Preliminary Rapid Assessment of

Child Psychosocial & Protection Services in Kashmir

- Sheila Ramaswamy
Community Child & Adolescent Mental Health Service Project
Dept. of Child & Adolescent Psychiatry, NIMHANS

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1. Background

Increasing reports of incidents of child abuse in various parts of the country, including most recently in child care institutions, have propelled government and non-government agencies to intensify their child protection efforts and re-examine their programs and strategies. With this imperative has also come the understanding that issues of child protection are closely linked to child mental health: that both the causes and consequences of child maltreatment and abuse are linked to children's psychosocial contexts and experiences.

Given the extensive experience of the Dept. of Child & Adolescent Psychiatry, NIMHANS, particularly through the Community Child & Adolescent Mental Health Service Project it has been implementing over the past nearly 5 years, not only in Karnataka but in different states of the country, and the Project's recent advice and inputs to UNICEF on child and adolescent mental health issues in their child protection programs, UNICEF is keen on partnering with NIMHANS to initiate a Centre for Child & Adolescent Psychosocial Care and Protection.

While this initiative might take some months yet to materialize in full, they have requested Dept. of Child & Adolescent Psychiatry, NIMHANS to conduct a preliminary assessment in 4 states in India (Uttar Pradesh, Jammu & Kashmir, Jharkhand and Bihar) to examine the needs and gaps, both systemic and skills & capacities-related, in child protection and mental health systems, namely through meetings and discussion of the following systems and personnel:

- Child Welfare Committees & Juvenile Justice Boards
- Government Integrated Child Protection Scheme (ICPS staff)
- Relevant personnel from the Dept. of Women & Child Welfare
- Community-based organizations implementing child protection and psychosocial programs
- Tertiary care child mental health facilities (government medical colleges etc).

While some states were selected due to their large and vulnerable child populations (i.e. high burden states), Jammu and Kashmir was selected as one of the priority states for assessments and intervention due to the situation of on-going armed conflict and the adverse impact that this has had on child mental health and protection issues. Like elsewhere in the world, the armed conflict in Kashmir happens in and around communities. As a result, communities suffer huge damage, such as loss of homes, schools, livelihoods, health facilities, and other infrastructure. Since the late 80s, generations of children in Kashmir have grown up in an environment of violence, which has become a part of their day-to-day lives. Due to the on-going insecurity and conflict, the state infrastructure has also been struggling to provide routine and specialized services to address the developmental, psychosocial, mental health and protection needs of children.

2. Objectives of Preliminary Rapid Assessment

The purpose of this brief rapid assessment was NOT, or at least primarily not, to assess children's psychosocial, mental health and protection needs. In the course of the assessment, while common protection and mental health concerns of children have emerged, the specific objectives were to:

- To mapthe types of psychosocial care and protection services available to children at primary, secondary and tertiary levels.
- To understand the nature and extent of the skills and capacities of the service providers who implement child protection and mental health programs and services in the state.
- To identify the gaps as well as opportunities that exist within the state child psychosocial care and protection system, so as to be able to define areas for training and capacity building.

3. Methodology

Qualitative methods, primarily entailing observation and interviews were used in the child mental health/protection service settings. Services located at primary, secondary and tertiary levels providing either child protection or mental health services were visited over a period of a week (as listed below). Based on the difficult security conditions, and on the Kashmir UNICEF team's advice thereof Srinagar and districts nearby were selected for the visits.

Primary Level	Child Friendly Spaces	Shopiyan, Srinagar
	Child Welfare Committees	Srinagar, Pulwama
Secondary Level	District Mental Health Program	Pulwama
	District Early Intervention Centre, G.B. Pant Pediatric Hospital	Srinagar
Tertiary Level	Child Nodal Centre, Institute of Mental Health & Neurosciences	Srinagar

Detailed interview schedules were developed for each type of service and used accordingly, to the extent that the questions were applicable. (Refer to annexe for the schedules). The information gathered was recorded as field notes, organized into themes and briefly analyzed to be able to make recommendations for further intervention and training/capacity building.

Note: Although interviews were scheduled with the Juvenile Justice Board also, a sudden deterioration of the security situation in Kashmir, did not allow for this interview to be completed.

4. Observation and Interview Findings

4. 1. Child Friendly Space

(a) CFS Activities

Children of all ages, ranging from 3years to 17 years come to the CFS. The activities of the centre are facilitated by an animator. Upon arrival, the children all gather together and recite some prayers; then, they sing rhymes and songs in English and Kashmiri. After this, the children are engaged in art and craft activities and sports, games and free play depending upon their individual interests and choices.

(a) Parents and Community Leaders

One of the major concerns of community members is how children are adversely impacted by activities of militancy. They say that children often hear and see things in their environment that they then emulate, for instance, stone-pelting. Even young children (below 10 years of age) are now beginning to participate in stone-pelting because they see adolescents and youth engage in such activities. The community is concerned about the dangers of engaging in stone-pelting i.e. children get hurt, and become victims of pellet injuries too. They want, instead, for their children to receive an education and grow 'normally' to be respectable citizens.

They report that when there are security issues in the district, such as military activities and Cordon and Search Operations (CASOs), children do not eat and sleep properly and are constantly fearful. Schools remain shut and the children tend to be out on the streets and at great risk of engaging in stone-pelting. [Schools and colleges remain shut a lot of the time due to the difficult security situation].

The community members feel that the CFS has been of great benefit to their children and families, in the following ways:

- When there was no CFS, children did not know much about hygiene and cleanliness, which they have now learnt; they have also learnt *'tameez'* and respect for elders since coming to the CFS.
- Although officially the CFS is meant to run two days a week, when there are security issues and strikes and schools shut down, the CFS remains open. So, there is at least somewhere for children to go, be safe and do play—and therefore stay off the streets and away from dangerous engagements such as stone-pelting.
- It is observed that since the CFS was started, fewer numbers of children take to the streets and engage in stone-pelting. Before the CFS started, children were often outdoors, looking out for the military and also joining older adolescents, youth and adults in stone-pelting.
- Behaviour change has also been observed in children in relation to cleanliness and better social interactions.
- Children do activities in the CFS that they are unable to do at home (due to the lack of availability of play materials and equipment)—for instance, they engage in many sports activities at the center. They are also engaged in 'moral education', mainly recitation of Koranic verses.

- Parents are less worried now, especially when schools are closed because they feel reassured that if the children are at the CFS, they are not wandering in the streets or participating in stone-pelting activities. Before the CFS started, they were continually anxious about the whereabouts of their children, particularly fearful that they may have got involved in some security incident involving the army and/or militants.
- Most parents in the South are from low income groups and are engaged in farming and labour(such as working in apple orchards). As such, they have very little time to spend with their children and play or teach them things. So, they have found that the CFS has been useful in engaging children during their absence through the day.
- Parents have also learnt about children's issues from sessions held for them at the CFS—they now know about child rights and issues relating to child (physical and verbal) abuse.
- Mothers come to the CFS and have opportunities to talk to each other and other people, thereby taking their mind of their many stresses, they also feel happy when they see their children in the CFS, knowing that they are safe and engaged/ enjoying play activities.

One member of the community, however, also spoke however, about the limited impact that the CFS alone could have given that children have been socialized in certain ways, for years by their families and that they spend the bulk of their time outside the CFS, in the community; and that the influences of the community, especially with regard to the conflict, were likely to continue to impact children adversely. He also said that given that the southern communities were heavily engaged in agricultural and horticultural activities and that parents had limited time to engage with children; he also said that thus far the parenting component in the CFS sessions had been relatively small.

(b) Mobilizer and Volunteer Perspectives on CFS

Basic Needs

The CFS staff said that education was one of the major needs of children in the southern communities. While there were many families in the district who were poor, working in agricultural labour, food was not in shortage i.e. in general children have access to food. Health care access tends to be difficult as the district primary healthcare centre is closed most days (due to the poor security situation). The District Hospital was reported to be about 5 kms from the communities surrounding the CFS, but not always easy to access due to security problems and curfews. The Integrated Child Development Scheme program is not properly functional in the southern districts, with the anganwadis closed most times. This is because there are lack of food supplies and the anganwadis are only able to, at times, give biscuits to children i.e. meals are not provided. Therefore, young children (between ages 3 and 6 years) do not go to the anganwadis as they are unable to avail of any nutritional supplements and/or schemes that the Government has made provisions for.

Child Protection Needs and Concerns

Stone-pelting is viewed as a major risk, primarily for boys. It results in the military picking up these children and adolescents and placing them in detention, in police stations; where the army uses force against children engaging in this activity, through use of pellets, children are badly injured, even visually impaired by the pellets.

