Review Article JIACAM Vol. 1, No. 1, Article 4

An Integrated Approach to the delivery of Child Mental Health Services

Malavika Kapur

National Institute of Advanced Studies,
Indian Institute of Science Campus, Bangalore 560012.

Since 1947, the Government of India has made several provisions for the welfare of children. Initially these appeared in an ad-hoc fashion as a part of various 5-year plans, but from 1974 these have come out as a series of long term and integrated policy documents. I refer to the following.

1. Integrated Child Development Services - ICDS (1972)
2. National Policy for Children (1974)
3. National Mental Health Programme for India (1982)
4. National Policy on Education (1986)
5. Integrated Education for Disabled - IEDC (1988)

While these documents contain very welcome recommendations for the well being of children, they touch upon the issues of child mental health only indirectly. Further, they do not set up any priorities; nor do they offer any data, which would help to set up the priorities.

One would have imagined that the mental health professionals would themselves have taken up the issue of priorities. What one sees is that while the professionals have fought valiant battles to safeguard the mental health of adult population, they have done very little for the mental health of children. In this context it is of interest that intense lobbying has been carried out for the care of children with developmental disabilities, so much so that mental handicap has become synonymous with mental health of children in the minds of the NGOs advocating the cause of the former, the authorities to whom representations are made and the population at large. One has no quarrel with the concern for mental handicap, but the effort seems to be unbalanced. One can only assume that if the mental health professionals had themselves taken part in this lobbying process, mental health issues could have been projected with as much enthusiasm as that of mental handicap. One must remember that in the West, a strong lobby for the cause of the mentally handicapped children arose as a part of an overall push for extensive and broad based mental health and counselling services for the children.

The situation in India is very different. While the first Child Guidance Clinic was started

in Bombay at the Tata Institute of Social Sciences, as early as in 1937, the spread of such clinics across the country has been sparse and patchy. One is told that there are 100 Child Guidance Clinics across the nation, but if their locations were examined, one would find that they mostly exist in Maharashtra and that too, mainly in Bombay. There are a few in Delhi, Gujarat and Karnataka. The largest service is at NIMHANS, Bangalore, which has a 40 bedded in-patient unit and caters to 1000 mentally retarded and 800 child psychiatric cases a year. It has 4 Psychiatrists, 3 Clinical Psychologists, 2 Psychiatric Social Workers, and 5 Nurses. It offers three months of training in Child Mental Health at Post Graduate level. First D.M. course in Child Psychiatry will start in 2002. Elsewhere in the country, there is little commitment to a serious concern about the Child Mental Health. There is no available survey of the facilities offered in the so-called 100 or so Child Mental Health Services across the country but the anecdotal information is that the services are poorly manned and more often than not headed by people who have little training in Child Psychiatry. There is an urgent need for a survey of the mental health / counselling services for children available in the country, the availability of trained staff, as well as the nature of services provided.

Epidemiological Surveys

There have been a fair number of clinics and community based epidemiological surveys in the urban and rural areas in the past two decades. In the 1970s children were seen as part of adult population and mostly cases of mental retardation were reported. With the advent of epidemiological surveys dealing exclusively with children, using tools with acceptable reliability and validity, better picture has emerged regarding the prevalence of childhood mental health problems. From 1967 onwards, there have been 14 clinic-based studies, 7 population surveys in rural areas and 10 surveys in urban areas. Unfortunately these are not comparable methodologically (Kapur, 1995). The multicenter ICMR study of 1984, which has a common methodology, offers clinic-based data on 1985 child psychiatric cases. In this study 29 percent suffered from neuroses, 23 percent from psychoses, 23 percent from hysteria, 14 percent from epilepsy, 12 percent from mental retardation, 9 percent from behaviour problems, 5 percent from emotional problems and 4 percent from the scholastic backwardness. However another well conducted population based ICMR study using a common methodology found that amongst 1578 urban and rural children, between 4-16 years, in the community, there was an overall prevalence rate of 11.9%. Prevalence rates for different diagnostic categories were: simple phobia 2.8%, enuresis 6.2%, ADHD 1.5% and stammering 1.5%. Urban boys had significantly higher rates than the rest of the sample. When one compares data from a population based study with a clinic based study it is obvious that what reaches the clinic reflects very poorly on what is found distressful at the general population level.

