

CHILD AND ADOLESCENT MENTAL HEALTH A MANUAL FOR MEDICAL OFFICERS



TO PROVIDE CARE DURING AND AFTER COVID-19 PANDEMIC

2020

Editors

Rajendra KM | John Vijay Sagar K |
Naveen Kumar C | Suresh BM |
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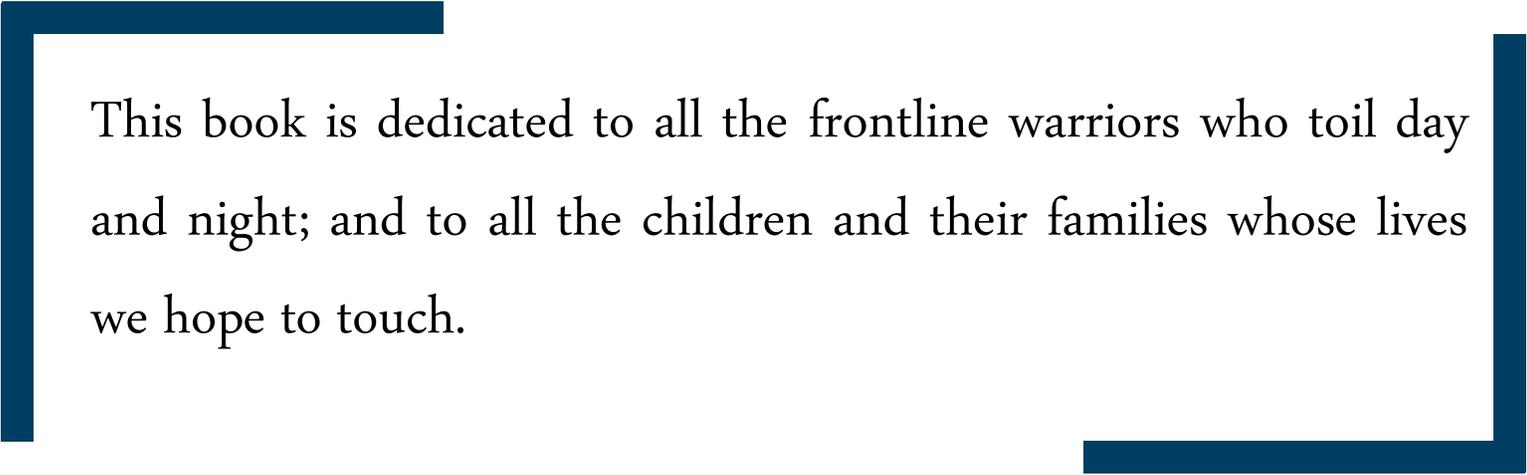
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This book is dedicated to all the frontline warriors who toil day and night; and to all the children and their families whose lives we hope to touch.

Dr Arundhathi Chandrasekhar I.A.S.
Mission Director
National Health Mission



Date: 29.07.2020

MESSAGE

The health of our children and adolescents determines the progress we have made as a nation. This is an important agenda for our Government and it is addressed through involvement of multiple departments including Department of Health & Family Welfare, Department of Women & Child health, and Department of Education.

NHM under Department. of Health & Family Welfare envisages achievement of universal access to equitable, affordable & quality health care services that are responsive to people's needs. Various programs under NHM, which cater to the health needs of children and adolescents include RBSK, RKSK, child health program and many more. The District Mental Health Program (DMHP) is another program which was initiated with a vision to decentralize mental health services and provide care in the community through integration with general health care. In Karnataka, DMHP has been hugely successful in achieving this mission. Integration of child and adolescent mental health services to the existing DMHP services is the next step to promote holistic mental health services at the community level.

An active collaboration between NHM, Government of Karnataka and NIMHANS led to the initiation of this training project "Strengthening Primary and Secondary Level Child and Adolescent Mental Health Services in Karnataka" for DMHP psychiatrists, psychologists, social workers, nurses, and other key community health workers in child and adolescent psychiatry. This marks a new milestone both for DMHP program and public mental health policy.

I extend my hearty congratulations to all the doctors at NIMHANS and H&FW, who have come up with this manual "CHILD AND ADOLESCENT MENTAL HEALTH" to further assist community health workers and DMHP team members, in steps to promote positive mental health through community programs, diagnosis and management of cases, and indications for referral. I hope that in the coming years, we are able to extend our work to make child and adolescent mental health services available to all, especially to the underprivileged and marginalized segment of people.

Best wishes!

A handwritten signature in black ink, appearing to read "Arundhathi".

Dr Arundhathi Chandrasekhar I.A.S.
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Prof P K Dalal

President
Indian Psychiatric Society

MESSAGE

Children and adolescents constitute 30% of the Indian population. Globally, 14% of the disease burden is attributed to mental, neurological, and substance use disorders and 75% of the people affected are in low-income countries without access to needful treatment. Recent National Mental Health Survey done in 2016-17 reports the overall prevalence of any mental morbidity among adolescents at 7.3%.

Despite the high prevalence and morbidity associated with childhood-onset mental health issues, mental health care services for this age group in the country are limited due to inadequate funding and lack of trained clinicians. Existing services are also inequitably distributed and primarily restricted to curative services in tertiary care facilities, thereby limiting access to most children in need. There is an urgent need of developing and providing evidence-based preventive measures and interventions at primary health care setting and community level for mental disorders in children.