Another risk is domestic violence and child abuse that takes place within homes and families, due to parental marital conflict and other family-related problems. However, there are no reports of child sexual abuse (CSA). The CFS staff feel that this is not because CSA does not occur but because it is not reported due to the stigma associated with sexual abuse. In fact, CFS staff stated that they see communities' silence around the issue of CSA as a major risk i.e. it will simply not come to light because people are in denial that it happens and do not wish to report if it does. When awareness programs on CSA are conducted by CFS staff, they report that parents and community members respond with silence and passivity i.e. they listen to what is being told to them but do not engage in any discussions on the issue. But where physical abuse, domestic violence and corporal punishment are concerned, communities are more willing to engage in awareness programs and discussions, possibly due to less stigma attached to these issues.

Planning and Implementation of Activities in CFS

The CFS serves children between ages 5 and 15 years (although younger children also come to it). It is open on Fridays and Sundays, nearly all day; it is also open on days when there are strikes and schools are closed, so that children are occupied and have somewhere to be.

Activities such as volleyball, carom, chess and indoor games taught to the CFS staff by Play for Peace NGO are conducted. Traditional games and activities such as stone painting, hopscotch and paper art are also taught to the children. Hygiene education is conducted at the centre—to teach children hand washing, toilet use, environmental cleanliness, menstrual hygiene (for girls), bath and nail hygiene. Children are also taught about values and morals, including etiquette and politeness.

In general, children decide (on a day-to-day basis) what games and activities they wish to engage in on any given day. There are no major differentiations made in activities based on children's ages—'everyone plays everything'. No specific life skills sessions are conducted for adolescents.

Referral

The CFS staff do not refer children to the child welfare committee for protection issues nor to any healthcare facilities in case of emotional and behavioural problems. In case they observe any behavioural or protection concerns, they report to the CFS counsellor, who develops a report for the child and makes a referral to the coordinator. The coordinator then refers the child to the ICPS, Dept. of Social Welfare or DEIC as required, depending on whether the problem is financial or psychosocial in nature.

Challenges

The CFS staff report that it was challenging to establish CFSs in communities. They said that since Kashmir did not previously have a history of non-governmental organizations being present in and assisting communities, and given the political insecurity, there is a general lack of trust when an agency comes to a community to start a new initiative. As a rule, Kashmiris do not easily trust ‘outsiders’. There were also rumours that CFSs, because they were being funded by UNICEF, were aiming at conversion of people to Christianity. Due to this, when the CFS tried to introduce games such as carom or chess to children, members of the community (including school principals) have even attempted to stop children from attending the CFS—because they felt that such activities were not in keeping with the religious beliefs of Islam.

Another challenge they reported was that when the CFS has tried to initiate discussions with community members on physical abuse and domestic violence, community groups become silent and passive i.e. they are not responsive or participative in such discussions. Communities are neither willing to accept nor report incidences of child abuse. The culture of silence and denial that surrounds sensitive issues such as violence, make it difficult to create awareness amongst parents on issues of child abuse. In such a context, it is near impossible therefore to discuss child sexual abuse.

The CFS staff reported that they have had to use intensive community mobilization strategies to overcome some of the challenges. For instance, a year ago, when they were attempting to establish the CFS, they contacted and spoke with leaders and other influential persons in the community, to ask for space to set up; they got local community members on their Board, visited each family to inform them about the centre, its timings and purpose and encouraged parents to visit the centre to see what activities were conducted there. Such strategies were adopted to gradually gain the trust of the community so that they would be willing to send their children to the CFS.

A final challenge reported by the staff pertains to the uncertainty that surrounds the continuation of the CFS. At the time of assessment, for instance, they reported not having received their salaries for the past four months; they were also concerned as to whether and how to develop an exit strategy in case the CFS project was discontinued—the project was to end by the last day of May 2019 and they had not received any information from the relevant agencies/ authorities on closure nor on continuation. Such uncertainty, they said, impacts their work—also because they fear that if they have to close suddenly, it would be unfair to do so without due notice to the community and the children; and that it would also be a waste of all the efforts they had put in to establish and successfully run the Centre in a community where trust is not easy to develop.

Benefits and Opportunities Presented by CFS

The CFS staff report that they have had feedback from parents that children who had emotional and behaviour problems, such as demanding behaviours, at home, are now better i.e. that children’s demanding behaviours have reduced because they have access to play materials and activities at the CFS. They also report that children have less anger issues now than before when the CFS was not in existence. The staff attribute this to the fact that parents spend long hours working (in orchards/ fields) and children were therefore unable to get to spend time with them; however, after psychoeducation by the CFS on the importance of spending time with children and the fact that children receive adult attention at the CFS, possibly children feel less upset now.

4.2. Child Welfare Committees (CWCs)

The CWCs in Kashmir are a relatively recent addition to the child protection services in the state. They were constituted less than two years ago and are still therefore in the process of understanding their roles and how to implement them in the context of child protection and Kashmir.A unique feature of the Kashmir CWC is that it functions under the High Court Juvenile Justice Committee (as opposed to under the Dept. of Women & Child Development or Social Welfare, as happens in other Indian states). Although the CWC remuneration is provided by the Dept. of Social Welfare, the High Court JJ Committee supervises the CWCs' work; there is also an amicus curiae appointed by the Chief Justice of the High Court to look into the needs of the CWC.

Referrals& their Contexts

The CWC reports receiving referrals from Childline, Anti-trafficking and local NGOs.They also receive referrals, particularly at the district level, from the DCPO, Social Workers and Outreach Workers of the DCPO (who work at field and community levels) and through anti-child labour drives and social media reports. These drives conducted by members of the CWC and the DCPO's staff seem to be unique to the Kashmir context—they entail visits to public places such as markets and observation of children i.e. to see if there are children working in hazardous occupations. The CWC members also visit places like industrial areas, mechanics shops and *'dhabas'* where vulnerable children are likely to be found at work. There, they warn the employers to stop employing children; and the children themselves are assisted by the CWC through schemes such as sponsorship and financial aid to orphan or disabled children or children belonging to families whose income is less than Rs.2400/month. Children often come into child labour from outside states, namely Bihar, UP, Rajasthan and even Bangladesh,

The contexts of referral are missing children, children who are victims of violence (by parents), child physical and sexual abuse, human trafficking, child labour, begging, rag picking, and substance use. Over a period of a year, the Srinagar CWC has restored 20 children to other states in India and 3 to foreign countries. On an average the CWC sees about 15 to 20 cases per month, through daily sittings.

Assessments and Intervention

One CWC said that the way they conduct assessments of a child who appears before them is to 'develop rapport with the child', 'by being friendly' and calling the counselor to conduct a preliminary session with the child. They state that they are able to recognize the mental health needs of a child by 'observing the behavior of the child'. In case they feel that a child has mental health issues, they refer him/her to IMHANS, Srinagar.

Another CWC said that the social investigation was conducted by the DCPO staff, namely the social worker. And once the CWC are able to understand the problem from the social worker, they also interview the child, 'making [him/her] comfortable' and calling for the parents. They inquire of the child, for instance, why he is begging/ whether anyone told him to do it/ offered any rewards. In case of child abuse, they ask about 'the situation' and how long it has been happening. Their response to the child is 'it will not happen after today' (particularly in the context of physical abuse at school). They then call a professional to 'do the counseling' with the child. In case of physical abuse by the school, the CWC calls the school to sensitize the teachers—they essentially tell the school that if the abuse continues, then it will cost the school their registration and the school will have to pay a fine.

One CWC gave an example of their intervention in the case of a young child who was expelled from a school: the child had lost his mother and also been physically and emotionally abused by the school, due to which he refused to go to school. He reported stomach aches and headaches daily and would not go to school, after which the child was expelled. The CWC fined the school and gave the money paid by the school to the child's family to pay his expenses for a school change.

The care plan they develop includes interventions for health, education, co-curricular activities and also includes the physical and emotional aspects of the child's life, they state.

Challenges

Case that the CWC finds difficult to handle pertains to child custody in the context of parental marital conflict and divorce and those of child sexual abuse. The CWC also reported that they found it difficult to do their work in cases of police interference and involvement. They feel that the police are not skilled or trained to work with children and use ways of questioning and inquiry that are unsuitable to children. They state that the SJPU is not present in many places; and where present the SJPU are neither skilled nor trained. The CWCs also believe that the police 'recognizes [the authority of]' juvenile justice boards but not of the CWCs and that they have little understanding of the CWCs' role and functions.

