thoughts, about the types of loss and trauma that we or our friends family might have experienced/ suffered. We will also talk "How did they feel and how did they cope with these situations."
- The children were asked to list out their difficulties which they know of their own experiences or those of their friends/family. And then asked them to rank their experience in order of most difficulty to less difficulty.
- Children were finding it difficult to think and share. Hence we provided examples to the children to assist them to think and share (when did you feel very sad or helpless? or do you know anyone who had such experience?).
- With further assistance and probing few children started to share their experience.
- At the end of the session most of the Children were able to share at least one experience.

- Thanked the children by saying "we understand it's very hard to share and you did it we appreciate".

Activity 2: We told the children that "now we are going to do another activity where we will build stories by using some of the experience which we have discussed now. One person will start the story and next person continues, then next person and it's continued, till everyone gets the chance. Like for example if I start the story i.e. "Once upon a time there was a boy called raja" then if I stop here, next person has to continue the story further".

- Children were shy and hesitant in the beginning but with further assurance that nobody will judge you or laugh at you, all of us here are to just share and discuss about ourselves"
- The story was started by one of the facilitator "once upon a time there was a boy". Children were asked to name the boy. They suggested "Chinnu". Then each child was given a chance to contribute and the story was finished by the second facilitator.
- Children were able to relate their difficulty situation in the story.
- After the story building, we did the discussion based on the below questions.
    - What was particularly difficult or traumatic for the Chinnu?
    - How do you think Chinnu was feeling?
    - How did other people see him?
    - How can the people know that this boy is in trouble?
    - Who helped him to cope and how?

- The highlight of the story built by the children "Chinnu was a young boy who had difficulty with his studies, hence he ran away from home with some money. Chinnu lost his money, and then he went in search of a job. Chinnu got a job in a hotel. Chinnu missed his home and wanted to go back home to his sick mother. Hence he saved some money to go back to home to his mother. After going back home Chinnu wanted to study he asked one of his teacher for the help, but he did not help him. Chinnu later asked another teacher who helped him to go to school and complete his education."
- Further discussion continued by asking below question
    - "How and why it is important to express difficult feelings or what happens if we do not do so.
- The children responded like " If we share our feelings we feel relaxed, but sometimes they may tease us or think that we are not good enough and make fun of us"
- Acknowledged children's view that few people may tease us if we share our feelings, so we should always make sure that we share our feeling to the person who we can trust(whom you think may help you, or has been nice to you before)

Observation & Analyses:

- 2-3 children in the group are hyperactive and impulsive hence they are unable to concentrate in the sessions for longer duration- further assessment for ADHD need to be done.
- Children expressed their doubts about confidentiality and were hesitant to share their feelings and experiences.
- It was also observed that few of the children in the group are dominating and insist on other children to follow.

- The children are not gathering for the sessions on the time agreed, repeated reminders are required.
- Children find it difficult to follow instruction repetition of the instruction and rules is required.
- As the children find it difficult to understand few emotions and feelings such as hopelessness and helplessness- Visual aids and pictures of different scenario can be used in further sessions to help children.

Activity 3: Continued **Date: 10/3/2016**

In previous session children were hesitant to build a story and said "if we share our difficulties, everyone will make fun of us".

Objectives:

- Create comfortable space to share their experience and feeling.
- To enable children to share their difficulties or traumas.
- To provide insights to children about different kind of people- people who are companionate, loyal, helpful who can understand our difficulties and support us, and there are people who are rude, harsh and cruel people who make fun us and not help us.
- To help children to understand the importance of sharing and expressing emotions.

Method: Story-telling and role play.

Time: 1h 10m

Process & Discussion:

- Facilitator greeted the children and asked them to recall what was done in the previous session.
- Children were told that "today we are going to build another story just like yesterday... after that, we can also do a drama session where we can all enact a few difficult situations."
- Children were asked to start story building children were more enthusiastic and more involved in the story building activity. (children were able to relate their story to difficult situation)
- Discussion was done based on the questions below:
    - What was difficult or traumatic in this story?
    - How did Raju (character name in the story) feel?
    - Did he ask or share his difficulties with others? How?
    - What did he do, when the other teacher did not help him?
    - Who helped him to cope with his difficulty?
- Then children were asked to do the role play. They were divided into two groups. To motivate children to do better an atmosphere of friendly competition was created.
- Instruction was given to children saying that- Each group has to think of any one difficult situation which should include seeking help from a person. Wherein one of them will be the person who is in difficult situation, he will ask the help for others (one should respond negatively and other one should respond positively). You have to think of the situation and dialog related to that.
- Discussion was done based on the below question:
    - How was the play?

- What happened in the play?
- Who helped him to cope with difficulty? And who did not?
- What did you understand by this?
- Is it okay to share our difficulties to others? If yes, why? If no, why?
- In your life with whom can you can share your difficulties?
- What happens if we share our difficulties?
- Have you shared your difficulties before? What was your experience?

- Most of the children mentioned that they could have shared their difficulties with their family like brother, sister, mother and even with friends before took decision. Children said that they are people who would not help and there are people who could understand our situation and helped us to cope with difficulties. If we share our difficulty we could have got some support and help to cope up with our situation. All most all children told that they did not share their trauma with any one and they took a decision of running away from the circumstances.
- Thanked the children for sharing their thoughts.

Observation and Analyses:

- All children were involved in the play. They were able to comprehend what happened in the play.
- Initially children found difficult while building a story, but it was better than the previous session.
- Children were often distracted.
- There is a need to repeatedly do role plays (to lay out emerging/ real life situations) and enable children to think/ reflect.
- There are language barriers—some children speak a different dialect of Kannada.

Activity 4: Our Dreams **11/03/2016**

Objectives:

- To enable children to talk about their plans and dreams.
- To help children understand that there may be hurdles and difficulties as they try to reach their goals and dreams.

Methods: Film screening and discussion

Material: Film 'Hejjegalu'.

Time: 3 hrs

Process & Discussion:

- Greeted the children and asked about the previous session.
- Introduction: "we have discussed some of our difficulties, feelings, experiences, seeking help, and so on. Today we are going to watch very interesting movie called "Hejjegalu" following which we will discuss our dreams and plans.
- Movie was screened.

- Due to time restriction the discussion was scheduled for the next session.

Observation: Two children were finding difficult to sit for long time and started distracting others.

Activity 4: Our Dreams-Continued… 14/3/2015

Process continued:

- We greeted the children and reflected about the previous session.
- We asked the children to close their eyes and asked them to think of "Hejjegalu" story.
- Started the discussion based on the below questions:
  - How was the movie?
  - What did you like most about the movie? The scene which you liked the best and unforgettable for you?
  - Chaitra did many things at home, in her life…what were all the different things she did?
  - What were her dreams?
  - What all did Chaitra do in order to win the 1st prize?
  - How was the Chaithra's childhood…her school days?
  - What quality do you admire most in Chaithra? Why?
  - What do you think about the family and what was the relationship of the child with her parents and sister?
  - When the father lied, how did Chaitra feel?
  - How did she feel when her parents were absent on her prize day?
  - How did Chaitra feel when she heard that her father was imprisoned?
  - How did Chaithra manage to get her father released? What or the ways and means she used?
  - Why did Chaitra feel the need to help her father? (Although he treated her badly/ made her feel hurt, she still helped him…why?)
  - Which character did you liked in this movie? Why? Which character didn't liked by you and why?

Summary of children responses:

- Some children were able to comprehend the movie very well and able to recognize difficulties in Chaitra's life, her school problems, all she did to get 1st prize. Some of the Chaitra's qualities and behaviours mentioned by the children were - the way she communicated with her parents and others, the way she helped her father to come out of the jail, when the father lied even though she felt sad she helped him.
- Which character did you liked in this movie? Why? Which character didn't liked by you and why? Responses for the above questions were: Most children liked Chaitra because the way she won the prize and helped her mother and father even with difficulties, some of them liked Thatha who helped Chaitra to participate in the competition.

Character disliked by children – all children mentioned Chaitra's father because of his habit of gambling, not taking care of the family, not taking responsibility of family, and lying.

We asked "you mean that you don't like person who do not have responsibility, and has bad habits like gambling and drinking, and lying."
Children said "yes".

- Then discussion was continued by asking below questions on their dreams and goals –
  - What are some of your dreams?
  - What are some of the hurdles and difficulties you face as you work towards your dreams? (These may be people, events, feelings…)
  - What qualities and actions of Chaitra's do you think you could use (or are using) to achieve your dreams?

- All children shared their dreams of what they want to become--electrician, plumber, hotel owner, and dancer. Children mentioned two goals, namely, earning the money (like Plumber, electrician) and other one is that what they want like cycle racer, dancer. A couple of children had no idea about their goals.
- The qualities which children liked ...the way Chaitra talked with others --softly, even though her father hurts her, she helped her father.
- Children wanted to imitate her helping qualities to achieve their dreams.
- Children were asked to share their experience of any achievement in their life whether big or small. Responses included:
  - "When I was in 5 std, I wanted to participate in sports, but PT sir did not give the chance as I was weak in sports. Then I started to practice running with my father every day. When I came to 8 std I got selected".
  - "I won the cycle race in my area by practicing hard. I felt very happy".

  This responses shows that children able to think of achievement and be positive about themselves.
- We ended the session by thanking them and saying "next as we move in our sessions together, we will talk more about our dreams, not only in terms of what we want to become in our life but also the kind of person we want to be. In this session we understand that – in order to achieve our goals, there will be hurdles as you shared, how (A) child achieved to participates in sport, winning the cycle race. So we need to look at how we can resolve some of the difficulties and problems in our life to achieve our dreams and plans".

Observation & Analyses:

- Some of the children had difficulty reflecting on the situations presented in the film and in expressing their views/ discussing issues.
- One of the children in the group who have severe hyperactivity needs further assessment and treatment.
- Children still find it difficult to organise themselves -- they don't come to the session on time etc.
- Children's life skills in terms of information processing, reflection/ situation analysis and communication all need more work; some conversation on (group) norms and commitments is also necessary.

4.2. Interventions in Children's Institutions: Children with Gender & Sexuality Vulnerabilities

As part of the Project's collaborations with the NGO Justice and Care, an agency that rescues and supports victims of trafficking, slavery and other abuses, psychosocial work in the area of child trafficking was initiated during this quarterly. Direct assistance to affected/ vulnerable children in child care institutions included assessment and first- level counselling responses as well as in-depth therapeutic work as required.

Table 4 (f): Child & Adolescent Mental Health Disorders: Children in Trafficking, January to March 2016

Emotional Problems	No. of Cases
Anxiety	1
Dysphoria/Depression/Adjustment Disorder	4
PTSD	2
Self-Harm Behaviours	4

A small group of 11 children between the ages of 13 and 17 years, residing in the Government Girls' Home, Bangalore, were provided with psychosocial assistance. Our initial observations and understandings of children in trafficking are as follows:

A. Individual Issues

Although the Project had the opportunity to work with only a small group of children, there were certain contexts, concerns and psychosocial issues that repeatedly emerged—and first level responses by the Project team address these, as outlined below.