Urban school studies show an entirely different distribution. Disorders of emotion and conduct range between 10 to 30 percent. Several of the studies have highlighted prevalence of scholastic difficulties as a major problem. These studies also reveal that multiple informants such as teachers, parents and self-report by adolescents, offer a more comprehensive picture of child mental health problems as they tend to be situation

specific. Teacher bias is operative in externalising problems, which leads to exaggerated reporting, while internalizing problems go undetected unless they are assessed from the parent or self reports. Girls tend to internalise more while boys externalise. These differences cause inflated rates for externalising disorders in the boys and fail to detect the emotionally disturbed children, especially girls. The clinic-based data reflects more serious disorders, while school data reveals milder forms of mental health problems and of scholastic problems. The nature of disorders reported in schools being milder, may not need clinic-based services. The differences in the nature of disorders picked up in the three types of studies, point to the need for different types of services required at the three levels.

Translation of the policies into child mental health services delivery

The translation of the policies into child mental health service delivery poses a great challenge. Most of the programmes in Health, Welfare and Education sectors are top-down programmes and often fail because of the absence of the knowledge of the ground realities.

For example, in the health sector the primary health care services even for adults are beset with problems of reluctance to work in the rural areas, frequent transfers, low morale, poor interaction between the locals and the doctors and poor drug supply. In the welfare sector, the ICDS programmes have the AW workers who are given very low pay, but are expected to bear the burden of all the government health and welfare programmes.

From 1976 onwards I have been working towards developing models of services, which would be suitable in the different contexts. I have worked in the urban schools adopting innovative approaches to sensitise the schoolteachers in identification referral and management of mental health problems in the school settings (Kapur, 1997). However, as the majority of the children live in the rural areas where service delivery is mostly absent, the need to develop programmes at the grassroots level, which are applicable to the under developed areas of the country and in the other developing countries, is undeniably evident (WHO 1992,1994). The programmes described here have been developed at the grassroots level in the Education, Health and Welfare sectors over the past four years. The programmes are being carried out in the backward tribal belt in the H.D.Kote Taluk, 250 KM from Bangalore. Most of the schools are single teacher primary schools, almost inaccessible, with poorly constructed buildings and lacking in basic facilities. In short, these represent the rural schools in India.

Education Sector

A cluster of 15 schools (with one high school and the rest being lower and higher primary schools) with 1200 children was taken for the project. 41 teachers formed the group. Two programmes were simultaneously taken. (a) The teachers were given orientation programme regarding normal development through childhood to adolescence, mental health problems and disabilities. In addition they were given extra inputs with slide shows and workshops to broaden their intellectual horizons. (b) For the children universal intervention to promote creativity, cognitive, social, emotional and moral

development, was attempted. Structured one hour programmes each day of the week were provided. In view of the paucity of teachers and large number of children in the rural schools with very poor infrastructure, these were essentially children-to-children programmes where groups were encouraged to function in small teams and learn art work, word and number games, music and dance, taking turns as leaders. Only with the very young i.e. first and second graders, teachers were needed for direct supervision. Evaluation was carried out before and after the programmes. Significant improvements in creativity, attention, vocabulary and psychomotor skills were seen in most of the children, subject to some variability amongst a few children and in one school. In addition, life skills education was incorporated in the programmes for high school children. The programmes were carried out in 20 sessions with1200 children who were assessed before and after the intervention. There were varied trends across age, gender and the domains assessed. In a sub sample of 200 children across all the age groups showed no such improvement without the intervention when reassessed after three months.

Children identified with disabilities were seen in the multiple disability camps. The prevalence of mental health problems in children is in the range 0% to 60 % (average around 10%). These figures are based on the reports of teachers in the different classes at six schools in a population of 350 children. They are yet to be provided intervention.