One of the most challenging contexts of work for the CWC is illegal detention of children in the police station. When this happens, parents come to the CWC and when the CWC contacts the police station, the police do not admit to have the concerned child at the station. What might even be several days later, the police write to the JJb to say that they have a child with them over the past 24 hours and then produce the child before the JJB (by this time a charge is also laid on the child). The most common charge is stone-pelting; however, even if a child has not directly participated in stone-pelting activities and has been a mere by-stander, the police pick up the child and hold the child for a period of ten to fifteen days after which sometimes they take money (bribe) from the child's parents and then release him. Parents are willing to pay off the police in order to avoid an FIR against the child. Such cases, many in number, are extremely challenging for the CWC to deal with—the committee report feeling powerless because not only are the police not aware of the role and function of the CWCs but they are also unwilling to cooperate on children's issues.

Furthermore, the CWC reported that the SJPU charge in a police station is often an additional charge for the concerned officer, who therefore has priorities other than children or SJPU duties. It is also the SJPU that has the authority to release children who are apprehended by the police but often the decision of release is made by Senior Superintendent of Police (SSP). The police also engage in severe forms of physical abuse against the children they pick up for participating in stone-pelting; the Special Task Force also interrogate these children who are picked up and detailed—asking them again and again, along with use of physical violence, who was behind the stone-pelting activity.

Another difficult context of child work mentioned by the CWC was that pertaining to when tear gas shells are used by the police at the time of rioting or disturbances in the community. Children are especially affected by tear gas shelling, they report, and cry all the time, and have to undergo the trauma of hospital referral. This is a common and recurring issue and the CWC feels the need to have skills to assist children affected by tear gas shelling.

Other challenges include paucity of staff and infrastructure to support CWCs' work and the security risks to the CWC when they go on drives in the community. Employers and others who abuse children tend to threaten CWC members and the police do not provide the CWC with security support.

The CWC also said that they do not have an appropriate system to refer children for severe mental health issues such as substance abuse (The one de-addiction centre that is located in Srinagar is run by the police and so people are reluctant at times, to avail of services there). They have also attempted to refer children with speech and hearing impairments for receipt of assistance from the state JJ fund, for implantations, but they are frequently faced with non-response from the Directorate of ICPS. They are unaware of any other places to refer children to and generally do not do so.

Training Needs

Thus, far the CWCs have had very limited training for the work they are doing. They have only attended a 4-day workshop on child abuse, which focused exclusively on the legal aspects of abuse. The members feel the need for capacity buildingand suggested the following areas for training:

- To be able to use a format for assessment, that contains open-ended questions.
- In addition to skills to conduct assessments, there must be training on child interviewing skills and techniques, including on how to develop a rapport and relationship with a child (because children can take a long time to talk or tell).
- A practical component of being able to observe other CWCs i.e. in other states, so as to learn procedures—as those CWCs have been functioning for much longer period.
- Training on specific areas of child work i.e. technical knowledge on children's vulnerabilities.
- Training on how to monitor child care institutions.

They also recommended that training programs for the CWCs should be conducted in smaller groups, in order to allow for depth work and skill building (rather than programs that cater to large groups and so tend to become very general in nature).

4.3. District Early Intervention Centre (DEIC)

The DEIC visited was located at the G.B. Pant Hospital within the Dept. of Paediatrics, under Government Medical College in Srinagar. It serves a huge catchment population, drawn from all over Kashmir, because it is attached to a specialty pediatric department that serves the country.

Functioning and Types of Cases Received:

The paediatric department is a feeder to the DEIC, referring many cases both of developmental disability as well as emotional/behavioural disorders to the centre. The Centre also provides financial assistance for hearing aids and other health-related issues as per the list of 30 diseases that fall under the Rashtriya Bal Swasthya Karyakram (RBSK) scheme (and under which the DEIC is established).

The types of cases received at the DEIC are:

- (Neuro) developmental disability-related issues such as Down Syndrome, Cerebral Palsy, Intellectual Disability, Specific Learning Disabilities, Autism and Attention Deficit Hyperactive Disorder (ADHD).
- Visual, hearing and other sensory issues with or without psychiatric co-morbidities.
- Dental issues in children with disability
- Speech problems, including articulation issues and voice disorders
- Psychiatric problems such as Conversion and Psychosomatic Disorders, Anxiety and Obsessive-Compulsive Disorders, Mood Disorder, Pica.
- Emotional problems relating to bullying, post-traumatic stress disorder and breath-holding spells (in young children).

Over the past nearly two years, this DEIC has received about 850 cases pertaining to child and adolescent psychiatric issues and an additional 2194 cases relating to speech, audiology, physiotherapy and dentistry issues in children. Therefore, this DEIC, unlike many others in the country, is not limited to dealing with developmental disabilities; it receives and treats a variety of child and adolescent mental health problem cases also. Consequently, this DEIC, although intended to be a secondary level facility, functions as a tertiary care facility—due to its location and catchment population. The psychiatrist from the IMHANS UNICEF Child Nodal Centre visits the DEIC and consults here once a week (which the head paediatrician considers to be inadequate, given the number and types of cases they receive). The presence of the psychiatrist is in fact drawing more families and children to the Centre.

Facilities and Staff

The DEIC has a large, open and airy space that is truly conducive to child mental health work. It has been set up (to the extent possible/ as much as current resources will allow) in accordance with the RBSK guidelines to establish DEICs. Much effort has been made to give it a child-friendly appearance, including the initiation of a play area and a sensory stimulation room. Dental and speech and audiology rooms are also available. The Centre is currently in the process of seeking government funding to develop further play room and sensory stimulation room infrastructure.

Upon request by the DEIC staff, for further suggestions to improve the facilities, the NIMHANS resources provided inputs on how to develop the sensory stimulation room (including what types of materials to have/how to organize them), further development of the play area with the establishment of sand and water play equipment, and the need to set a play therapy room.

The DEIC is managed by a paediatrician from G.B. Pant Hospital. Other staff includes the psychiatrist (who visits weekly), a clinical psychologist, speech therapist, special educator and other administrative staff.

Staff Training

The paediatrician who heads the DEIC is keen to develop this facility into a model centre for the state, and also take on training of other DEICs in the state. However, so far, the staff from this centre have received no training and he is anxious for them to also receive training, particularly to avail of any upcoming training opportunities at NIMHANS.

4.4. District Hospital Services

(a) District Mental Health Program (DMHP)

General Overview of District Mental Health Facilities and Services

The state of Jammu and Kashmir has 4 medical colleges (3 government and 1 private), each with a department of psychiatry. The state is divided into 3 regions: Jammu, Kashmir and Ladak. Kashmir has a consultant psychiatrist post in every one of its 10 districts, through the Health Department. However, out of 12 posts, only 4 have been filled—in Pulwama, Badgaon, Baramullah and Anantnag. The government has also sanctioned 2 new medical colleges in Baramullah and Anantnag, with two psychiatrists, who have started out-patient services there. In other districts, of Kulgaon and Kukwara, 3 Medical Officers in the Primary Health Care Centres are working as psychiatrists. Districts such as Shopiyan, Bandipora and Gandharbal are not covered by psychiatric services.

The District Mental Health Program (DMHP) is currently running in 4 districts in Kashmir, namely, Pulwama, Gandarbal, Kulgaon and Bandipura. They started in 2016-17. The challenge has been to recruit psychiatrists at district level as the government is willing only to pay Rs.50,000 despite recommendations to pay Rs.1 lakh, based on the Karnataka model. Therefore, the number of psychiatrists in the Kashmir DMHP is low. Like other DMHPs in the country, each team is staffed (in addition to the psychiatrist) by a social worker, clinical psychologist, psychiatric nurse, program manager, record keeper and data entry operator. In Pulwama, it is the strong support of the psychiatrist that is enabling the DMHP to be functional.

Cases and Context

It was observed in the Pulwama DMHP (and corroborated by the psychiatrist there) that most patients accessing out-patient mental health services were women; apparently this is true for other medical services also. In fact, there was a huge crowd of women, standing squashed within a room, one behind the other, with the psychiatrist seated at a table, at the end of this line. He was almost single-handedly dealing with what seemed to be about 50-odd women seeking mental health services. On an average, the out-patient service receives 150 to 200 patients per day[1].

Women access mental health services for depression, anxiety and somatization—most of which they suffer as a result of the on-going conflict and insecurity situation in the state. According to

[1]According to the Kashmir Mental Illness Survey 2015, 45% of the Kashmiri population is under psychological stress, with 9% of the population depressed at any given point in time; depression levels are double those of national figures.

the psychiatrist, women are over-represented as they tend to play pivotal roles within families, also being greatly affected on a day-to-day basis by the security situation and the implications it has for other family members. For instance, if a woman's husband/son leaves for work early morning, she is worrying all day, wondering if they carried their IDs, whether they will return home safely…Thus, they are constantly exposed to stress and since they are mostly at home, to CASO attacks.