A.1. Contexts

Children may appear to be from the same general context, that of sex work, raid and rescue, because that is where we/ service providers come into contact with them. However, the pathways to trafficking are many and can be different for each child. Since the pathways are varied, children's experiences are different—and so we need to consider sub-contexts and variables such as age, family background and how the child was trafficked. Only then can we understand each individual's emotions and behaviours, which are likely to be unique due to her distinctive experiences. Some of the variations in pathways to trafficking and their emotional/ behavioural impact may be understood as follows:

- Whether the child was trafficked with or without complicity of the family— in the former case, the feelings of betrayal are great and it may impact the child's relationship with the family, including her desire to go home/ be united with them (there are also additional risks of re-trafficking).
- What the initial processes involved were/ whether there was the promise of job/ money versus coercion and kidnapping—in the former case, there might have been less trauma initially and the betrayal may have occurred later but in the latter case of coercion and kidnapping, the child's trauma is immediate and likely to be much higher.
- Short trafficking process/ journey versus a long arduous multi-stop journey—long journeys often prolong experiences of hiding/secrecy, thereby also increasing the unpredictability and exacerbating feelings lack of agency and control in the child.
- Experience of threats and physical abuse/ starvation versus manipulation/ inducement/ grooming—these two factors may impact how children view the issue of rescue and rehabilitation. In the former case, they may be eager to be rescued/ rehabilitated; but in the latter case, children may perceive the rescuers as a threat to their well-being and may even express anger or reluctance as they are

seen to be taking away economic opportunities from them. Often when children are rehabilitated in NGOs where facilities are not what children are used to, children may express that they felt that they had a better life in sex work contexts and may feel that they are being deprived of their rights to enjoy certain benefits (that they may no longer have in the NGO).

Children's Concerns

While the contexts and sub-contexts are many, the following are some of the commonly emergent themes in our work with the children:

- **Guilt and Self-Blame:** 'I must have done something wrong...after all, the police caught me.' Children were not really sure how they were to blame but the fact that the police had been involved gave them a sense that they were also culpable. Other than this, there was the issue of having 'done bad things.'
- **Repeated Requests to Go Home:** "When am I going home?" Some of the children who asked this question repeatedly were also the ones who appeared to be unprepared as to how they would respond at home. They were either in denial or had simply not anticipated questions/ reactions at home.
- **Worries about the Future:** 'What will I do or be now? When I go home, should I tell my family the truth? What should I tell people about where I was?' Many children were unequivocal about not wanting to share any information with their families but some were confused. Often children seemed to hope or imagine that going home would end all their troubles; there was a perception of home being an idyllic place wherein they could resume their old lives and activities by simply not telling the family about their experiences. Children seemed to deny or be unable to predict the sort of questions their families may ask about their whereabouts and experiences. Some children (from Bangladesh) said that it was even a well-known fact in their villages that if some girl disappeared for so long, she must have been in sex trafficking—in such instances, children were unsure of how to content with the social stigma attached to sex trafficking.
- **Response to Family Pressures and Decisions:** "like what if they ask me to get married...or tell me I cannot work..." Children were firm on their decisions not to marry or at least not to marry immediately or to learn a trade and work. However, said 'I will just tell my father this is what I want'. They were unable to discuss further their reasons/ basis for their decisions and think of ways to communicate them to family. They were also unable to foresee that their families may view these decisions differently or not be in agreement with them.
- **Resilience:** "Now I know...I have leant...I have sense now that I did not have before because I have seen all that happened to me..." Some children were also exceedingly resilient and spoke about how they wanted to share their experiences with other girls, in order to protect them from such events, by telling them how to be careful and keep safe. However, this does not explain the confidence some of them expressed about their parents' reactions and how they will be received at home. Children tended to have a lot of assumptions such as 'I know my father will not get me married' or 'they will believe me' or 'they will not ask where I was' or 'they will allow me to work'. There appears to be a notion of the ideal home and the basis for this thinking is not entirely clear—except to wonder whether it is founded on desperate hope that all these good things must (or will) happen, or to somehow believe that after all these traumatic experiences, there must be a place where things are different and home might be the place that children wish to bestow with this quality of acceptance and goodness.

First Level Responses to Children Rescued from Sex Trafficking

- Acknowledgement of difficult experiences and emotions..."It seems like you have been through extremely difficult and traumatic experiences. Most people with your experiences would have felt the way you do...and found it difficult to deal with their emotions—so it is absolutely normal to feel distressed, depressed or angry—in fact you should feel angry with the people who hurt you. It is a proof of your courage that you sit here now and share some of your experiences—it is not easy for many to do that either. But I am glad you are safe now and over time, I hope, that as we talk you will feel supported...so that your distress slowly reduces."

- Addressing feelings of guilt and shame..."You are not guilty/ to blame...people who cheated/ coerced/ hurt them are evil and thus guilty. You tried your best to get out of that situation and given how powerful those people were, it may not have been easy or possible...but you tried, so you are not guilty...you cannot be guilty if you did not give your consent to those people."..."The police was there to catch the guilty people who were responsible for cheating/ coercing/hurting you—not to catch you/ in fact they were there to protect you from those people."

- Converting difficult and traumatic experiences into useful/ strengthening ones... "Now that you have been through so many difficult experiences, and have an understanding of so many issues that you did not earlier/ before you left home, what would you tell other girls like you? What might you share with them about issues of safety and protection?"

- Reclaiming a sense of identity..."Let us make a list of all your talents/ interests/skills...if someone asked who you are, how should you be described?...so there is so much more to who you are...you cannot be described as just 'the girl who was abused/ in trafficking'—that is just one aspect of your life...you have certain experiences from it and have learnt certain things from it. But your identity cannot be reduced to that single aspect...you are also a daughter/ friend/ sister...a singer, a good cook, a lover of music, a great hair stylist..."

- Future orientation... "What do you want to do or be when you grow up/ in the next few years? ...Let us discuss how best you could achieve your goals...what you can do when you go home..."

Promoting child's sense of agency... (since the trafficking experience is essentially also a loss of agency) by allowing the child to share what she wishes to with the family after she has been repatriated and providing accurate information on her repatriation status and/or discussing CWC's plans for her to be shifted to a longer term child care home and allowing child to state her needs/ what kind of home she would like to live in.

Planning & preparation for what to tell at home..."many people such as you may not wish to share with their family what actually happened and that is alright. They might tell parts of the story how they were caught by the police with no passport and how they were sent to the hostel... these are all true. Between saying nothing at all happened and that you were made to be with 100 men, with every detail of what was done to you, there are middle ways...One way if you want to tell more is that you were met by some bad people who tried to hurt you and that you fought hard to get away from them and that is when you were rescued by the police and sent to hostel. You could also say that it was a very traumatic time for you and you just need some rest and time to recover at home. But you decide how much to tell and what to tell, if at all. There is no pressure or compulsion—I can help you think about how to tell what you want to so that you are clear and feel confident as you go home."

Responding to family pressures and decisions... "If you have decided that you would not like to get married immediately, that you wish to wait a few years, that is entirely your decision—you have a right to make it. But let us think how you might convince your parents to agree to let you do this...what might you say? What reasons would you give so that they also understand how you feel and are supportive about it...in case they are not supportive, let us think what else you might do..."

B. Systemic Issues

B.1. Apathy and Insensitivity of Institution Staff: Nearly all the children seen had been in the girls' home for 1.5 years but had received little or no psychosocial assistance—their emotional problems were unaddressed and their questions and doubts about the future un-answered. The apathy of the care-taking staff is a real barrier to the psychosocial well-being of these children, either exacerbating immediate distress by providing no avenue or opportunity for children to express their experiences and feelings, or by giving rise to more uncertainty about the future, which serves to increase anxiety and related mental health morbidities.

B.2. Child Abuse: Other than not providing access to psychosocial support, staff also actively engage in acts of child abuse (as was witnessed by the Project team in the Government Girls' Home): One of the girls who had been rescued from a context of domestic labour with severe physical abuse by her employers, was in much distress (over 6 months after her rescue) and continued to have symptoms of depression. When the Project team evaluated her and diagnosed her with adjustment disorder, recommending medication, the superintendent of the Home suddenly decided that the child's age was above 18 years and that she should be transferred to the women's reception centre; further, the Project staff were witness to the superintendent's aggressive verbal (emotional) abuse of the child for speaking with the Project team and sharing her distress and difficulties—'*How dare you not eat your food now? Come on...what is wrong with you?*'.

B.3. Denial of Child Rights and Welfare: In another instance, a 14 year old girl had been in sex trafficking for 2 years, following which she continued to suffer severe levels of PTSD; a child care agency accommodating such children had, in fact, 'brought her back' to the girls' home as there had been incidents of the child becoming angry and violent towards some male staff in the agency. Following depth assessment by the Project team and recommendations for treatment and medication, the Girls' Home staff did not administer the recommended psychiatric medication to the child. The reasons for not giving the child medications were not clear. Further, the Home staff kept telling the child: 'there is nothing wrong with you; if it was not for them [NIMHANS Project team/ Justice & Care], you could have been sent home by now'. Such statements turned the child against the treating team, making it hard to convince her to avail of therapy and hospital admission as required. Such insensitive and ignorant systemic responses go beyond mere inefficiency or apathy—they may be seen as active attempts by the staff and system to sabotage efforts to ensure children's welfare, to completely deny children of their rights to assistance—and serious actions should be taken by DWCD in such matters.

B.4. Lack of Psychosocial Skills and Training

Counselling or Investigation?

As has been discussed in previous Project documentation, most child care service staff do not have skills in trauma work and inquiry. This was further reflected by the fact that one of the children assisted said that she had never shared 'all this information' and all her experiences before. About 95% of interaction between counsellor and child appears to be questioning and the remaining 5% about information-giving. As a result, children's real worries and questions are simply not addressed. All this leads us to conclude that the initial assessment or inquiry protocols in child care services are in adequate or (as we have often been told by the staff themselves) are conducted in an investigative style i.e. the communication between the child and staff (including counsellors) is more akin to a question and answer session (wherein the

staff/counsellor questions and the child rather than the inquiry being embedded within a process of counselling.

In other words, any inquiry for difficult and traumatic experiences (and indeed all children's experiences) should be conducted using counselling principles and approaches, not legal/ judicial/police enquiry protocols and processes; and this means that whilst taking the information and facts from the child, an attempt must be made to genuinely understand the child's experiences and emotions, and then to respond in such a way as to provide some immediate perspectives and frameworks to address the child's thoughts and questions.

Inappropriate Responses to Children's Emotions:

Staff who have attempted to provide some comfort to children from sex trafficking, do not have the contextual understanding nor the skills to do so. When children have emotional issues such as depression about their experiences or anxieties about the future (what to do when they get home/ to tell or not), staff have responded by providing them with information on repatriation processes—or rather by assuring them that they will be repatriated. There are several issues with this sort of response:

- When children express distress or difficult emotions, as a result of their traumatic experiences, these emotions need to be acknowledged and validated. One of the most powerful counselling skills or responses is recognizing and acknowledging emotions—this is because it i) enables children to feel that their experiences have been truly heard and believed; ii) to normalize difficult emotions as those that are naturally felt by anyone in those circumstances. And from here on, children can gradually move to further reflections, healing and recovery, which they would be unable to do if they are not assisted with the first step in emotional support and processing. Thus, if children's expressions of distress are simply met with assurances about repatriation, however well-intentioned this response may be, it is inappropriate at this point in time.
- Provision of information about repatriation processes is important and must be done—however, it needs to be done in a detailed manner, providing accurate information without vague or false assurances. This is also because these children have already experienced mis-information, mis-representation and manipulation multiple times (by the traffickers). Thus, they have serious issues around trust and predictability—and if the rescue/ rehabilitation team needs to be different from the traffickers, they need to ensure that they use approaches and methods that are transparent and consistent.