Welfare Sector (ICDS)

180 Anganwadi workers in the entire taluk were taken up for the project. They were covered in 3 batches. The AWs were trained in three sessions over three days. The training aimed at promoting psychosocial development, identifying behaviour and emotional problems and disabilities in children below the age of 5 years 10 months. The AWs were trained in (a) promoting psychosocial development of the preschoolers under their care by observing the natural potential of the children for play and creative activity with the available material in their environment (not necessarily toys) and what adults can learn from them. They were told to observe the children and encourage them to learn rather than teach them. For the AWs the experience was an eye opener. (b) They were asked to report various disabilities such as mental retardation, hearing impairment, visual and locomotor disabilities. In addition, identification and simple management of strategies for enuresis, hyperactivity and speech problems and where to refer those cases were also taught. Total number of children covered by the one third of the total AWS is about 1200. Thus the 180 Anganwadis workers would probably take care of about 4,000 children. These Anganwadi workers of the first batch were able to identify 55 children with varying disabilities. The Anganwadi workers with great enthusiasm took up promotion of psychosocial development without additional equipment or materials capitalising on the innate creative potential of children. The children with disabilities were brought to the camps. The 189 AWs covered a population of 10,000 children below the age of five years and six months which was 51.2% of the entire child population in the age range.

Health Sector

(a) 21 Primary Health Care doctors and 5 general hospital physicians are covered by the training programme. The components of the programmes are:

- Identification and management of mental health problems and disabilities of children referred.
- Liaison with teachers in maintaining health records
- Liaison with primary health workers in referral of children with mental health problems and disabilities.

However most of the PHC physicians were least responsive to the programme because of low morale and commitment to their work.

(b) Primary Health Workers

60 PHC workers were trained in recognising the maternal and child mental health, child development and identification of disabilities. These workers were interested in what was taught to them, but were more concerned about the difficulties faced by them in their day-to-day work.

To summarise, orientation to the training of workers in Health, Education and Welfare sectors to work in an integrated manner was attempted.

In addition, camps are being organised to provide support to the disabled in terms of financial, aids and appliances and counselling. One such camp has been organised for multiple disabilities, three more are to be held over the next year. In the first camp the teachers brought the children. Out of them 37 Children were intellectually disabled, 42 had physical disabilities, while 64 had speech and hearing problems. 8 children with poor eyesight were provided spectacles. The three groups of the disabled will be issued Identification (ID) cards which would enable them to get the disability benefits offered by the Directorate of the Welfare of the Disabled. Unfortunately the camp received very little support from the local hospital doctors.

The programmes described above were developed gradually and cautiously over several failures and successes. Some of the important insights are:

1. That the various cadres of workers work under extremely poor and disadvantaged circumstances.
2. The training programmes should be interesting and simple.
3. The programme should provide enough incentives in terms of token honorarium and decent snacks or meals.
4. The programme should have officially sanctioned time off to attend the programmes.
5. The programmes have to be organised at convenient locations and times (to adjust to available bus services)
6. To have liaison with local groups (schools and community and central groups (general hospital, block education officers, community development officers and NGOs) is equally important.

7. School teachers and Anganwadi workers provide the ideal infrastructure for the identification and referral of disabilities and mental health problems. They can also be trained as facilitators to promote psychosocial development of the children under their care.
8. Organisation of the camps for disabilities is exceedingly complex and involves the following steps:

    a) When the camps are organised, the informants, the children and their parents have to be reimbursed bus fares and provided meals or snacks.
    b) These should be single window camps.
    c) All the forms and assessments should be completed in the camp itself by the different specialist professionals (for example, IQ assessment, testing for hearing and visual impairments, accurate examination for locomotor deficits etc).
    d) ID cards to be completed including taking the photographs, affixing them on the cards and counter signing by the appropriate professionals.
    e) Those not eligible for the cards should be counselled regarding the management of the reported problems.
    f) The benefits to be availed with the ID cards should be made known to the workers and the families of the children in a clear manner.
    g) teachers or the AW.networking between the health, education and welfare sectors is crucial for the success of any programme.

I would like to state explicitly that we as professionals need to work at the grassroots level to evolve the models before imparting training to the various cadres of workers in the different contexts. Unfortunately most of the programmes are carried out in a 'top down' manner leading to poor transfer of the knowledge and practices at the grass roots level.

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Acknowledgements:
The author gratefully acknowledges the funding agencies, National Council for Rural Institutes Hyderabad and Departments of Welfare of the Disabled, and Women and Child Development, Karnataka for supporting the work.

Address for correspondence:
Prof. Malavika Kapur, National Institute of Advanced Studies, Indian Institute of Science Campus, Bangalore 560012, India. Email: malavikakapur@yahoo.co.in