The proportion of child cases that come to the DMHP are relatively low—only about 10% of the total caseload is children. Children under age 10 years only form 3 to 4 % of the caseload and while some of them have anxiety and depression, others avail of services for ADHD and intellectual disability. Conduct Disorder is relatively less common. [This approximation is only for Pulwama DMHP and not representative of other DMHPs]. It was reported that children present with low mood and palpitations—similar to adults.

Adolescents present with anxiety, depression and substance use. The psychiatrist reported that while many adolescent cases present with loss of consciousness and other conversion/ dissociative symptoms, the DMHP does not make a diagnosis of dissociative disorder. Instead they make a diagnosis of a 'primary psychiatric disorder such as depression, anxiety or bipolar disorder' because dissociation is viewed by them (he stated) as a personality disorder or as a manifestation of other primary psychiatric disorders; dissociation is not viewed as a primary disorder in itself. The psychiatrist also said that if one focuses on conversion symptoms, adolescents are likely to receive secondary gains and so the symptoms are likely to intensify.

Child sexual abuse is occasionally seen by DMHP and also physical abuse, although that is seen to a lesser extent now, according to the DMHP psychiatrist.

Assessment Protocols

No standard protocols for assessment of children and adolescents are used by DMHP-- they simply write their notes on blank paper. The DMHP only uses a protocol for implementing clinical assessments and history-taking for adults. They use the Patient Health Questionnaire (PHQ-SADS) for adults. This is a standardized questionnaire developed to reflect that most primary-care patients with depression or anxiety disorders present with somatic complaints and is used in primary care settings, mainly for screening purposes.

Intervention Methods

Where children have depression and anxiety-related issues, they are treated using pharmacotherapy (prescriptions for SSRIs are provided by the psychiatrist) and the social worker or the MSF counselors are asked to provide inputs. About 20 to 25 minutes are spent with the social workers who said that no specific inputs are provided except some 'supportive work' in severe cases. The team said that sessions were done for the family (but no description was provided of what inputs are provided in these sessions). De-sensitization techniques with gradual exposure to whatever children were fearful of/ traumatized by (such as graveyards or areas of encounter) are also used.

In some instances, the DMHP alsosaid that they sensitize teachers, telling them not to rebuke children as children can then get into depression. Following such sensitization, teachers have brought children to be assisted by the DMHP. They also conduct various sensitization programs in the community to educate the public about symptoms of depression, anxiety, headaches; and also on adolescent issues related to physical and emotional abuse. [Early childhood development issues are not covered]. Referrals are made to IMHANS, Srinagar for children, as required.

Training

The DMHP itself engages in training of medical officers in PHCs on how to manage primary psychiatric disorders. They reported that IMHANS is slated to train the DMHP and primary medical officers but so far, this has not happened. The DMHP feels that it would benefit from training on management of ADHD and depression in young children (i.e. children under 8 years of age).

Challenges

Mental health does not appear to be the focus of the Health Directorate. The DMHP interviewed believes that unless there is a focus on mental health in general, child and adolescent mental health is unlikely to receive much attention. A major challenge as reported by them is the lack of psychiatrists at district level—with poor remuneration for psychiatrists being one of the reasons why many vacant posts are not filled. Thus, the few districts which have functional DMHPs and psychiatrists are extremely over-burdened. Pulwama DMHP, for example, is in itself very vulnerable due to the contantly difficult security situation; but it also caters to the districts of Shopiyan, Badgaon, Kulgaon and even to parts of Srinagar.

(b) Medicine Sans Frontiers Counselors

MSF has had a long-standing presence in Kashmir, providing mental health services to affected people since 2001. Currently, their teams provide counselling services at hospitals in four districts — Baramulla, Bandipora, Pulwama and Srinagar. In Pulwama, they were interviewed to obtain an understanding of the types of child cases that come from this very insecure and sensitive area.

Common Mental Health Problems and Contexts

The MSF team, comprising of 3 counselors reported that they see only about 2 to 3 child clients in a week. They present with issues related to anger and anxiety, largely in the context of strikes, curfew, school closure and witnessing/ experiencing of army and police violence—wherein their frustration leads to anger and aggression-related behaviours. In this context, the counselors gave example of a 16 year old boy studying in 10th grade who was part of the protests and whom the police picked up; the child, even upon release, continued to participate in stone-pelting and other forms of protests. He eventually developed Obsessive-Compulsive Disorder (OCD) with a compulsion to throw stones but along with anxiety behaviours relating to checking if doors and windows are closed for fear that the army will come in and wearing his shirt a certain way, in the belief that if he does not, then something bad will happen.

Another example was of an 18 year old boy whose cousin joined the militants. The boy feels very angry and that his cousin should not have done so. His anger, stemming largely from insecurity and trauma, accompanied by anxiety and panic attacks, is mostly directed at himself in the form of self-harm but also towards his family and friends.

The team reports seeing children between ages 11 and 14 years, with post-traumatic stress disorder (PTSD) symptoms. They do not always present with core PTSD symptoms—rather, they appear to have symptoms of depression, including decreased interest in daily activities and 'mood swings'.

Substance abuse is an increasingly common mental healthproblem amongst adolescents and youth. frequent strikes, curfews, military search operations and school closures leads adolescents to be angry and frustrated or bored (due to lack of gainful engagement), and so gravitate towards substance use. PTSD also leads to substance abuse.

The interesting thing is that when asked about their trauma or other behavioural symptoms, children and adolescents seldom attribute it to the environment that they live in, saying, 'no, it is not because of the situation'. But when efforts are made to probe the reason for the behavior, the counselors state that the on-going conflict and insecurity is nearly always at the root of the psychological problem. Even family dysfunction and conflict is related to the outside environment—for instance, lack of employment of the family adults and the resulting financial problems and frustrations are due to the political and security situation in the state.

Another problem that older adolescents and youth face, the counselors report, is that while on the one hand, there are few opportunities for education in the state, but on the other, they no longer wish to go to other states to avail of such opportunities. In Pulwama especially, after the security incidents that took place in early 2019, students who were in colleges in other parts of the country started to leave their education programs and return to Kashmir because of the severe discrimination they faced . Parents are also now fearful of sending their children out of state and want their children to return.

Interventions

In terms of interventions, the MSF team reports that they 'do not use any specific techniques' with children. They use methods of anger management along with basic counseling techniques, such as empathy, listening, allowing for ventilation of (pent-up) emotions and assuring confidentiality for most cases. In the experience of the counselors, what works is to provide psychoeducation—to make children aware of 'how you are feeling, where the feeling comes from…the thought it comes from…'

They have also concluded that certain methods such as cognitive-behaviour therapy (CBT) are not useful in the Kashmir context. The example they gave was of a lady whose son got killed. In response to the team's request for her to attend follow-up sessions, she said 'I know that my son is in heaven…and that is a solace for me' so she did not feel the need to come for further sessions.

The MSF counselors also spoke about their attempts to conduct a psychosocial intervention program for 40 adolescents who were pellet victims. However, in the first ten minutes of the initial session, they said 'we don't need it'. MSF counselors suggested ways to manage stress (including helping them to understand signs, symptoms and emotion-focused ways of coping)but the adolescents denied that they needed these methods, saying ‘we are fine…we want to get freedom…whatever we are doing, we will face the consequences…we believe that we are right’.

The MSF team refers children and adolescents to the IMHANS Child Nodal Centre in case there are diagnostic confusions or if children require IQ assessments or inputs of learning disabilities. The MSF team deals only with conflict-related trauma issues, not with learning and other disabilities that children may present with. They also refer some children to the DMHP psychiatrist for pharmacotherapy.

4.5. UNICEF Child Nodal Centre at Institute of Mental Health & Neurosciences (IMHANS)

In March 2019, UNICEF has been supporting a Child Nodal Centre located in the Institute of Mental Health & Neurosciences under its Mental Health and Psychosocial Support(MHPSS) programme. It aims to provide specialized care and services to the heightened child and adolescent mental health needs in the Kashmiri context of conflict and instability.

The Centre is staffed by a multi-disciplinary team of 14 mental health professionals: 1 psychiatrist, 1 clinical psychologist, 4 counselors (3 clinical psychologists and 1 social workers), 1 occupational therapist, 1 speech therapist, 1 special educator, 3 community coordinators, 1 lawyer and 1 nurse. The Centre is functional two days a week (Mondays and Thursdays) and sees about 35 to 40 cases per day. Earlier, when it first started, the Centre used to receive only 6 to 8 cases per day but now, as word has spread about its specialized services for children, the case load has increased dramatically.