B.5. Mind the Gap:

When children are rescued from sex trafficking, there are several players in the raid-rescue-rehabilitation process. Police, legal personnel, child welfare committee members, counsellors, NGO staff (who comprise of various types of staff)—to name a few types of stakeholders who provide assistance to these children.
Perhaps each one assumes that the other will talk to the child about certain issues, especially those that concern children's anxieties and related psychosocial impacts. Since there is no inter-sectoral coordination, planning or discussion, these conversations with the children remain fragmented, incomplete, often absent or contradictory. This only compounds the confusion for the child and adds to psychological distress.

Thus, as recommended in any situation of child sexual abuse, it is best to avoid multiple interviews (by varied professionals) and to have a single point of contact for the child—someone who does the in-take/ assessment and remains to support the child at least through the initial psychosocial distress (such as

PTSD issues) and systemic processes—even if deeper therapy issues were to be handled by another counsellor once the child is placed in a children's home for longer term care.

4.3. Interventions in Children's Institutions: Children in Conflict with the Law

Given the recent developments in the country i.e. the new Juvenile Justice Amendment December 2015[1], the Project felt that it would be timely to initiate psychosocial and mental health care services with children in conflict with the law. Thus, during this quarterly, upon receipt of requisite permissions from the DWCD, including the District Child Protection Officer (DCPO), Bangalore Urban, the Project initiated mental health services for children in conflict with the law, at the Government Observation Home (OH) in Madiwala, Bangalore.

The objectives of the Project services are:

- To ensure restorative and transformation processes which address accountability and encourage the under-taking of responsibility by understanding the impact of children's actions on victims/community and repairing harm.
- To examine the (seriousness of) circumstances that the children come from and address the neglect/ abuse and trauma issues thereof.
- To identify children with psychiatric and/or personality issues and implement interventions accordingly.

Since 1st March 2016, the Project team has been providing the following services in the Home:

- Individual assessment (from a mental health perspective, including conducting psychological testing for children with neuro-developmental and psychiatric problems).
- Individual counselling and therapy for each child with a view to effecting transformation and preventing recidivism (in relation to this, we are also engaged in the process of getting permission from the DWCD to allow us to provide interventions to those children with psychiatric disorders requiring pharmacological treatment and psychotherapy).
- Collaborative work with the staff/ superintendent to develop daily schedules and activities for children that will serve the purposes of rehabilitation (so that the Observation Home is not viewed as a mere place of detention or punishment).

Group therapy to enable children to acquire the requisite life skills with special focus on decision-making, social judgment and empathy (necessary for transformation) was to be started in April 2016, when the Project's permission to work in the OH was withdrawn (see operational challenges for details).

Initial Experiences and Observations of Working with Children in Conflict with the Law

During the course of providing services at the Observation Home, the Project documented issues concerning children in conflict with the law using the vulnerability-pathology-consequence framework. As per this framework, i) vulnerability refers to the risk factors that lead children to committing offence or coming in conflict with the law—these factors pertain to family dysfunction, abuse and trauma, education and academics-related issues, and individual factors such as developmental deficits and vulnerability to mental health conditions; ii) Pathology refers to mental health problems, both internalizing disorders

[1] The Juvenile Justice (Care and Protection of Children) Amendment Bill 2015 passed in December 2015 allows for juveniles 16 years or older to be tried as adults for heinous offences like rape and murder. Heinous offences are those which are punishable with imprisonment of seven years or more.

(anxiety/ depression) and externalizing disorders (ADHD, Conduct Disorders and Substance Abuse) and the processes therein (such as emotional dysregulation, social judgement issues); iii) Consequences refer to the offence committed, including acts of aggression, stealing, and coming into conflict with the law.

In all, 30 children were assessed using an assessment form developed for this group of children. All 30 children were male[2] and between ages 13 and 18. While the sample size of the children assisted is small (N=30), some descriptive statistics have been collated. The objective, for the present, is not to draw depth statistical analysis but to begin to put together a profile of children in conflict with the law, by presenting emerging trends in pathways to vulnerability, child and adolescent mental health disorders they have and the types of offences they commit. We have also presented our experiences in terms of technical and systemic issues that pose challenges to providing interventions for these children.

An average of 2 hours was spent evaluating each child with the protocol developed and **first level responses** were provided to children to enable them to initiate the process of transformation through some inputs on insight-building, reflection and perspective-taking on their behaviours. (See boxes below)

Items for Assessment Proforma for Children in Conflict with the Law

- Basic Information(Name/ Age/ Place of Origin)
- Presenting Problems/ Complaints (if any—emotional or behaviour problems observed currently including self-harm risk and physical aggression problems)
- Family History (Child's living arrangements/parental relationships/ child's emotional relationship & attachment to parents/ illness & alcoholism in parents/ single-parenting…)
- School History(Was the child attending school/Last grade/class attended current grade/class/ if child was not attending school, reasons for child not attending school, including child refusing to go to school).
- Institutional History(where child has been/lived, for what periods of time, experiences & difficulties, circumstances of coming to the institution, incl. offence for which in institution)
- Physical, Sexual & Emotional Abuse Experiences (Trauma)
- Substance Abuse (type of substances used/when substance use started/frequency of use/ craving/medical, legal impact of drug use)
- Child's Perception of Problem (Child's version/ understanding of his problem & why he is in OH/ future plans to stay out of trouble/ skills to avoid conflict with the law)
- Cross-sectional Observations of Child (cooperation/ social skills/ cognitive & thought process/activity levels/ time-place orientation/speech & language abilities)
- Summary & Diagnosis (Vulnerability, Pathology and Consequence)
- Care plan (Immediate interventions/ first level responses/ recommendations for further evaluation/ interventions)

Vulnerability--Pathways to Coming in Conflict with the Law

Family Issues and Dysfunction: As found in a recent Indian study[3] on socio-dempgraphic characteristics of children in Observation Homes, we also found that most children (87%) were from lower socio-economic strata of society i.e. from families engaged in day labour or small businesses largely dependent on daily

[2] The Observation Home at Madiwala, Bangalore only houses male juvenile offenders. Female juvenile offenders, fewer in number are sent to the Reception Centre for Women.

[3] Gupta, A, Biddala, O.S, Dwivedi, M, Variar, P, Singh, A, Sen, P.S, Bhat, S, Kunte, R, Nair, V, Shankar, S (2015). Sociodemographic characteristics and aggression quotient among children in conflict with the law in India: A case-control studv. National Medical Journal Of India vol-.28, No.4,2015

income for their survival. Nearly third of children come from backgrounds of family dysfunction such as parental marital discord, domestic violence, family conflicts, substance abuse in the parents, single parenting and abandonment. It is noteworthy that only 1 child came from a context of permissive parenting and parental inconsistency i.e. what in lay terms is described as parents being 'over-indulgent' and 'spoiling the child'. Contrary to what is believed frequently, children's conduct and behaviour problems are not always attributed to 'bad' parenting—at least not in the 'spoilt, over-indulged' sense. Thus, how family issues contribute to children's vulnerability to crime therefore needs to be understood in terms of poverty, deprivation, physical and emotional neglect.

Abuse and Trauma: Closely related to the issue of family dysfunction is that of abuse and trauma. Dysfunctional families are often those in which there is domestic violence and this includes considerable physical and emotional abuse towards children. Nearly half (40%) of the children and a third (30%) of the children have been subjected to physical and emotional abuse respectively. Harsh and punitive parenting/ care-giving patterns including physical abuse, with rejection, humiliation and other forms of emotional abuse make children vulnerable to developing aggressive behaviour patterns, both by adversely affecting their emotional regulation mechanisms as well as enabling children to learn behaviours that are modelled for them.

Aggressive instincts in the context of the quality of family relationships can arise both from exposure to aggression and as a consequence of anger that comes with experiences of emotional rejection. Children who are exposed to domestic violence in the context of marital discord or the abuse that children themselves suffer through harsh, punitive disciplining are likely to have more aggression. This is both through displacement dynamics (when children are subjected to aggressive treatment by others, they in turn, behave aggressively with others to vent their unresolved anger) and identification with the aggressor/ learnt behaviour. Children who experience emotional rejection and lack of parental care feel resentful and angry because of unmet needs. This resentment often manifests as aggression.

School and Education Issues: 60% of children in the Observation Home are school drop-outs. The reasons for dropping out range from academic difficulty (30%)—wherein children have had learning problems due to specific learning disabilities, ADHD, change in medium of instruction (due to migration) and under-stimulation. Whatever the underlying cause of the learning problem, it has been a major reason (along with bullying and corporal punishment which children having learning issues are vulnerable to) for children to lose motivation for education and so decide to drop out of school. Most children who dropped out of school told the Project team that they then 'wandered around the neighbourhood' with their peers who had also dropped out of school—in fact, some children also shared that they had been influenced to quit schools by peers who had dropped out. Being out of school meant that they had a lot of unstructured time on their hands, that then tended to lead children to constantly seeking entertainment (films etc) and use of substance. Sustained engagement in such activities requires monetary resources, and has thus served as a major reason for stealing.

The role of school is therefore not limited to literacy and education (which in turn is not just about the 3 Rs). Going to school, or rather, staying in school enables children to be occupied on a daily basis, in a structured and constructive manner and therefore protects children from substance abuse and other anti-social behaviours. For this reason, not only is it important to ensure that children are supported (including provision of support to cope with academic and developmental disabilities through remedial education) but

also to never to use suspension or expulsion as means of punishment for children's 'bad' behaviour—this latter measure, frequently used by schools as a disciplinary method only serve to increase the number of juvenile offenders in the country[4]. The Dept. of Education therefore needs to understand school as a safety net, especially for children who come from vulnerable dysfunctional family contexts—indeed, for these children, school is their only hope, and teachers their only chance for providing strong counter-socialization processes to those (often adverse) processes that occur in children's home environments.

Table 4 (g): Vulnerability--Pathways to Coming in Conflict with the Law

Vulnerability Factors		**No. & Percentage of Children (N=30)**
Family Issues	Low Socio-Economic Status	26 (87%)
	Marital Conflict/Domestic Violence/Family Conflict	8 (27%)
	Substance Abuse (Alcoholism) in Parents	7 (23%)
	Parent With Mental Illness/ Disability	1 (3%)
	Single Parents/Abandoned	5 (17%)
	Parents Involved In Criminal Activities	1 (3%)
	Parental Inconsistency/Permissiveness	1 (3%)
Abuse & Trauma	Accident/Injury	1 (3%)
	Death/Loss And Grief	1 (3%)
	Physical Abuse	12 (40%)
	Emotional Abuse	9 (30%)
	Sexual Abuse	1 (3%)
School/ Education Issues	Never Went To School	1 (3%)
	Dropout	18 (60%)
	Academic Difficulty	9 (30%)
	Corporal Punishment	2 (7%)
	Bullying	2 (7%)
Individual Factors	Attention Deficit Hyperactivity Disorder (ADHD)	6 (20%)
	Behaviour Regulation (Aggression)	9 (30%)
	Anti Social Values/ Limited Pro Social Emotions	2 (7%)
	Substance Abuse	14 (47%)
	High Vulnerability to Peer Influences	12 (40%)
	Life Skills Deficit	12 (40%)

Individual Factors: Individual risk factors refer to certain psychological or behavioural factors that place a child at higher risk of committing offences. These factors are likely to include low intelligence, and neuro-developmental problems such as Attention Deficit Hyperactivity Disorder (ADHD), aggression, high vulnerability to peer influences, anti-social values and limited pro social emotions, substance abuse/ addiction and life skills deficits. While these factors are presented as individual factors, it is to be noted that apart from the neuro-developmental issues such as ADHD, and intellectual abilities, the other factors mentioned, although categorized as individual traits/ temperament/ habits, are also linked to family dysfunction, abuse and trauma experiences and school problems.

[4] 'Guidelines for Eliminating Corporal Punishment in Schools' developed by the National Commission for Protection of Child Rights (NCPCR) lays out how to deal with behaviour and disciplinary problems in school through use of Affirmative Action and positive engagement with children with a view to promoting positive development of children. (It condemns various types of corporal punishment, including physical and emotional abuse of children).

Attention Deficit Hyperactivity Disorder (ADHD): This neuro-developmental disorder causes children and adolescents to have behaviours such as restlessness, impulsiveness, inability to delay gratification, difficulty with emotional regulation and poor social skills and judgement. 20% of children seen in the Observation Home had ADHD—their difficulties, therefore, with impulse control and social judgement, their impulsivity and poor emotional regulation has increased their risk of engaging in anti-social activities.

Behavioural Regulation (Aggression): A third of the children (30%) reported problems relating to anger control or aggression. Behavioural dysregulation refers to children with poor emotional regulation mechanisms—a problem that may be caused by multiple factors, ranging from ADHD to difficult temperament, emotional neglect and physical abuse, and other experiences of abuse and trauma. The violent and unpredictable nature of a home (or school) environment wherein abuse repeatedly takes place (as is the case with these children from early childhood), adversely affects their abilities to control and manage difficult emotions such as anger and anxiety. Studies have shown that repeated exposure to abuse and trauma also lead to Neurobiological changes that in turn can lead to life-long psychiatric issues. Such repeated early-life stress leads to alterations in central neurobiological systems leading to increased (mal) responsiveness to stress. Clearly, exposure to early-life stressors leads to neurobiological changes that increase the risk of psychopathology in both children and adults[5].

Anti-Social Values and Limited Pro-Social Emotions: Related to the issue of aggression is that of anti-social values and limited pro-social emotions. As already discussed above, exposure of children to domestic violence and physical abuse at home and at school, lead children to i) understand these as being the only ways to respond to problems and conflicts faced; ii) emulate these behaviours because that is what is modelled for them by parents/ teachers. As a result, such children suffer deficits in emotional development other than regulation; they also fail to develop empathy, and consequently imbibe and practice anti-social behaviours, that are either violent (such as assault and murder) or coercive (such as theft, sexual abuse) in nature.

However, and again, often contrary to what is commonly believed about juvenile offenders, only 7% of the children served were assessed to have what the DSM diagnosis terms as 'Conduct Disorder with Limited Prosocial Emotions'. In DSM-5, the criteria for conduct disorder are largely unchanged[6] from DSM-IV, but the limited prosocial specifier is new to this DSM. The specifier applies to those individuals with a more serious pattern of behaviour characterized by a callous and unemotional interpersonal style across multiple settings and relationships. The conduct problems are further characterized by lack of remorse or guilt, lack of empathy, callousness, unconcerned about performance, shallow or deficient affect.

[5] http://www.ncbi.nlm.nih.gov/pubmed/?term=Nemeroff%20CB%5BAuthor%5D&cauthor=true&cauthor_uid=14728093 [9] Nemeroff CB (2004). Neurobiological consequences of childhood trauma. J Clin Psychiatry. 2004;65 Suppl 1:18-28

[6] Criteria/ Symptoms of Conduct Disorder as per DSM V:Aggressive behavior toward others and animals; Frequent physical altercations with others; Use of a weapon to harm others; Deliberately physically cruel to other people; Deliberately physically cruel to animals; Involvement in confrontational economic order crime- e.g., mugging; Has perpetrated a forcible sex act on another; Property destruction by arson; Property destruction by other means; Has engaged in non-confrontational economic order crime- e.g., breaking and entering; Has engaged in non-confrontational retail theft, e.g., shoplifting; Disregarded parent's curfew prior to age 13; Has run away from home at least two times; Has been truant before age 13.

Substance Abuse: ADHD as well as other trauma and abuse experiences (that cause internalizing disorders such as anxiety and depression) also cause children to engage in high risk behaviours such as substance use and inappropriate sexual behaviour. Nearly half the children (47%) had engaged in substance use, most of them having started these habits at age 11 to 12 years and being dependent for periods ranging from 2 to 5 years. Since substance abuse is dependent on children having money to buy/ source it, it leads children to engage in behaviours such as stealing. Further, substance abuse has also led children to committing offences such as murder, which they have done in a state of inebriation or under the influence of substances such as alcohol and other drugs. As already noted above, children who are out of school are more likely to engage in substance abuse behaviours.

Higher Vulnerability to Peer Influences: While nearly all adolescents, given their developmental stage, are vulnerable to peer influences, certain children, mainly those with ADHD (due to impulsivity and poor social judgement) and those from dysfunctional families are likely to be more vulnerable to peer influences. Our assessments showed that 40% of the children seen had higher vulnerability to peer influences—as they attributed most of their decisions, whether to drop out of school or use substances to persuasion by their peers.

Life Skills Deficits:

All children with conduct disorder may be said to have life skills deficits pertaining to problem solving, conflict resolution, emotional regulation, assertiveness, and coping with peer pressure. While this is a given for all children seen by the Project team in the Observation Home, this has been listed as a specific individual factor for children whose problem cannot be accounted for by individual factors such as ADHD, aggression, substance abuse, anti-social values/ lack of prosocial emotions. What this means is that some children, especially those who are not guilty of criminal offence, have been convicted due to decision-making processes that were not necessarily anti-social in nature but that led to difficult consequences. Inappropriate decision-making about romance and sexuality issues is one such example, and appears to occur fairly frequently in adolescent boys: there were at least 3 to 4 children who were charged with rape under POCSO when in fact they were in legitimate, mutually consenting relationships with their (female) peers and/or had been persuaded by their (female) peers to run away/ live together/ engage in sexual intercourse; this is indicative of the fact that they lacked the knowledge and skills to make such decisions i.e. with due consideration to health and safety (pregnancy/ STI protection), consent and permission versus coercion, assertiveness/ refusal/ negotiation skills. Consequently, they found themselves in difficult predicaments due to these life skills deficits.

Thus, there are two types of children in the OH who have life skills deficits—those who have committed offences and those who have not engaged in anti-social activities/ offence but landed in difficult predicaments due to poor decision-making and other life skills. Thus, life skills deficits place children at risk of coming in conflict with the law. Again, while it is an individual factor in that it pertains to the (life) knowledge and skill of an individual child, the acquisition of life skills are dependent on the child rearing and parenting practices of care-givers and on the nature/ type of education provided by the school.

Contrary to common understanding, value education or instruction is NOT equal to life skills training. Thus, parents and teachers telling children that ‘stealing is bad’ is inadequate. Life skills is about engaging children in discussions about daily issues and problems, as they face in their everyday lives, and helping them reflect on, assess and select possible/ appropriate ways to cope with them; it is about using creative

methods such as film, art, games, drama and role play to have conversations that enable children to develop perspectives on various life problems. In the absence of such opportunities, as has frequently happened with children in conflict with the law, either due to dysfunctional families and poor parenting or dropping out from school and school system's inability to provide life skill education, children fail to develop critical skills necessary to navigate life in a healthy, happy and responsible manner.

Pathology: Child & Adolescent Mental Health Disorders in Children in Conflict with the Law

Internalizing Disorders:

In terms of pathology, as cross-sectionally assessed by the Project services, very few children (about 10 to 13%) had internalizing disorders. Out of the 4 to 5 children who had anxiety and adjustment disorders, most were actually not guilty of any crime, and were depressed and frustrated that they were being held in the Observation Home 'for no real reason' ('Why am I here?'), anxious and disheartened about the legal procedures ('when am I going to get out of here?')—all reasons for their emotional problems. 1 to 2 children had developed emotional problems while at the Home because they found it difficult to 'be here with children who shout and hit and talk badly'. Indeed, as is typical in any school/ child care setting, in the Observation Home too, socially appropriate children avoid their more aggressive peers as they either fear them or find it difficult to contend with them. However, in the Home, children who are actually not guilty of offence and have no externalizing disorders are forced to mingle all the time with other children who have externalizing problems—this, coupled with the uncertainty and unpredictability of legal processes, feelings of having suffered injustice due to erroneous conviction, exacerbates their feelings of sadness and anxiety (and anger) in the Home.

Developmental Problems:

As discussed previously, some children, especially those who are not guilty of criminal offence, have been convicted due to decision-making processes that were not necessarily anti-social in nature but that led to difficult consequences. 27% of children had life skills deficits such as decision-making, negotiation/ refusal skills, assertiveness, conflict resolution, emotional dysregulation, in the contexts of sex & sexuality, substance use but which did not necessarily lead to committing an offence. Thus, while these children may not meet the criteria for any psychiatric disorder, they still have life skills deficits (thus recorded under pathology) which have led them to some of the difficult circumstances they have found themselves in, including being accused of committing an offence (even if they did not do so).

Table 4 (h): Pathology (A)—Child & Adolescent Mental Health Disorders in Children in Conflict with the Law

Child & Adolescent Mental Health Disorders		No. & Percentage of Children (N=30)
Internalizing Disorders	Anxiety	4 (13%)
	Adjustment Disorder/ Depression	3 (10%)
Developmental Issues	Life Skills Deficit	8 (27%)*

* Children with internalizing disorders also had life skills deficits.

Note: As previously mentioned, all children with conduct disorders and ADHD have life skills deficit. They are thus not categorized specifically as having life skills deficits—their categorization under externalizing disorders, by virtue of the diagnostic criteria for these disorders implies they have life skills deficits along with other behaviour problems.

Externalizing Disorders:

Out of 30 children, the remaining 22 children had externalizing disorders, namely Conduct Disorder (CD), Attention Deficit Hyperactivity Disorder (ADHD) and Substance Abuse.

Overall, the 17 children with conduct disorder formed 57% of the (30) children in the Home, and 77% of the (22) children with externalizing problems. A majority of these children, 65% of them with CD also had co-morbid substance abuse with CD. 1 child (6%) had ADHD co-morbid to CD and 2 children (12%) had ADHD and substance abuse co-morbid to CD. The 2 children having a diagnosis of CD with Limited Pro-Social Emotions had no co-morbidity of substance abuse or ADHD (this is not to say that this would be true always—it was only recorded for this sample, which as mentioned is very small).

Table 4 (i): Pathology (B)-- Child & Adolescent Mental Health Disorders in Children in Conflict with the Law

Externalizing Disorders	No. & Percentage of Children
CD only	1 (6%)
CD with Limited Pro-Social Emotions	2 (12%)
CD with Co-Morbid ADHD	1 (6%)
CD with Co-Morbid Substance Abuse	11 (65%)
CD with co-morbid ADHD & Substance Abuse	2 (12%)
ADHD Only	2 (%)
ADHD with Co-morbid Substance Abuse	1 (%)
Substance Abuse Only	1 (8%)

In all, 6 children with ADHD formed 20% of the (30) children in the Home, and 27% of the (22) children with externalizing problems. In a larger sample, these proportions may not be insignificant, suggesting that ADHD is both a risk factor for as well as a disorder found in children in conflict with the law. While this sample shows that ADHD does not often occur with CD or substance abuse as a co-morbidity, the sample size is too small to draw any such conclusions—larger sample sizes, obtained through continued work in the Observation Home, will enable us to understand further the association between ADHD, CD (and juvenile offence) and substance abuse. Furthermore, the 2 children who had ADHD only (with no CD or substance abuse) although convicted for some offence, have actually not directly engaged in the commission of the offense—these children, because of their poor social judgement and tendency for sensation-seeking (ADHD symptoms), tend to be easily influenced by their socially inappropriate peers, and end up being present at the scene of crime, actually committed by someone else.