An all-day observation was conducted at the Centre’s out-patient services, to understand the types of cases that the Centre receives (i.e. the types of mental health issues that children and adolescents present with at a tertiary care centre), the assessment, intervention and case management methods used by the team at the Centre. Although the primary purpose was to observe and understand, on-the-job training and inputs (including demonstrations on case history-taking and child interviewing), were also provided to team members, who were very keen to learn case formulation and intervention methods from the resource person (particularly as she was able to share experiences and methods from the Dept. of Child & Adolescent Psychiatry, NIMHANS). Below are examples of cases that were assisted at the Centre, including the methods and approaches used by team members and the needs and gaps thereof:

Cases		**Methods/ Approaches used by IMHANS Team**	**Gaps/ What needed to be done/ Inputs provided or demonstrated**
i.	16 year old boy with borderline intellectual functioning, scholastically backward, poor social skills	“We will try to make him understand his issues, see how he understands human relations…what challenges he faces with communication…focus on bringing assertiveness to his	*Intervention was at an ‘intent’ level; no evidence of methodology. - Psychoeducation to parents on child’s (intellectual) disabilities incl. scholastic difficulties + what these would mean for future education/ their expectations. - Focus on life skills—such as road safety, personal

		communication…"(Team) The team told the child and family to focus on developing his drawing skills since that was his interest. They said they would teach the child anger management techniques since he tended to be frequently angry and irritable with family/others.	safety skills, helping with house chores, planning /decision-making at household level, knowledge of bank/post office processes and other practical skills necessary for daily life… - Understand basis of child's anger/irritability and then use anger management techniques. - Exposure to social spaces and teaching child social skills (helping parents teach them)… - Encourage drawing/art but explore how it could be converted into a vocational training activity—like an apprenticeship with a painter?
ii.	9 year old girl with headaches, anger outbursts and dissociation spells; father works in the army and she is attached to him/worries about him.	Sentence completion tasks done but there were 'no significant findings'. Child was told that she had no medical issues and 'it is just stress, nothing else'. Play and art techniques to be used to 'explore more' and understand child's 'unconscious worries'.	*Absence of methodology - Play and art techniques to be used to help child express her attachment to her father and her worries about him (being away from home for long periods). - Validation of her fears and worries (in conflict context). - No false reassurances. - Explanatory model of pain-- mind-body connection using simple analogies…how when we worry/ get tensed, different parts of our bodies hurt. - Psychoeducation of mother and encouragement to her to reiterate the explanatory model of pain.
iii.	11-year old boy with ADHD symptoms, oppositional behavior/ aggressive, conflict at home and parents fight with neighbours; also hates loud noises.	Unsure of how to proceed—had received instruction to 'explore psychosocial aspects of patient'.	-Elicit child's narrative on what happens at home/ his exposure to conflict and aggression. - Use standardized check list to understand severity of ADHD. - Provide inputs to parent on attention-enhancing tasks etc for ADHD. - Therapy with child to focus on life skills on emotional regulation, problem-solving, decision-making…using simple daily life situations an activities to help child to 'stop, think, act'. - Inputs to school to help an ADHD child (classroom seating/ leadership activities etc)
iv.	14 year old girl fighting/violent towards everyone; first on treatment for OCD but now being considered for mood disorder though team thinks it could be conduct disorder	Team unsure on how to take history to determine whether the child has mood disorder or conduct symptoms; also struggling to interview child (who was not very cooperative)	*Developmental history not clearly elicited, nor family history and events that may have affected the child in pre-adolescence (such as illness in the father) An interview was conducted with the child to demonstrate how to elicit the child's narrative, do MSE and assess for clinical symptoms of mood disorder versus conduct issues but in ways that are child-friendly.
v.	16 year old boy with conversion/ loss of consciousness/ dizziness, anger issues and low mood	Team attempted to elicit stressor but was unable to do so.	*Lack of skills and methodology on how to assess/ elicit narratives/ experiences from children. An interview was conducted with the child to demonstrate how to interview a child to elicit the causes (and degree) of emotional distress/ anxiety, using visual analogue, listing and ranking methods.
vi.	13 year old girl with irritability, reports sexual	Team unsure what to do with child's information—continued to want to 'assess' by talking to	*When child discloses CSA, no projective/ psychological tests to be administered (completely out of context/ incorrect use of testing).

	abuse by family guru/ 'pir'; child was nervous & hesitant, at times retracting her narrative; she did not want her parents to be informed of her CSA experience.	mother and administering projective psychological tests.	- An interview was conducted with the child to demonstrate how to interview a child who is hesitant/ oscillating in CSA disclosure and how to navigate sensitive issues of confidentiality. - NIMHANS activity books on personal safety and CSA recommended to engage child in personal safety education alongside gentle inquiry into abuse experiences.
vii.	16 year old girl with stammering; high intelligence and emotional distress due to speech problem/ discrimination by school teachers.	-	First level response demonstrated by engaging child in discussion on: -Internal and external response to bullying/ discrimination. - Child's identity Suggestion to draft a letter to school to advocate for the child (how systemic interventions also require to be implemented as part of mental health assistance).

The community team of IMHANS said that they have been working over the last 3 months visiting schools, child care institutions and colleges to 'spread the word about the Child Nodal Centre'. In schools and child care institutions, they said that they discuss, with the children, what good (and bad) mental health means and causes and symptoms of mental health problems; they have a module they use, which is on common child mental health disorders. The module they use for community awareness i.e. for children and adult caregivers essentially comprises a detailed description of child mental health disorders such as ADHD, conduct disorder, depression etc.

They stated that they have plans to develop separate modules now, for children and caregivers. The legal personnel on the team visits and sensitizes District Legal Services Authority and law students on mental illness and the Mental Health Act 2017.

5. Gap Analysis and Recommendations

Based on the above findings, a gap analysis, with related recommendations are presented below for the various levels of services, at primary, secondary and tertiary level.

(A) Primary & Secondary Level Services		
	Gap Analysis	**Recommendation**
5.1.	**Lack of Systematic Assessment of Children's Concerns** Protection agencies such as CWCs and mental health services such as DMHPs do not make use of assessment methods, including the use of a proforma to assist them to systematically evaluate and understand children's protection/mental health issues and concerns. Consequently, they do random assessments, missing a lot of critical information, which in turn results in poorly planned/ designed interventions. Primary service providers have no orientation at all on developmental and mental health issues—and are therefore unable to recognize them (and/or refer children for mental health care when necessary). They are also not equipped with knowledge of the existing mental health services available in the state.	The NIMHANS Community Child & Adolescent Mental Health Service Project has developed different types of assessment proformas for use of different cadres of child protection and mental health workers. There are proformas for CWCs/ JJBs and community-level workers; as well as child mental health screening proformas for use in the community by the DMHP. These are available online on www.nimhanschildproject.in Training must include orientation on basic child mental health and developmental problems, including criteria for referral. A list of mental health services available in the state (however few) need to be provided to primary level workers.
5.2.	**Absence of Linkages between Context and Mental Health/Protection Concerns** Every child mental health issue i.e. emotional and behavioural problem occurs in a context. For example, if there are three children with dissociative symptoms, in one child it might be in the context of separation from caregiver, in another from exposure to violence and in a third due to learning disability. Recognizing and understanding the context of each child's mental health (or protection concern) is critical to developing appropriate interventions. Except for the MSF team at the district level, none of the other primary and secondary level services had the ability to understand and locate their responses within specific contexts of children's problems—which is also why they have difficulty in providing any response at all.	Training of these cadres of child care workers must include simple conceptual frameworks for helping them analyze and understand each child's unique world and context—and provide responses accordingly. Additionally, the link between protection risks and mental health issues needs to be made to allow for the adoption of an integrated approach to child psychosocial care and protection.
5.3.	**Inadequate Skills for Interviewing Children** The mere use of an assessment proforma would be inadequate in the absence of skills to talk with and interview children. Without adequate skills, child protection and mental health workers are unlikely to be able to elicit information from children, especially sensitive information on experiences of violence and abuse or even their decisions on engaging in stone-pelting or joining militia.	Basic communication skills training on rapport building, listening, recognizing & acknowledgement of emotions, non-judgmental attitude and questioning/inquiry techniques requires to be conducted for child workers at primary & secondary levels. The emphasis of the training program needs to be not on theory, but on practice—necessitating skills training.