Children from vulnerable backgrounds may have conduct symptoms and resort to substance abuse later on; or they may have substance abuse issues from which conduct problems arise, related to poor social judgement. Whichever problem occurs first, whether it is conduct symptoms or substance abuse, it forms the low intensity problem that is also the gateway to high intensity problems. The Project is unable to clearly determine the order in which children's pathology occurred i.e. whether CD resulted in substance abuse (and consequently in commission of more serious offences and conflict with the law) or whether substance abuse led to conduct issues (and eventually to coming in conflict with the law). This is because much of the history is obtained from the Home staff and the children themselves, so there are limitations of knowledge and insight respectively i.e. we do not have corroborative (childhood) history from the parents/caregivers. The only postulate regarding children coming into conflict with the law may be about ADHD, wherein we can say that children with ADHD may have developed conduct symptoms and/or

substance abuse (in whichever order or simultaneously) thereby leading them to engage in anti-social activities.

If one looks at gateways or pathways processes, it has been postulated that low intensity problems are not only a pathway to high intensity problems but are significantly associated with them. It is clear that low intensity problems arise from the vulnerability factors already described and managing these risk factors or the low intensity behaviours early will prevent progression. Management of the risk factors can also reverse persistence of high intensity behaviours.

The Challenge of Establishing Mental Health Diagnoses

One of the key challenges for mental health work with children in conflict with the law in the Observation Home is that of obtaining history. Parents/ caregivers of the child are usually not available to provide details of childhood and developmental history. The behavioural observations shared by the OH staff from their experience of the children have spent in the Home, are often inadequate, erroneous or biased. This inadequacy on the part of the OH staff is due to their own lack of knowledge and understanding of child and adolescent mental health issues as well as because of their judgemental attitudes towards children who have committed offence.

Consequently, a lot of the child's history is reliant on self-reporting. In cases where children are suspected to have ADHD, for instance, self-reporting hinders accurate diagnosis because, often, children are unable to provide clear childhood and developmental history about themselves; and also, they may lack insight—this has been frequently observed in case of children with ADHD, who when asked questions about the difficulties they face with sitting tolerance or social situations and impulsivity, tend to either deny that they have any problem or are vague or inconsistent in their responses—'I don't know...may be...sometimes...a little'. This is not only due to lack of insight but also possibly to do with social desirability issues, which makes them reluctant to admit to certain types of behavioural difficulties they might have. Further, for children in conflict with the law, they might be hesitant to freely admit to certain behavioural problems for fear that such information might be used against them in legal processes--especially as it is reported that their lawyers persistently instruct them 'not to admit to anything' if they want to get bail or go free.

In order not to rely only on clinical impressions, the Project team has attempted to select and use the best possible self-reporting psychological scales available to test for ADHD. However, it is realized that these scales are frequently dependent on the child's insight of his problem and his willingness to share it. Thus, the reliability of results for children in the OH is often questionable. What we find is that the scales, with their limitations of use in this context, are sensitive to severe ADHD, which they manage to establish; but mild to moderate ADHD is not diagnosable through the scales. In another context i.e. of 'normal' children who reside in regular families, a establishing the level of ADHD may not be so imperative; in the OH, however, presence of ADHD in a child could have a lot to do with offence and recidivism, thus making for a mental health basis for commission of offence, thereby also having legal implications. And so, even mild to moderate ADHD matters for children in conflict with the law—it therefore needs to be correctly identified and treated as part of the interventions to prevent recidivism.

In attempt to overcome the challenges of history taking, testing and diagnosis, therefore, not only for ADHD but other areas of concern, such as presence of intellectual disability or prosocial emotions/ age-appropriate emotional development, the Project team plans to develop diagnostic methods (story stems/ situation analysis questions) to try and consolidate clinical assessments, in order to establish stronger diagnoses, and enable more appropriate interventions for children in conflict with the law.

Alleged Offence and Consequence

Alleged offences refer to the offenses that children were charged with by the police, at the time of conviction. This information was obtained from the police charge sheets available in each child's file.

Consequences refer to offences too, or the reason why children came in conflict with the law. Early into the assessment process, the Project team realized that some of the children who were in the Home had been wrongly convicted or detained i.e. that they had not committed the crime. This conclusion was drawn by corroborating two sources of information/ history:

i) An interview with the child which obtained an account of the alleged offence by asking the child: 'What is your understanding of why you are here (in the OH)?'

ii) Recording what was told by the child to the OH social worker when the child first came to the OH i.e. what the child said about the offence immediately, upon admission to the OH. This is because many children (according to the social worker) tend to 'tell the truth' initially, and later on 'change their version' of what happened due to legal pressures i.e. their lawyer may insist that they do not admit their offence to anyone, no matter what is asked of them, in the interests of getting bail or closing the case. And so children, at a later stage, may or may not acknowledge the offence they committed.

While we acknowledge that this approach has its limitations, in the absence of multiple persons/ caregivers to corroborate history and given the sensitivity and complexity of the (legal) issues, it seemed to be the most balanced way in which we could ascertain the 'truth' as well as give children the right to speak and articulate their opinions and their side of the story.

Recidivism: Table 4 (j) shows that 22 children were first time offenders, or rather that they were all in the OH for the first time (since some of them had actually not committed an offence). 8 children had recidivism and were in the OH for the 2nd or 3rd time. Of these 8 children, 2 had ADHD—which might also explain why they repeatedly commit offences.

No Offence: 7 (23%) of the children in the Home had actually not committed any offence. These children were actually known to other children who had committed the offence, but they happened to be there at the time and were caught for acts they did not engage in i.e. because of their acquaintanceship and friendship with the offenders, they got implicated. Other coercive, manipulative and abusive processes, through families and police also seem to play a part in these unwarranted convictions about which more detailed studies are required.

Stealing and Murder: As per Table 4 (j), if we compare the alleged offences to the consequences, in case of stealing and murder, the alleged offence fully corroborates the consequences as per our assessments/ children's accounts. In most cases, theft was an offence that children readily admitted to and the nature of the offence was mild—out of 12 cases of stealing, only about 3 to 4 cases (25%) were serious offences entailing breaking into homes and theft of jewellery and large sums of money of about Rs. 10,000. The remaining 8 cases (75%) ranged from petty thefts wherein children stole amounts ranging from Rs. 100 to a couple of thousands from home or from small shops and mobile phones especially from people on the street. All thefts were engaged in as part of gang activities. Given that most cases were not large-scale robberies, these cases would have benefitted more from being referred to the mental health system rather than the legal system, wherein children could have been counselled on behaviour change.

For the children who had attempted and for those who had committed murder, it emerged that in all cases, these acts was committed under the influence of substance. So, there was a background of severe substance abuse, requiring treatment in a mental health system. While these children may have been in provocative contexts, they also had anger and impulsivity control issues, which were compounded by poor judgement under the influence of substances. There does not appear to be planning or pre-meditation involved.

Table 4 (j): Consequences-- Offences Committed by Children in Conflict with the Law

Offence	**No. & Percentage of Children (N=30)**	
Recidivism	First Time Offences	Multiple Times Offenders
	22	8
Types of Offence	**Alleged Offence**	**Consequences**
Stealing	12	12
Kidnapping	2	
Sexual Abuse/Rape	7	2
Attempt to murder	4	2
Murder	2	2
Inappropriate Sexuality-Related decisions*	(NA)	4
Unfairly Arrested	-	7

*The law does not charge children of 'Inappropriate Sexuality-Related decisions'—this category was created from a mental health/ life skills perspective to explain the consequences for some children who had not committed sexual abuse/ rape but were convicted for being in a (mutually consenting) relationship with a female peer.

First Level Responses to Children in Conflict with the Law

- Future orientation (the impact of current behaviours on their future plans/ ambitions)
- Examining consequences and decision-making processes in behaviours such as stealing, violence and substance abuse and high risk sexual behaviours (pros and cons of actions)—impact on health, relationship with family and friends, on income/ economics
- The basis and motivation for change (other than being out of the OH)
- Anger management and control strategies
- Conflict resolution (in brief/ with a few examples)
- Considering other people's feelings/ empathy
- Frameworks for sexual decision-making
- Anxiety management and control strategies (for children with internalizing disorders)

*All the above themes will be discussed in detail in life skills sessions to be conducted through group interventions, using

Controversies around Sexual Offence/ Rape: The major difference in data occurs in sexual abuse and rape wherein 7 children were charged with sexual abuse and rape. But an assessment of consequences, through obtaining children's accounts as well as the OH social worker's account, revealed that only 2 children had actually perpetrated sexual abuse--these are also the 2 children diagnosed with conduct disorder with limited prosocial emotions. The remaining 5 children had engaged in mutually consenting romantic and sexual relationships with their female peers. But because they had run away together or (more frequently) the girl's family had got into conflict with the boy's family over the boy and girl being in a relationship and complained to the police, the boy was usually charged under POCSO and thus convicted of sexual crime. Thus, the law does not charge children of 'Inappropriate Sexuality-Related decisions'—this category was created from a mental health/ life skills perspective to explain the consequences for some

children who had not committed sexual abuse/ rape but were convicted for being in a (mutually consenting) relationship with a female peer. Given the limited role of POCSO in cases (as the ones discussed in the box below), it is suggested that such disputes and conflicts around adolescent sexual relationships (except where clearly established that the relationship was not mutually consenting/ that there was coercion and violence) be brought to the mental health system first, not to the legal system—so that adolescents can be counselled on life skills, especially those related to sexual decision-making.

Limitations of the Use of POCSO with Children in Conflict with the Law

The issue of boys/ adolescents being charged under POCSO is a complex one and has several implications. First, when applied to cases wherein adolescents are in mutually consenting sexual and romantic relationships with their (female) peers, the use of POCSO to convict them of an offence speaks of a society wherein adolescent sexual rights are not respected and convicting adolescents who are in mutually consenting sexual relationships reeks of the 'moral policing' that some sub-groups within our society are up in arms against in other (adult) contexts of romance and sexuality.

Second, there is a certain degree of absurdity in selectively convicting adolescents for being in mutually consenting relationships, based on family conflicts and complaints. If the issue of complaint really is that adolescents should not be engaging in sexual relations and all those adolescents who are doing so should be convicted, then thousands of adolescent boys would have to be convicted for 'being in love' and engaging in sexual activities—and the existing numbers of Observation Homes in the country would be unable to accommodate them!

The previous point raises concerns about how the POCSO law is framed. While its intention is to prevent/ respond to child sexual abuse, the question is how is child sexual abuse defined? A key element that determines sexual abuse is the issue of consent. It is fully agreed that the law should apply to young children who, due to their developmental stage and cognitive processing, would not be able to give informed consent and of course are not biologically or emotionally prepared for sexual relationships. But can the same be said of an adolescent—who is at a different stage in his/her life cycle, with developmental needs and abilities that are so different from that of a younger child? POCSO therefore does not acknowledge or make the distinction between the developmental needs and abilities of a 6 year old versus a 15 year old—and this is problematic because a blanket application of a law, without consideration of age, child and adolescent development and psychology leads to unfair conviction of adolescents, thereby violating their rights.

(Note: This discussion does not apply to an adolescent who may have legitimate sexual needs and desires but coerces or assaults another child or adolescent/peer in order to meet his needs).

Further, the application of the law is extremely gendered. Where there are mutually consenting sexual relationships between adolescents, and conflicts and disagreements around this, only the boy seems to be culpable; the girl does not seem to have to be (legally) accountable or responsible for decisions jointly made by both boy and girl. In fact, in 2 to 3 of the cases reported, the girl was reported to have 'pressured' the boy to run away/ 'take her away' due to her family conflicts and fears that she may be married off elsewhere. The law does not take into account the girl's role and decision at all.

Finally, what is both interesting and saddening is that there are exceedingly low conviction rates for adults who have committed child sexual abuse and been charged under POCSO. However, children/ adolescents seem to be quickly and easily convicted under POCSO, not granted bail even when they have been in mutually consenting romantic and sexual relationships with their peers (in fact, there appears to be little inquiry and evidence gathering around this, especially to get the peer-partner's point of view). What this shows is that a law that is essentially meant to protect children/ adolescents from abuse is being unjustly and whimsically used to convict and detain adolescents, in violation of their rights—is this really a legitimate use of a law meant to protect the rights and safety of children and adolescents?

Potential for Transformation

At the outset, let it be said that any treatment or therapeutic intervention assumes that every child/ adolescent has the potential for transformation—and the basic premise for any therapeutic treatment, not only in case of children in conflict with the law but other children, even those that have internalizing disorders, is that there is a potential for (behaviour) change. If we did not believe this, there would be no need to try to provide treatment at all. Contrary to some discussions happening in the country following the Nirbhaya episode, no tools or protocols developed would be valid or reliable in assessing whether or not an adolescent has the potential for transformation in way that allows a decision for him/her then to be transferred to the adult criminal justice system. Whether or not transformation can occur, can only be determined after adolescents receive opportunities for process-oriented reflection and life skill acquisition and training, and other requisite treatment and interventions.

'**Potential for Transformation'** in the context of child and adolescent mental health (and consequently in case of children in conflict with the law) does not seek to make any predictions about whether the child can actually change or not—we do not know that until we have provided opportunities and interventions that facilitate change. So, what this phrase refers to is:

i) **Children's insight into the problem** –-this refers to what understanding children have of the offence they have committed: Do they see it as a problem for themselves and others? Children who have an understanding of their offence and acknowledge the difficulties the offence has created for self and others, are said to have insight. As discussed earlier, insight into/ acknowledgement of the problem are the first steps for transformation to occur and consequently, presence of insight can be seen as having potential for change.

ii) Children's Motivation for Change--other than needing to stay out of trouble because they don't want to get put into an institution, are children able to reflect on reasons to not engage in the actions/ behaviours that brought them into conflict with the law in the first place? This factor actually refers to higher levels of moral development: avoidance of punishment and benefits to self are more basic levels of moral development and reasoning that motivate people to not perform certain actions; but social desirability, the importance of empathy and inter-personal relationships, and maintenance of law and order, social contracts and universal ethics are higher levels of moral development and reasoning. The potential for change seeks to examine where the child stands in his/her moral development—the higher the levels of moral development and reasoning, the greater the potential for change[7].

Potential for Change: For Mental Health Assessment, Not Legal Decision

While every child is assessed for potential for change, the objective of understanding potential for change, for mental health purposes, is only to establish the baseline, with a view to designing interventions, depending on what levels of reflectivity the child is at and what skills (deficits) he/she has. The Potential for Transformation, at assessment stage i.e. before interventions and opportunities are provided for transformation, should NOT:

- Be aimed at contributing to legal judgements about the child.
- Be used to make decisions about bail or release.
- Be used for transfer to adult systems of criminal justice.

iii) Skills to Avoid Offence—this refers to life skills such as emotional regulation, empathetic response, problem solving and conflict resolution. Children who have some of these skills are likely to have higher potential for behaviour change.

[7] Our definition of motivation for change is based on Kholberg's theory of (six stages of) moral development.

In our sample in the OH, 33% of children had low reflectivity for change i.e. low insight into problem and low motivation for change; however, an almost equal proportion of 30% of children had reflectivity for change to some extent i.e. they had some insight into their problem and acknowledged it to have difficult consequences for themselves but had difficulty articulating why they needed to change behaviours. Only a few children (17%) had complete insight and motivation for change—one of these was a child who had spent about 2 years in the OH (longer than any other child there) and the others were children who had relatively mild conduct problems and/or had committed an offence as a one-off i.e. a momentary impulse or lapse of judgement.

Table 4 (k): Children in Conflict with the Law: Potential for Transformation

Potential for Transformation		**No. & Percentage of Children (N=30)**
Reflectivity for Change (Insight into Problem and Motivation for change)	To a Low Extent	10 (33%)
	To Some Extent	9 (30%)
	To a High Extent	5 (17%)
	Not Applicable*	6 (20%)
Skills to Avoid Offence/ Consequence	Not at All	23 (77%)
	To Some Extent	0
	To a High Extent	1 (3%)
	Not Applicable*	6 (20%)

*'Not applicable' refers to children who had not committed any offence and therefore did not require potential for change.

Finally, in the light of the above definitions, what is important to note is that low potential for transformation, as reflected by initial assessments, in no way implies that a child cannot or will never transform. As already stated, child welfare systems, including legal and mental health systems, must operate on the premise that every child/ adolescent has the potential for change if provided with appropriate access to treatment and interventions, in keeping with his/her context and problem. Such opportunities and treatment, in the form of individual counselling and perspective-taking, group interventions and life skills training, and pharmacological therapy where necessary, will certainly enhance children's reflectivity for change, to begin with, and then enable them to acquire the (life) skills required to prevent recidivism.

Other Systemic Issues and Challenges in Working with Children in Conflict with the Law

Mental Health Objectives in Conflict with Legal Agendas

When children who have committed an offence come to the Observation Home, as per the rules of the Juvenile Justice System, they usually have a lawyer appointed for them. Children are almost immediately told ('brain-washed') by their lawyers not to admit to the crime they have committed, 'no matter who asks, no matter for what purpose' according to the OH staff reports. This is in the interests of them getting bail soon or going free, and so from a legal perspective, such methods may be perfectly legitimate. However, from a mental health perspective, the child's not admitting to the offence is counter-productive—unless the child admits to the offence, it is not possible to work on transformation through provision of psychotherapy. This has made providing therapeutic inputs in certain cases very difficult as children deny that they have committed an offence. Psychotherapy processes rely on acknowledgement of the problem or insight into one's problem as a first step to transformation—if acknowledgement of and insight into the problem are not there, there is no basis for behaviour change.

Likewise, certain other forms of justice, namely restorative justice views crime as more than breaking the law – it views the problem as causing harm to people, relationships, and the community. Consequently, it requires the harm to be repaired, for both parties (the law breaker and the victim) to discuss and resolve the harm caused, and for transformation to occur in people, relationships and communities—and this calls for transformation of the rule breaker. So, like mental health approaches and therapeutic processes, this form of justice is also based on the premise that the person who committed the offence must first acknowledge the harm done before he/she proceeds to repair it.

Legal processes and methods that are counter to mental health and transformation therefore will not be beneficial to the child or his future nor to society as a whole. Only legal processes that allow children to 'tell the truth' without fearing the consequences can be supportive of the mental health processes that need to take place for children to transform—and indeed, the essence of the Juvenile Justice System is to allow children a chance at life, to support them to change and be socially responsible well-adjusted citizens. After all, the main premise of placing juvenile offenders under the JJ system instead of within the adult criminal system is the belief that children cannot be put in the same category as adults under the Criminal Justice system of the country and given their physical and mental immaturity and dependence on others, require special provisions.

Child's Rights to Growth and Development Hindered by Unnecessary Legal Bureaucracy

It was observed that the Home also housed some younger children (13 to 14 year olds) who had been convicted for mild offence (theft). These children came from backgrounds of severe emotional abuse and neglect, with parents who were alcohol dependent and did not come to bail the children out. As a result, these children were in the OH for months on end, denied education and other opportunities that they could avail of if they are shifted to a care and protection home—which is where they should be considering their difficult family circumstances/ the inability of their parents to care for them. However, the legal bureaucracy persists, stating that it is 'unable to close the case' since the parents of the children do not show up in court; when asked what would happen if the parents never came and how long these children will continue to remain in the OH, the answer is 'until the case is closed', with no definite timelines on how soon this can happen.

There are many children who have committed far more serious offences than some of these children in the OH; however, they are not in the OH only because schools/ families/ communities have not (yet) complained about them. JJ processes should actually recognize the vulnerability of these children, the hopelessness of their families coming in to bail them out or indeed to look after them, and see them as children in need of care and protection; instead lengthy bureaucratic legal procedures are prioritized over children's rights, development and welfare.

Limited Opportunities for Children's Transformation

While the OH claims that there is a daily activity schedule, the Project team's observations show that children are not really engaged productively all day. The existing schedule is neither one that is concrete with activities that keep children busy all day, nor are the activities rehabilitative in any way i.e. there are no sessions to enable children to reflect on their offences, life skills sessions to equip them to do things differently in the future (and thereby prevent them from coming in conflict with the law again). There are dance classes twice or thrice a week and some inputs from NGOs who tell stories with moral values or engage the children in art activities. None of these are sufficient to enable children to work on behaviour

change issues. The NGO staff and others working with the children may be well-intentioned but they do not have the requisite training and skills to assess, understand and provide depth assistance to children in conflict with the law.

Consequently, there are continuous complaints about the children, who are expected automatically, without any skilled inputs, to change their behaviours. This transformation is expected to occur merely based on the fact that they are in the Observation Home—which then implies that being in the Home is a punishment, thereby suggesting that the JJ system follows a retributive system of justice rather than a rehabilitative one at least, let alone a restorative justice system. It is indeed unjust to expect that without any reflection or guided processing on what happened or how to cope in the future, children will simply change or 'behave better'—this is all the more so considering their vulnerability and difficult life circumstances and the resulting life skill deficits. The lack of opportunities for transformation will also only serve to increase rates of recidivism.

Barriers to Treatment of Mental Health Disorders

In addition to the above-described issues around navigating legal agendas in provision of mental health services and limited opportunities for children's transformation, mental health services face yet another challenge in the Observation Home, namely the use of medication to treat neuro-developmental disorders such as ADHD, and any other psychiatric disorder that might require pharmacological interventions.

The Juvenile Justice (Care and Protection of Children) Act, 2015 ***states****: 'AND WHEREAS, it is expedient to re-enact the Juvenile Justice (Care and Protection of Children) Act, 2000 to make comprehensive provisions for children alleged and found to be in conflict with law and children in need of care and protection, taking into consideration the standards prescribed in the Convention on the Rights of the Child, the United Nations Standard Minimum Rules for the Administration of Juvenile Justice, 1985 (the Beijing Rules),* ***the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990)****...*

United Nations Rules for the Protection of Juveniles Deprived of their Liberty—On Issues of Medical Care...

53. A juvenile who is suffering from mental illness should be treated in a specialized institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental health care after release.

54. Juvenile detention facilities should adopt specialized drug abuse prevention and rehabilitation programmes administered by qualified personnel. These programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug- or alcohol-dependent juveniles.

55. Medicines should be administered only for necessary treatment on medical grounds and, when possible, after having obtained the informed consent of the juvenile concerned. In particular, they must not be administered with a view to eliciting information or a confession, as a punishment or as a means of restraint. Juveniles shall never be tested in the experimental use of drugs and treatment. The administration of any drug should always be authorized and carried out by qualified medical personnel.

During the course of individual mental health assessment of children in the Home, some of them, especially those with ADHD were found to require medication. When the Project team made a request to be allowed to prescribe medications through legitimate NIMHANS medical processes and prescriptions, the

superintendent discussed the matter with the DCPO and other DWCD staff who agreed for the children to receive pharmacological treatment. However, the current (urban) magistrate on the JJ board refused to grant permission for this stating that while children in care and protection homes can be given medication the matter was 'different' for children in conflict with the law—that for the latter group, parents' consent was necessary, and that the state could not take responsibility for these children; and that because they were children who had committed offences, their parents might later accuse the Home/ state of giving medicines 'wrongly' to children and blame the authorities—'our child was fine before he came to this Home—he has become like this because you gave him some medicines.'