5.4.	**Paucity of Knowledge and Skills on First Level Responses** Primary and secondary level child care workers and service providers are not required to provide depth therapeutic assistance to children in their settings. First level responses entail: – Recognizing and acknowledging (accepting) the child's emotions, – Providing reassurance and comfort. – (Re)framing the problem in such a way as to help the child gain insight/ understanding of the problem and its consequences, – Suggesting to the child certain steps he/she can to reduce the problem. [This part depends on the problem—for instance, a child with anxiety may be taught relaxation exercises, or a child with anger issues may be taught anger management techniques]. – Providing relevant psychoeducaction to caregivers – Measures to ensure child's safety and physical well-being – Plan for any further (medical or mental health-related) referrals required. At present, also due to lack of systematic assessment methods, child care workers are unable to provide such a comprehensive first level response.	Training to recognize basic psychosocial and protection issues in children and responses to address these at first level i.e. to enable containment of a situation (whether it is a protection or a mental health risk) so that the problem does not escalate, thereby causing greater distress to children and their families.
5.5	**Challenges and Opportunities in Child Friendly Spaces** Child friendly spaces seem to be of great value to children, families and communities, creating a space for children to gather together, to relax and do activities for leisure and recreational. The existing recreational activities are not designed in a manner that is age-appropriate. The ages of the children range from about 3 years to 16 years. For older children and adolescents to be engaging in rhymes and songs for meant for preschoolers is not developmentally appropriate. Since children of various ages are at different developmental levels (i.e. in terms of physical, social, speech & language, emotional and cognitive development), they consequently have very different developmental needs and require activities and opportunities to be provided accordingly. Also, restricting conversations with older children to issues on health	The activities in the child-friendly spaces need to be designed in age-appropriate ways--for instance, it may be appropriate to engage young children in early stimulation activities, while adolescents need to be engaged in life skills training activities that are geared to equipping them to cope with some of their difficult situations and contexts. Life skills for adolescents should include themes that are relevant to them, such as socio-emotional skills, decision-making and problem-solving skills on common adolescent issues such as gender and sexuality but also on context-specific issues such as engagement in stone-pelting and activities of violence. [Life skills activity books are freely available online, along with materials for the activities, on www.nimhanschildproject.in. These life skills have been developed by the NIMHANS project, for children in difficult circumstances. The situations and stories used in these life skills activities could be used as they are to begin with—so

	and hygiene is inadequate—and these topics although useful, cannot be termed as 'life skills', particularly as they do not address the daily stresses and issues that adolescents cope with in the conflict situation.	that adolescents obtain a basic conceptual understanding; they can then be extended to use examples and situations from the Kashmir context, in which adolescents can practice using the basic skills they have learnt through simpler implementation of (a given) activity. - It would also be useful to extend the child friendly space support to include deeper level counselling support to children who are particularly vulnerable, or those affected by the trauma of loss, separation, violence and abuse. This may be particularly important as mental health services in the state are few and given the security issues, not easy to access either. - The child friendly space staff would require training in basic communication and counselling skills with children as well as advanced skills in responding to trauma and abuse issues. - CFS staff should also be linked with CWCs and know when and how to refer children for protection and psychosocial concerns; similarly, knowledge of 'danger' signs and symptoms for timely referral to mental health services is essential to such frontline workers.
5.6.	**Need for Further Child & Adolescent Mental Health Orientation at DMHP Level** As of now, child mental health work is nearly non-existent in the DMHP. The fact that children form such a tiny proportion of the overall cases seen and that there no systematic assessment protocols for children (although standardized questionnaires for adults are used) is indicative of the fact that child and adolescent mental health are not prioritized by the DMHP. Of course there are serious staff shortages but there is also a lack of knowledge and skill, amongst those DMHPs that are functional. The team (like other service providers) were unable to describe child-related cases and intervention in any depth. Take for example also the issue of dissociation in children—which given the environmental conflict and insecurity, is a common mental health issue. There are two types of dissociation: protean dissociation and dissociation as an epiphenomena. In the former, dissociation is a disorder in itself; in the latter, dissociation is a symptom of another disorder i.e. a primary psychiatric disorder such as depression or adjustment	The DMHP requires detailed orientation and training on the following, in order to strengthen their skills in terms of assessment/ case-history taking and interventions: - Conducting systematic psychiatric assessments of children and adolescents (through the use of appropriate assessment proformas). - Skills in child interviewing - Knowledge of child and adolescent psychiatric disorders, including assessment and management techniques. - Case formulation and analysis for appropriate diagnosis of disorders - First-level responses to children and adolescents Additionally, the nature and type of public awareness programs that the DMHP conducts at community-level requires much re-thinking. Their orientation of the community on child and adolescent mental health issues needs to be much broader so that the community understands that children can also have difficulties (particularly in the situation that

	disorder. Thus, while the DMHP's view on dissociation may not be incorrect, it only refers to one type of dissociation. More importantly, dissociation in general is related to stress/ trauma/conflict, and the severity of symptoms is directly proportional to the distress, so the kind of hair-splitting and positioning that the DMHP engages in is neither technically nor practically viable. The bottom-line is that a range of interventions require to be used, from treating primary psychiatric disorders (if any) to symptom reduction through a variety of methods such as environmental manipulation, normalization, suggestion, reassurance, education, removal of secondary reinforcers.	they are in) and that these need to be addressed.
5.7.	**District Early Intervention Centre** The passion and commitment of the paediatrician and his eagerness to develop the DEIC into providing tertiary level services, provides a tremendous opportunity to develop a child mental health service. In fact, this centre has the potential to develop into another nodal child centre (similar to the one UNICEF is supporting in IMHANS). The one child psychiatrist that is currently available to the Centre is able to consult there only once a week—this is inadequate considering the number and range of child and adolescent mental health issues that the Centre receives. Under the current arrangements, the type of therapeutic inputs provided to children is inadequate. More time needs to be spent providing (psycho)therapeutic inputs (in addition to medication) and an additional psychiatrist with the ability to provide such inputs would be essential to addressing the types of child mental health needs that that this Centre addresses.	- Given the types of cases that this DEIC receives and its deep interest and commitment to broadening its work to provide more depth/ comprehensive tertiary care type of services, the staff training needs are beyond disability i.e. the staff require to be trained in child and adolescent psychiatric disorders, including assessment and intervention methods for these. - An additional/ full-time psychiatrist appointment would be essential for this DEIC; this psychiatrist should be especially trained/skilled in child and adolescent mental health assessment and intervention methods to be able to provide depth therapeutic inputs to children/families as well as train other staff at the DEIC. - Once government funding is received, NIMHANS could assist the Centre (with advisories on material, equipment, organization and use) in development of its play/developmental/therapeutic material and infrastructure to be make it a state-of-the-art child centre—that could be a model not only for the state but also for the country.
(B) Tertiary Care Services		
5.8.	**Technical Knowledge and Skills** The IMHANS Child Nodal Centre team is a dedicated bunch of professionals, most of whom are eager to work and enhance their knowledge and skills. As qualified child mental health professionals, they seem to have adequate text book knowledge of child and adolescent disorders/ disabilities i.e. in terms of signs and symptoms as described in the DSM/ICD-10. They also have some amount of	As documented, using case examples, there are several gaps that require to be addressed, through training, and that would thus enhance the functioning of the mental health team: - Greater clarity on psychological testing and the contexts in which such tests are to be used (i.e. avoidance of mechanical use of testing or substituting clinical assessments and child interviewing/inquiry with psychological tests).

	theoretical knowledge of therapeutic methods. However, the gap lies in the application of knowledge and theory i.e. translation into skills and field methodology. They are also observed to be using certain methods without a full knowledge of the conceptual frameworks on which they are based. A theory is worth its content only if it leads to meaningful intervention; on the other hand, every intervention should be based on a strong conceptual framework. Only then can interventions be effective.	-Skills to conduct systematic assessments including how to elicit symptoms from children particularly, and how to take detailed developmental history in order to make accurate diagnoses. (This skill is also critical in contexts of differential diagnosis). - Depth intervention and therapeutic methods, including field-based individual and group methods for use with children and adolescents, including the use of play, art and creative cognitive methods to address various mental health and protection problems. (This was found to be one of the key gaps in the skills of the mental health team). - Responses to child sexual abuse (including methods of assessment and inquiry, family and systemic responses as well as depth therapeutic/healing methods). **Some of the above issues have been addressed in the 10-day training program that NIMHANS organized for the Kashmir child mental health and protection staff in July 2019, in Bangalore.*
5.9.	**Pre-Occupations with Specializations and Professional Hierarchies** One of the issues observed was the hierarchies that appeared to be present amongst mental health professionals. These group dynamics and pre-occupations with specializations were observed during the assessment visit to Kashmir (in May 2019) as well as in the training sessions at NIMHANS. It appeared that there were divisions between the 'clinical' and 'community' teams—with the former being those who work in the child nodal centre premises at IMHANS versus those who are attached to IMHANS but work in the community. There were notions that psychologists are superior because of their 'clinical skills' and social workers should not be doing therapeutic work (with children) due to lack of clinical skill. Such notions are counter-productive to mental health professionals, both individually and as a team for the following reasons: A multi-disciplinary team means that each person has a special function and role to play; undermining and disrespecting one's colleagues due to perceptions about their professional inadequacy is unhelpful to children (and makes for poor interpersonal relationships	One of the reasons the Kashmir team was requested to visit NIMHANS for training is so that they could be exposed to ways of working in child psychiatry, that were multi-disciplinary and non-hierarchical. In the NIMHANS Child Psychiatry Department, all mental health professionals, whatever their specialization, learn and use a range of (therapeutic) techniques and methodologies to work with children; psychiatrists do as much individual psychotherapy as do psychologists and social workers. **The importance of doing away with such notions and hierarchies were noted and discussed at a later stage, during the NIMHANS/Bangalore training, so that the mental health team could reflect on such professional attitude and behaviour related issues and how their work both individually and collectively could be impacted by the (professional) positions they take.*