There are several problems with denying children in conflict with the law psychiatric medications when they require it:

- Allowing for children in care and protection but not for children in conflict with the law is clearly discriminatory and very much against the spirit of the JJ system.
- It is a violation of children's rights to health and to treatment when they are ill.
- Not allowing for treatment for mental health disorders such as ADHD will result in children's inability to make the necessary behaviour changes and to prevent recidivism.

4.4. Interventions in Children's Institutions: 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—Nirmala Shishu Bhavan, which is a shelter home for disabled children who are orphan and abandoned and Morning Star- a shelter home for disabled children.

Table 4(l): Group Interventions Provided to Children with disability, January- March 2016

Institution	Session Content	No. of Children	Age Group
Nirmala Shishu Bhavan	IEP planning for each child	5	8 -15 years
	Demo of activities and implementation of IEP in each session.	5	
	Demo of activities and implementation of IEP in each session.	5	
	Demo of activities and implementation of IEP in each session.	5	
	Demo of activities and implementation of IEP in each session.	5	
	Demo of activities and implementation of IEP in each session.	5	
	Demo of activities and implementation of IEP in each session. .	5	
	Demo of activities and implementation of IEP in each session.	5	
	Demo of activities and implementation of IEP in each session.	5	
	Demo of activities and implementation of IEP in each session.	5	
Total No. of Children Reached		5	
Total No. of Sessions		10	
Morning Star	Observation and understanding the Children's daily routine	20	
	Rapport building	20	

	Rapport building	20
Total Number of Children Reached		20
Total Number of Sessions		3
Grand Total Number of Children Reached		**25**
Grand Total Number of Sessions		**13**

A. Nirmala Shishu Bhavan

Home Schooling in the Institution:

It was felt that 9 of the children with functional loco-motor and intellectual abilities would benefit from attending school. 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. 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 Association for People with Disability (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 medical needs such as 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 care givers 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. The Project team felt that the schooling programme could be 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.

Programmatic Interventions:

The Project team prepared a step-by-step programme to implement the plan. The authorities have demarcated a room that is to be the school room. The Project team visits the Home once a week. Specific training sessions with the Home teacher started in November, 2015. 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. These sessions focussed on the teacher being able to differentiate between her role as a care-giver and her role as a teacher. While in the former role, how she could best serve the children such that their needs were taken care of was her primary concern, in the latter role she would have to be conscious of devising methods that facilitated an enhancement of their self-help skills rather than provide them with the help. In the December2015

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.

During this quarterly period, the teacher has been 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, speech skills, reading skills and writing skills.

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, the physical age, the 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.

IEP Implementation:

The next step was to put the IEP into practice. The teacher started with assigning activities to each child according to the current level in each of the 4 skill areas. At the end of the time period the teacher was to record her observations of the changes, if any, in that particular area. The progress made would serve as the current level in that area for the subsequent plan. For example, for a male child, 7 years approximately, with ID, physical and loco-motor disability, the current levels for fine motor skills described his grip and grasp ability as loose, wrist and finger movement non-directional. The child was asked to hold a piece of chalk and make visible marks on a slate. The goal set for this child in this skill area was 'to hold a piece of chalk/ pencil/ colour-stick firmly such that it wouldn't slip out of his grip when he tried to use it on any surface'. This activity was to be repeated till the goal was achieved. The time period set was one month. The teacher was to observe and note the progress made by the child, both when he was helped by the teacher and when he worked independently. Every time that the chalk piece/pencil/colour-stick, slipped out of his grip, the child was to be encouraged to pick it up and hold it again with minimal help from the teacher. To facilitate a correct hold, the teacher had to hand the piece of chalk/pencil/colour-stick, back end first, angled such that once the child got it in his grip, it would rest on the curve formed by the thumb and first finger. It was suggested to the teacher to use different writing materials and surfaces through the month. Secondly, it was suggested that the writing tool must be of a length that extends at least an inch beyond the thumb-forefinger curve and should preferably be thick. Moreover, the surface should be firm and held down.

Thus for each child, the IEP described the current levels in each of the 4 skill areas, set a goal to be achieved over a period of one month and described the activities and methods to be used by the teacher to achieve those goals. Then the teacher, with help from the project team member, made a list of the materials that would be needed to carry out the activities. For the fine motor skill lessons, materials like beading and string sets, building bricks, safe scissors, play dough, colour-sticks, glue-sticks, picture outlines, chalk, slate etc were suggested.

The teacher faces many challenges in practically implementing the IEP. While she has been able to identify the requisite features and plan the IEPs on paper, translating them into action poses several problems.

- **Access to materials:** Different materials like chalk, slate, colour-sticks, pens, pencils, building blocks, beading and stringing sets, books etc are needed for the implementation of the IEPs. While most of these materials are available in the Home, they may not be placed in the school room all

the time. Moreover, the books are not specifically identified for each child and so the teacher has to resort to random choices depending on the availability of the books for a particular lesson. Since the teacher has to spend time searching for appropriate material for each lesson, her time management is affected and the flow of the lessons disrupted. The Project plans to discuss the purchase of specific books with the Home staff i.e. a list of requisite books/ materials will be provided for procurement of the same.

- **Class Disruptions due to Visitors:** The home gets frequent visitors who come in to spend time with the children, celebrate birthdays etc. When this happens during the lesson time, the children get distracted. There is a plan to suggest that the Home structures its time so as to not interrupt classroom schedules and demarcate a time in the day (preferably afternoons/ evenings) for visitors/ celebrations—this will also enable children to have active opportunities to develop their social skills.
- **Differentiated teaching:** The teacher is still grappling with the difficulties of addressing the different needs of the children, in a given area, at the same time. Although her plan clearly states the activity to be done with each child in a particular area, while actually conducting the lesson, the teacher is not always able to execute the plan. Each child is heavily dependent on the teacher and they all demand constant attention.
- **Volunteers:** The Home gets many volunteers who come in to work with the children. In the absence of any structured volunteer activity program (and given that most of them do not have any special skills to work with disabled children) it is left to the different individuals to choose activities to do with the children. Most of the time such random activities are not according to the levels planned for each child as per the IEP and this might leave the child confused about that particular skill.
- **School Holidays:** On the days when the external school remains closed, the children from the Home who attend that school are incorporated in the Home school group. It becomes very difficult for the single teacher to manage this bigger group and her time is generally spent in managing behaviour rather than in teaching-learning activities.

Observations and Plans:

The Home schooling programme has been received very enthusiastically by the children. They look forward to the weekly sessions with the project team member. They have expressed a desire to have a school bell and school uniforms. They have named the school – Nirmala Shishu Bhavan School. They tend to get irritated when visitors come in and their activity is interrupted.

The teacher is cooperative and keen to follow a structured teaching-learning programme for the children. She needs to be supported to help her implement the IEPs more effectively:

- A set of books must be identified according to the reading level requirements of each child and placed in the school room.
- All the other materials required must be organised and placed in the school room.
- On the days that the external school children are also incorporated in the Home school group, the teacher needs another adult in the school room.
- If possible, the Home authorities must be persuaded to discourage visitors during the lesson hours.
- The teacher must be empowered to be able to moderate and supervise volunteer activities with the children.

Moving forward, the following plans have been made to better facilitate home schooling program at Nirmala Shishu Bhavan:

- The project team will make efforts to negotiate with the Home authorities to acquire the materials required and bring about systemic and other changes that would better facilitate the home School program.
- The teacher will be further trained to practically implement the IEPs. She will be supported in enhancing the differentiated teaching skills required for effective implementation of the IEPs through demonstration sessions and repeated practice under supervision.
- The program will be reviewed in October, 2016, through collated feedback from the IEP observations, the teacher the Home authorities and the Project team.
- Planning of the Home school program for the time period of November 2016 to April 2017 will be done after considering the outcomes of the review.

B. Morning Star

The Morning Star Ashram is home to about 45 individuals with severe to profound intellectual disability of ages from 10 years to 40 years. Many of them also have physical disabilities and hearing-speech impairments. There are 5 permanent staff members who multi-task in the roles of care givers, teachers and all service providers. A few volunteers pitch in from time to time. Many of the individuals, depending on their abilities, also participate in cleaning and care giving roles.

The NIMHANS project team, having initiated work in this agency towards the end of this quarterly, has made 5 visits till date. The first two visits were spent in orientation. The Project staff got information from the Home authorities about the routines and practice's followed there, the requirements of the individuals, and their ability levels in different areas. The 3rd and 4th visit was used for rapport building--time was spent with each individual to establish familiarity and methods of communication. Most of them respond to spoken language and some need gestures to facilitate language comprehension. Most of them responded favorably to gestures of friendship too. For the 5th visit the Project staff worked with 4 children in the age group of 11 to 14 years, doing an activity of matching colour and shape. She used a set of plastic fruits that are cut in half with pieces of velcro on one end of each piece. One half of a fruit would be held up, the colour and shape repeatedly emphasized and the child encouraged to find the other half. 3 rounds of matching were done with each child. Similar activities need to be practiced with the individuals to facilitate cognitive development. Further plans will be made as the work in this agency evolves, including facilitation of disability certification for individuals in the Home, with the assistance of the NIMHANS Dept. of Psychology.

5. Training and Capacity Building

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

In continuation of the training initiative conducted for child care institutions and Integrated Child Protection Scheme (ICPS)[8] Staff on child psychosocial care for children in difficult circumstances, a one-day training was provided on understanding children in conflict with the law. Attended by 19 child care staff, the session

[8] 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.

covered conceptual issues such as the basis of conduct problems in children, their trouble spots and life skills deficits, the factors that contribute to their vulnerability and skills for interventions with such children.

5.2. Completion of KHPT Secondment

The two staff seconded from agencies working with children in care and protection and children infected/affected by HIV completed their 3 month training on the Project. During the course of their secondment, they acquired theoretical learning on child psychiatric issues, including special issues such as child sexual abuse, dealing with loss/ grief/death issues in children, illness and disclosure issues in children with HIV, and conduct problems. They developed both individual counseling skills as group intervention skills, through field observation as well as direct work/ participation in Project activities. They have now returned to their agencies to continue working on child mental health issues there.

5.3. Orientation and Sensitization Program for School Teachers

As mentioned, the Project team began its services in Gottigere Government School with a brief orientation program for teachers. 14 teachers were oriented on child mental health issues. A basic understanding of children's learning problems was provided including causes of learning problems, ranging from intellectual disability to specific learning disabilities, ADHD and emotional/ behavioural problems in children. The teachers and the NGO staff were also briefed on the nature and type of project services--mental health assessment of children identified by the teachers followed by a 1st level response; feedback and inputs to the teachers and parents on how to support children with problems; remedial education inputs and support to the teachers for setting up resource rooms; life skills sessions to school children; referrals to NIMHANS for acute/ severe mental health issues so they may avail of medication/ depth therapy services; fast-tracking of referrals and disability certification for children with intellectual disability, SLD etc. The orientation was followed by a question and answer session to understand as well as address the teachers' concerns. The teachers raised many issues and challenges about dealing with the children, such as sexuality/ relationship issues, anger/ aggression, truancy, lying and stealing, disobedience. The Project team provided frameworks used to deal with such problems in children.

6. Material Development

As the Project provides services to various groups of children, materials are developed in order to ensure provision of systematic interventions. A range of materials have been developed, some of which have been completed and printed; others are either awaiting further piloting (for modification and revision) and/or art work/illustrations to be complete—all of which are work-in-progress. Below is a list of materials developed by the project (however, more materials are planned and will be developed over the next 6 months).

	Name	Target group		Type of Material	Themes
		Disorder/Problem	Age		
1	Getting to know you	Rapport building	7+	Card Game	Rapport building- part of the Life Skill Module
2	Monster and balloon game	ADHD, CD, ODD	6+	Board game	Anti social and pro-social behavior
3	Feelings Wheel/ Cards	Emotional issues	7+	Card game/ Wheel game	Emotional development, expression of emotions, rapport building- part of the Life Skill Module
4	Stories and Story	Different disorder	4+	Story narration and	Stand alone with various

	Stems			Story building	themes, others embedded in Life skill modules- themes such as Adoption, loss death trauma, Disclosure, Personal Safety/CSA etc
5	Life Skill Module- Emotional Development	Emotional dysregulation / Emotional expression and Emotional Development	12+	Written Modules with different Activities using methods such as, storytelling/building, role play, art etc	Trauma, Loss, Grief, Anger Management, conflict resolution, Empathy, Assertiveness etc
6	Life Skill Module- Sex and Sexuality(personal Safety/CSA)	Sex and Sexuality issues, CSA, Inappropriate sexual Behaviour	13+	Written Modules with different Activities using methods such as, storytelling/building, role play, art etc	CSA Prevention, CSA Trauma work, Relationship issues, Decision making related to romnce/ sex and sexuality.
7	Child Sexual Abuse (CSA)/ Personal Safety Prevention Module	CSA Prevention and Personal Safety	4-7 yrs	Written Modules with different Activities using methods such as body-mapping, storytelling/building, role play, art	CSA Prevention, CSA Trauma work
8	CSA Prevention Module	CSA Prevention and Personal Safety	8-12 yrs	Written Modules with different Activities using methods such as, storytelling/building, role play, art etc	CSA Prevention, CSA Trauma work
9	Movies	50 plus children's movies with different themes and issues in English/ Kannada/ Hindi	6+	Movies with different themes	Focusing on various themes like- Motivation, Loss trauma, Bullying etc
10	Home based Early Stimulation Flip Chart (Final Ready)	Home based Early stimulation for Children (English & Kannada versions)	0 to 6 yrs	Flip chart to guide Parents and caregivers	Early stimulation for children in the 5 domains of development.
11	Activity Book for Pre-school Children	Activity book (English & Kannada versions)	3-6yrs	Different types of Activities in 5 domains of development for pre-school children	Early stimulation for children in the 5 domains of development.

Also, some materials are stand-alone full modules and some of the games/ materials form parts of the life skills and other modules. Training materials (targeting various types of staff/ child care service providers) also being written up into manuals—not listed above. But they consist of basic counselling skills training/ child sexual abuse/ trauma/ loss/grief issues/ HIV-AIDS/ conduct issues…slides (in English) and training activities available.

Child Sexual Abuse Prevention and Personal Safety modules for Children

In addition to the Life Skills on Sex and Sexuality developed earlier for adolescents, during this quarterly, the project developed 2 Child Sexual Abuse Prevention and Personal Safety modules for younger children aged 5-7years and those aged 8-12 years. The concept of child sexual abuse needs to be introduced gradually and through varied related concepts. Hence a **Window Approach** was used wherein the module begins with understanding health and body issues, moving onto general safety and people safety, privacy and boundaries, before finally talking about sexual abuse, including what to do if sexual abuse happens[9]. These modules consist of around 16 activities (each) on various themes such as Body parts and functions, physical safety, safety from strangers and known people, maintaining privacy and boundaries, understanding sexual abuse. The project has piloted these modules in 2 institutions with 3 groups of children, making the necessary additions and modifications. Currently, the art work/ story illustrations are in process after which the modules will be completely ready for print and dissemination.

D. Operational Challenges

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

a) Arbitrary Cancellation of Permission to Work in Observation Home:

After a month's work in the Observation Home (with children in conflict with the law), the Project was abruptly informed by the OH superintendent to withdraw our services from the Home—according to her, this instruction was given by the JJ Magistrate, who said that *her* permission was not sought by DWCD for our team to work in the OH. No other reasons have been stated by her about why we cannot continue work there—nor was the instruction communicated as a written order.

This move by the JJ magistrate is surprising given that:

- The Project team had a meeting with her as we initiated services (10th March 2016)-- to inform her of our work with the children and convey that we had the DWCD's permission to do this. During this meeting, she had made clear her reservations and disagreements regarding mental health assistance to the children in the OH and her views about psychiatric problems being the basis of (some of) the children's offences. However, she also clearly stated that she had no problems with us continuing our work in the OH--but that she would not be taking cognizance of children's mental health issues or our mental health assessments in her judgements with regard to the children. At the time, for reasons not clear to us, she also instructed us not to put her views on record/ in written or quote her.

- The meeting at Capitol Hotel, Bangalore (20th February 2016) organized by DWCD and which addressed the need to respond to the problems of children under the JJ system--in which children in conflict were specifically mentioned, and several legal persons/ magistrates/ members of the Karnataka High Court Committee on Juvenile Justice and others serving on JJBs, were present.

- DWCD has selected the Observation Home in Madiwala as one of two model homes in Karnataka (the other is the Girls' Home, Davangere) .Dr.Shekhar Seshadri has been requested to be on the committee to work on developing this model home. It is ironic that he is on the advisory committee to provide psychosocial and mental health assistance to these children but is being barred from entering the Home.

[9] The sex and sexuality module developed for adolescents also uses the window approach but with two differences: i) one of the windows includes issues of consent and permission; ii) the focus, unlike for children, is also very strongly on decision-making skills in issues relating to love/romance and sexual behaviour (risky sexual behaviours).

The lack of awareness of child rights and mental health issues on the part of the JJ Board is disturbing, not the least of which is the arbitrary nature of decision-making and instruction. In order to solve the problem, the Project has approached and sought assistance from both, the Principal Secretary DWCD as well as Justice Hinchigeri, Judge, Karnataka High Court and Chairperson, Karnataka High Court Committee on Juvenile Justice. We are hopeful that once the permission problems are solved, the team will be able to return to providing the much needed child & adolescent mental health services in the OH.

b) Challenges Assisting Trafficked Children in the Government Home

As already described in the section on children with gender and sexuality vulnerabilities i.e. children rescued from sex trafficking, there were various systemic barriers to providing psychosocial assistance, particularly in the Government Girls' Home. The apathy and ignorance of the superintendent and staff, their unwillingness to give the child prescribed psychiatric medications and their overt acts of verbal and emotional abuse made it difficult to provide services in the Home. The Project team discussed these concerns with the District Child Protection Officer (DCPO), Bangalore Urban and with the ICPS Project Director/ DWCD; however, none of these officials have taken the necessary action towards their staff, in support of child rights to health and psychosocial assistance.

E. Plans for the Next Quarterly Period, April to June 2016

- Continue individual assessment/ first level response in the Observation Home, for children in conflict with the law; initiate group work services in the Home.
- Initiate psychosocial and mental health services at Dept. of Pediatric Oncology, Kidwai Hospital for cancer affected children.
- Development of materials:
    - Documentation of first level responses in schools.
    - Completion of art work and illustration of stories for personal safety/ child sexual abuse as well as those for children infected/ affected by HIV.
    - Initiate piloting of Life Skills Series part II on sex and sexuality issues, for adolescents.
- Continue remedial education work in government schools as they re-open in June.

Annexe

Service Provision Sites

I. Schools, January to March 2016

	Name of the school
1	Govt. High School- New fort
2	Govt. High School- Hombegowda
3	Govt. High School - Sarakki
4	Govt. Urdu High School – Tank garden
5	Govt. High School - Gottigere
6	St Mary's Higher Primary school- Chamrajpete

II. Primary Health Care Centers, April 2015- March 2016

	Name of the Primary Health Care Centers
1	J.P.Nagar Primary Health Care Center
2	Kumarswamy layout Primary Health Care Center
3	Yarabnagar Primary Health Care Center
4	Banashankari Primary Health Care Center
5	C.T.Bed Primary Health Care Center
6	Vidyapeeta Primary Health Care Center
7	T.R.Mills Primary Health Care Center
8	Avalahalli Primary Health Care Center
9	Bapuji Nagar Primary Health Care Center
10	G.G.Halli Primary Health Care Center
11	Wilson garden Primary Health Care Center
12	Koramangala Primary Health Care Center
13	Adugodi Primary Health Care Center
14	Madiwala Primary Health Care Center
15	Tavarekere Primary Health Care Center
16	N.S.Palya Primary Health Care Center

III. Anganwadis, April 2015 – March 2016

	Name of Anganwadi
1	E Stop Anganwadi
2	Kaveri Nagar Anganwadi 1
3	Kaveri Nagar Anganwadi 2
4	Kaveri Nagar Anganwadi 3
5	Kaveri Nagar Anganwadi 4
6	Ambedkar Nagar Anganwadi 1
7	Ambedkar Nagar Anganwadi 2
8	Srinivagilu Anganwadi
9	Ejipura Anganwadi

10	Indragandhi Slum Anganwadi
11	Maduramma Colony Anganwadi
12	Madeena Nagar Masjid Anganwadi
13	Old Madiwala Anganwadi
14	New Madiwala Anganwadi
15	Bovi Colony S.G.Palya Anganwadi
16	Bismillanagar Anganwadi
17	Gurappana Palya Slum Anganwadi
18	S.G.Palya Anganwadi
19	J.P. Nagar Anganwadi
20	Rajarajeshwari Slum Anganwadi
21	Sanjay Nagar Anganwadi 1
22	Sanjay Nagar Anganwadi 2
23	Janashakthi Nagar Anganwadi
24	Srinagar Anganwadi 1
25	Srinagar Anganwadi 2
26	Bapujinagar Anganwadi 1
27	Bapujinagar Anganwadi 2
28	Bapuginagar Anganwadi 3
29	Shamannanagar Anganwadi
30	Pantharpalya Anganwadi 1
31	Pantharpalya Anganwadi 2
32	Arundathinagar Anganwadi
33	Chandralayout Anganwadi
34	Ananth Nagar Anganwadi
35	Devagowda Slum Anganwadi
36	Arfath Nagar Anganwadi 1
37	Arfath Nagar Anganwadi 2
38	Baterayanpura Anganwadi 1
39	Baterayanpura Anganwadi 2
40	Maruthinagar Anganwadi
41	Nayan Halli Anganwadi 1
42	Nayan Halli Anganwadi 2
43	Gondanahalli Anganwadi 1
44	Gondanahalli Anganwadi 2
45	F.A.Nagar Anganwadi 1

IV. Child care Institutions, January 2016 – March 2016

Children in need of Care and Protection (Incl. Gender & Sexuality Vulnerabilities)	
	Name of the Institution
1	Govt. Boy's Home
2	Govt. Girls Home (especially in the context of sex trafficking)
3	ANC Rainbow Home- Chamrajpete
4	ANC Navajeevana - Chamrajpete
5	ANC Navajeevana - J.J.R.Nagar
6	BOSCO Vatsalya Bhavan- Chamrajpete
7	APSA
8	BOSCO Rainbow Home – Wilson Garden
9	Makkala Jeevodaya
10	Ananya Foundation
11	St Mary's Institution for Girls - Chamrajpete

Children with Disability	
Sl no	Name of the Institution
12	Nirmala Shishu bhavan
13	Morning Star

Children in Conflict with the law	
14	Govt. Observation Home - Madiwala