	on a team). - The practice of child psychiatry is different from that of adult psychiatry in that medication is prescribed to relatively limited extents. The bulk of the work pertains to understanding children's problems, communicating with them, doing therapeutic work to assist them and their families. So, if psychiatrists and psychologists wanted to assume very restricted roles, they would have very little to do in child mental health. - In child mental health work, everyone is equal in that everyone has to do so-called clinical work, which includes assessment and interventions/ therapy. Psychologists are only different in their functioning in one respect i.e. they have the additional skill of testing, and do it when necessary; similarly, psychiatrists are different in their functioning in one respect i.e. they have the additional skill of medicine, and do medical-psychiatric assessments to make decisions about and prescribe medication when necessary. - In a country such as India, mental health professionals do not have the luxury of super-specialization and role restriction. For instance, it would be an untenable position for psychiatrists to decide to only to pharmacotherapy or psychologists to do only testing. This is because the number of mental health professionals is relatively very few as against the total population to be served and the number of people in need of services. This would be particularly true in Kashmir, where due to the conflict, mental health morbidities are likely to be higher than average or in other states of the country. Therefore, all mental health professionals need to have basic skills to be able to provide a minimum level of assistance to individuals in need of mental health care.	

6. Training Program in Dept. of Child & Adolescent Psychiatry, NIMHANS (July 2019)

A 10-day training program was organized by the Community Child & Adolescent Mental Health Service Project at the Dept. of Child & Adolescent Psychiatry, NIMHANS. The program was supported by UNICEF and attended by 24 participants from Kashmir. Of these 18 were from Institute of Mental Health& Neurosciences (IMHANS), 1 from the District Early Intervention Centre (DEIC) at G.B. Pant Paediatrics Hospital, and 5 from the Kashmir Integrated Child Protection Scheme (ICPS).

The training program comprised of:

(i) An initial 3-day workshop on ‘Basic Psychosocial Care for Children in Difficult Circumstances’.

The objectives of this workshop were:

- Understanding children’s psychosocial issues.
- Linking child protection and psychosocial care, including understanding issues of abuse and trauma.
- Skill building with a focus on:
  - Getting started with children.
  - Developing basic communication skills to facilitate supportive care worker-child relationships.
  - First level responses to emotional problems in children.

Contents of 3-Day Basic Skills Workshop

1. Children & Childhood	Reconnecting with children and Childhood
	Applying the Child Development Lens
	Power & Rights
	Identifying Emotional &Behaviour Problems & Contexts: Child’s Experience & Inner Voice
2. Basic Communication Techniques with Children	Skill 1: Getting to Know the Child Skill 2: Listening and Interest Skill 3: Recognizing and Acknowledging Emotions Skill 4: Non Judgmental Attitude & Acceptance Skill 5: Questioning & Paraphrasing
3. Individual Care Plans & Referral	Assessment & Individual Care Plans Case History-Taking Criteria for Referral

Examples were drawn from the Kashmir context—such as children engaging in stone-pelting, separation, loss and grief, adolescents and militancy—in order for the participants to develop understanding and skills relevant to the context of children affected by conflict.

(ii) Sessions Focussing on Specific Child and Adolescent Mental Health Disorders

Faculty from the Dept. of Child & Adolescent Psychiatry conducted detailed sessions on specific child and adolescent mental health disorders but also with a focus on the Kashmiri context.

The aim of these sessions was to strengthen the clinical skills of the IMHANS team i.e. in terms of assessment/ case-history taking and interventions. The focus forthis initial round of training, was on developmental disabilities and internalizing disorders—as these form a big part of the

IMHANS centre's case load currently. Based on observations and time spent in the IMHANS centre, the training sessions ensured a huge emphasis on interventions, mainly therapeutic interventions.Again, examples were drawn from the types of cases commonly seen at IMHANS—of how disorders such as anxiety and depression, for instance, manifest in children when they live in militarized zones.

Contents of Sessions on Specific Child and Adolescent Mental Health Disorders

Internalizing Disorders	• Anxiety Disorders in Children & Adolescents • Post-Traumatic Stress Disorder • Mood Disorders in Children & Adolescents • Brief Introduction to Child Sexual Abuse
Externalizing Disorders	Substance Abuse Disorders in Children & Adolescents
(Neuro) Developmental Disorders	• Autism • Attention Deficit Hyperactive Disorder • Intellectual Disability • Specific Learning Disabilities
(Additional) Intervention Methodology	Introduction to Life Skills Methods and Activity Manuals
Field Observations	• Observation of Out-Patient Department Consultations • Observations of In-Patient Department Consultations • Community Team: Field Visit to Child Care Institutions &Orientation on Community-Based Child Mental Health Interventions/ Observations in CWC • Speech Therapists & Occupational Therapist/ DEIC Staff: Observation in Dept. of Speech & Hearing/ Occupational Therapy/ Special Education in CAP

While delivery technical content and skills was the main purpose of the training, the NIMHANS team also used the time and opportunity through the training program to discuss work ethics and ideology, including the issues of hierarchies and specialization (discussed in the assessment recommendations). As the UNICEF-supported Child Nodal Centre has recently started in IMHANS, addressing these issues are also critical to laying the foundations and ways of work in equitable and technically effective and efficient ways.

7. Ways Forward

Discussions were had with the team on the issues described below and agreements were made on how the work may proceed, based on the NIMHANS training.

7.1. Immersion in the Field: Practice, Practice,Practice!

It is suggested that the 24 participants return to their settings and do individual and/or group work with children, using the skills and methodologies learnt in the training workshop.

- The IMHANS clinic team will work in the Child Nodal Centre; the life skills methods and other therapeutic methods they have learnt would be implemented with individual children who come to the Centre with various psychiatric problems.
- The IMHANS community team will be required to go to child care institutions and schools and implement individual assessments with the children (along with referral to IMHANS for severe cases); they will also be required to implement life skills sessions (using the manuals and materials provided) in these settings. They may do their work in collaboration with the institution/ school counsellor—so that they already begin to orient the staff on what psychosocial care and protection with vulnerable children entails.
- The ICPS staff, similarly, will be required to do one-on-one and group work with the children who come to the state care and protection, using the assessment formats they have been trained in and the life skills materials.
- The lawyers from ICPS and IMHANS team would need to collaborate with the CWCs and JJBs and sit in with them and use the child psychosocial care skills to understand how best to assist these committees/boards to be child-friendly in their approach and make decisions in the best interests of the child (i.e. in keeping with child mental health and protection needs).
  [NIMHANS has connected UNICEF to a human rights lawyer who has previously worked in Kashmir on juvenile justice issues. We recommend that this person works with the lawyers to provide additional/ specialized training on the child and law, so that the lawyers develop better understandings of their role in the ICPS/JJ system and build strong capacities to apply their legal knowledge in the field to assist CWCs and JJBs].

7.2. On-Going Learning and Training

A google group of the participants has already been created and all the materials from the training program have been shared on it. The NIMHANS team will provide continued learning and guidance to the participants through Zoom/ google classroom/ skype as feasible. Once a month, a learning session, with case conferencing or a specific topic, may be done.

More importantly, the UNICEF-Child Nodal Centre is headed by a child psychiatrist who has a DM (super-specialty) qualification in child and adolescent psychiatry from NIMHANS. He is therefore a repository of interventions, methods, materials and training used in NIMHANS. It would be critical for him to engage with the IMHANS team on a regular basis, preferably conducting weekly learning/training sessions with them on a variety of child and adolescent psychiatry issues.

7.3. Training of Trainers

The NIMHANS team does NOT subscribe to commonly adopted approaches to training of trainers. No one can learn to train in a few days time and therefore, programs done for training of trainers are of little use. Cascade models have not been known to work—little knowledge transfer takes place this way. If a ‘trainer’ does no work in the field, with children, he/she cannot be a quality trainer. This is because he/she will lack practical field experience and not be able to respond appropriately to the questions and challenges that field workers face; such training then will be purely theoretical and therefore of no benefit to the trainees or to children in need of care.

You cannot teach a teacher or counsellor to work with children when you have not done so yourself!

Therefore, we work on the premise that all trainers have to do field work i.e. work with children directly, before becoming trainers, before beginning training activities and continue thereafter, to routinely work with children between conducting training programs. This is why, for the next five to six months, we have suggested (above) that the participants do direct work with children, to consolidate their own skills first.

After five to six months, a sub-group of the participants (based on their interest and ability) may be selected to become trainers. Let us assume that a group of ICPS staff need to be trained. The NIMHANS facilitators would then work and plan with the sub-group to allot parts of the basic training workshop to them (the same workshop that they attended at NIMHANS); other parts would be done by the NIMHANS facilitators. Thus, the NIMHANS facilitators would conduct the training workshop along with the sub-group of trainee-trainers. Feedback and inputs would be provided to the trainee-trainers, on-the-job, during and after the training workshop.
Then there would be a plan to train the next group of ICPS staff. This time around also, the NIMHANS facilitators would do a joint training with the trainee-trainers. However, in this round, the NIMHANS facilitators will allot major parts of the training to the trainee-trainers but be present throughout to watch, assist where necessary and provide feedback.

In a third group of ICPS staff training, the NIMHANS facilitators would participate very minimally but be present as the trainee-trainers do almost the entire training on their own.

In this way, a group of trainers would be created as a resource for the state—through this approach of hand-holding and mentorship, the a skilled and confident group of trainers would be developed for child protection and mental health work, and they in turn could train others in the same manner.

Annexe

Interview & Observation Guidelines Used to Conduct Preliminary Rapid Assessment

(A) Child Friendly Spaces Interview Guidelines

- **Observation of activities in child friendly space**
- ✓ Types of activities and methods used
- ✓ Content/ themes of activities—are they relevant to children's lives and contexts?
- ✓ Age-appropriateness of activities

- **(Understanding of) Children's Needs & Issues**
- ✓ Based on your experience and observations, what are the risks/ dangers that children (in the community) are facing? (Different risks for boys vs girls?)
- ✓ In general, what do children in the community do, on a day-to-day basis? (What are their routines…gender difference within that?)
- ✓ Tell us about any emotional or behavioural concerns that you have noticed in children (when they come to the CFS or outside)?
- ✓ Have children ever spoken to you about their fears/worries/concerns? Tell us about what they say…

- **Objectives & Functioning of CFS**
- ✓ What are the objectives of the CFS?
- ✓ How do you mobilize children to come to this space?
- ✓ What age groups of children come? Gender—boys and girls come in equal numbers or…?
- ✓ What are the days/ timings for the CFS?
- ✓ How are the types of activities that you implement? How are they planned and decided?

- **How community views CFS**
  - ✓ Emotional and behaviour problems of children/adolescents from a caregiver perspective
  - ✓ Benefits of CFS to children (and caregivers)
  - ✓ What else caregivers feel that CFS could focus on

(B) Child Welfare Committees (CWC) Assessment Guide

- From where and how do you receive referrals?
- Tell me, when a child comes to you, how do you proceed, with regard to:
  - Assessment and interviewing (do you use any proforma/ format?)
  - Identifying protection needs
  - Identifying mental health issues
  - Developing a care plan (what components does your individual care plan have?)

  *[Use a case example if required].
- What are some themes and problems that you frequently see in children? How do you respond to these?
- What are some challenging issues that you have to deal with in children? How do you deal with these?

- Do you refer children for any mental health issues? What are the criteria for referral? Whom do you refer to?
- What are some systemic challenges you are faced with?
- How long have you been in office?
- What training have you received so far? (content/ duration) Has it been helpful?
- What further support and training would be useful? (Suggest topics, themes, methods…)

(C) District Hospital Assessment Guide

- What population does this hospital serve?
- How many districts does it end up serving? (in case it is the only one with Dept. of Psychiatry/ Gynaecology/ Paediatrics)
- Does it receive cases of child abuse (physical, sexual)?
- On an average, how many children with CSA/ physical do you receive per week?
- Which department do the children go to for assistance in abuse issues? Dept. of Psychiatry, Gynaecology, Paediatrics ? (Composition of team…?)
- What is the in-patient facility/ capacity for each of these departments?
  (Observations of in-patient facilities for children…are there special facilities/ activities for children or are they housed in general wards?)
- Whether Paediatrics/ Gynaecology/ Psychiatry Dept:
  - What are the procedures followed to assist a child with physical abuse? Describe…
  - What are the procedures followed to assist a child with sexual abuse? Describe…who treats the child at the time child is brought/ presence of counselor/ access to immediate and longer term mental health assistance/trauma therapies/ how mandatory reporting issues are dealt with…
  - What are the challenges in assisting children who comes with abuse issues?
  - Has your team received any training in treatment of abused children? From whom? Describe…any person specifically trained in child counselling (or same counsellor for women and child?)
  - Would your team benefit from training? What areas of child abuse would training be useful in? Who would be available for training?(incl. the qualifications of this staff)
  - In case there is no psychiatry dept., do they refer child abuse cases for mental health issues to other places? If so, where?
- If there is a Dept. of Psychiatry:
  - Do they see child cases?
  - Is there a dedicated child mental health service? Frequency?
  - How many children are seen per week?
  - What types of child and adolescent disorders come to them?
  - Are they brought directly by families? Where do they receive referrals from?
  - Who is on the team? How many?
  - What assessment formats/ protocols are used for assessment of children?
  - Describe the types of methods used to treat children with various disorders…what types of therapeutic interventions are used?
  - What types of therapeutic interventions do they do with children with trauma and abuse problems? (Any particular methods, materials, approaches used?)
  - Do they every receive children from child care institutions? Describe the kinds of cases…(Why not—in case they do not receive any cases?)
  - Do they have any collaboration with the Government child protection services (ICPS)?

- Are they called upon to do any training for government child protection officers?
- Are they familiar with the workings of the CWCs and JJBs?
- Do they receive requests/ referrals from CWCs and JJBs for treatment of children (or preliminary assessments in case of CICL)?
- Do they have any collaborations/ work with schools or anganwadis in the district? If so, what kind of work do they do in schools?
- Are they interested in doing community outreach? Do they have the capacity to do it?
- What is the relationship between the dept. and DMHP?
- What is the relationship between the dept. and RBSK?
- In case you want to refer children to tertiary care facilities, where do you refer them?

(D) Tertiary Child Mental Healthcare Facility Assessment Guide

- Do they see child cases?
- Is there a dedicated child mental health service? Frequency?
- How many children are seen per week?
- What is the capacity of their in-patient facilities? How many beds for children/adolescents? Is there are separate in-patient facility for children? (Observations…on structure/ space/special activities for children/ how the ward is run…)
- What types of child and adolescent disorders come to them?
- Are they brought directly by families? Where do they receive referrals from?
- Who is on the team? How many?
- What assessment formats/ protocols are used for assessment of children? (Can we have a copy?)
- Describe the types of methods used to treat children with various disorders…what types of therapeutic interventions are used? For children with conduct issues/ behaviour problems…? Children with emotional problems…?
- What types of therapeutic interventions do they do with children with trauma and abuse problems? (Any particular methods, materials, approaches used?)
- With regard to child sexual abuse:
    - What are the procedures followed to assist a child with sexual abuse? Describe…who treats the child at the time child is brought/ presence of counselor/ access to immediate and longer term mental health assistance/trauma therapies/ how mandatory reporting issues are dealt with/ do they do any forensic work…What are the challenges in assisting children who comes with abuse issues?
- Do they every receive children from child care institutions? Describe the kinds of cases…(Why not—in case they do not receive any cases?)
- Do they have any collaboration with the Government child protection services (ICPS)?
- Are they called upon to do any training for government child protection officers?
- Are they familiar with the workings of the CWCs and JJBs?
- Do they receive requests/ referrals from CWCs and JJBs for treatment of children (or preliminary assessments in case of CICL)?
- Do they have any collaborations/ work with schools or anganwadis in the district? If so, what kind of work do they do in schools?
- Are they interested in doing community outreach? Do they have the capacity to do it?
- What is the relationship between the dept. and DMHP?
- What is the relationship between the dept. and RBSK?

- In case they want to refer children further to other specialized centres, where do you refer? What kind of cases might these be?
- Are they interested in more/ specialized training on child mental health? Specifically what areas of child mental health would they wish for training on…?
- If they were asked to be involved in more community-based child mental health work, would they be interested?
- How do they view child protection work in relation to child mental health work? Do they see them as being linked? Would they be interested in doing more child protection work?
- Would they see themselves serving as a support/ resource to the state, for child protection and mental health? (Doing training, capacity building, engaging with government child protection systems, serving as referral for both child protection and mental health issues?)
- If NIMHANS were to offer them the requisite training and support, would they be willing to participate/ collaborate on initiatives relating to child mental health and protection services?