Support for child and adolescent mental health research is needed, particularly in low-and-middle-income countries (LAMICs), including prevalence, longitudinal studies, high-quality clinical trials, and cost-effectiveness analyses.

Indian Psychiatric Society (IPS) is happy to be associated with the Institute of National Importance, NIMHANS which has come up with an initiative to take child and adolescent services to the unreached through effective integration with existing services such as District Mental Health Program (DMHP) and Rashtriya Bal Swasthya Karyakram (RBSK). This is a cost-effective strategy to maximize our potential using existing resources. The manual that has been developed will serve as a simple guide for medical officers who work at ground level to decide on essential management and red flags for a referral to higher centres. I sincerely request the Ministry of Health and Family Welfare to validate this model and inculcate similar models in all other states to ensure quality services across the country.

This manual is likely to be of immense importance for the members of IPS, trainee mental health professionals and teaching institution for further training purposes as well. Through IPS, this useful manual is to be made available to all the IPS members also.

On behalf of IPS, I take this opportunity to congratulate and wish good luck to all the team members involved in the development of this manual.



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MESSAGE

The mental health issues of children and adolescents have long-lasting effects into adulthood. The overall prevalence of mental health morbidities among adolescents is 7.3% (as per the National Mental Health Survey report published in 2017). Research indicates that a significant proportion of mental health problems in adults tend to have onset in childhood/adolescence. Early intervention and prevention offer the hope to avoid later adult mental health problems and improve personal well-being and productivity. So, it is the responsibility of every stakeholder to address mental health needs of this age group; otherwise, it can adversely affect the child's full developmental potential.

Successive governments have introduced a number of policies and schemes to address the needs of children and adolescents. The Ministry of Health and Family Welfare has launched multiple programs under the National Health Mission, most notably Rashtriya Bal Swasthya Karyakram (RBSK) program which focuses on early intervention services for children between ages 0 to 6 years and older children, and Rashtriya Kishor Swasthya Karyakram (RKSK) for adolescents in the age group of 10-19 years. These programs aim at comprehensive care of the health and development needs for this age group. Apart from this, the District Mental Health program (DMHP) has been successfully delivering mental health services since many decades, but it predominantly caters to adult populations. Regarding delivery of child and adolescent mental health services, there has been a challenge so far due to lack of trained manpower. Furthermore, the emerging needs of the children are becoming very complex due to which the existing skills and capacities of governmental and non-governmental staff need to be updated on a regular basis.

The Department of Child and Adolescent Psychiatry, along with the Community Mental Health Unit of Department of Psychiatry, NIMHANS jointly collaborated with National Health Mission, Government of Karnataka and took up a training project involving all Karnataka DMHP psychiatrists, psychologists, social workers, nurses and select RBSK officers. The agenda for this training was manpower enhancement and capacity building in order to provide affordable primary and secondary mental health care services to all children and adolescents at their doorstep. All staff have been extensively trained through classroom teaching, clinical skills and online case-discussion based teaching over the last 18 months. This book: "**CHILD AND ADOLESCENT MENTAL HEALTH: A manual for Medical Officers**", is the collective effort of The Department of Child and Adolescent Psychiatry, and the Community Mental Health Unit of Department of Psychiatry, NIMHANS. It will serve as a guidance manual and further help these professionals in smooth implementation of child and adolescent services. We hope that this training model sets a precedent in de-centralising child services and bringing it to the community. It also requires active participation from parents, teachers and communities at large, which should be propagated by health officers working in this field.

I sincerely thank the Government of Karnataka for supporting this initiative. I wish best of luck for all the future endeavours in this field. Step by step, we can move forward to achieve our dream of providing accessible mental health care services to one and all.

Date: 30-07-2020

Dr. B.N. Gangadhar
Director, NIMHANS

EDITOR'S NOTE

Child and adolescent mental health services are so far largely restricted to urban set-ups. The manpower and training required to tackle the existing healthcare burden is already limited. The COVID-19 pandemic has further exposed this vulnerable age group to stress and related mental health issues. Therefore, it is imperative that urgent steps are taken to address child and adolescent mental health needs at every level and to gear up training and service delivery within the community. Effective delivery of such services would require integration of mental health services into existing programs and utilization of existing manpower such as primary care doctors at PHC, district mental health program professionals (including psychiatrists, psychologists, nurses, and social workers) and community health workers. These professionals can then sequentially involve other stakeholders (parents, teachers, social services, and community services).

*With this goal in mind, the Department of Child and Adolescent Psychiatry, and Community Mental Health Unit of Department of Psychiatry, NIMHANS jointly collaborated with the National Health Mission, Government of Karnataka and came up with a training project called **“Strengthening Primary and Secondary Mental Health Services in Karnataka”**. The aim of the project was skills training and capacity building in the domain of child and adolescent psychiatry so that we have more trained professionals to deliver mental health services in a graded manner to all children and adolescents across the state. Through this project, we were able to train all Karnataka district hospital and DMHP professionals (psychiatrists, psychologists, social workers, nurses), and 100 RBSK officers over a period of 1 year in both preventive measures and early identification of childhood mental illnesses. We continue to do online case-discussion based teaching for DMHP teams on a weekly basis.*

The onset of COVID-19 pandemic brought forth new challenges including an increase in childhood mental health problems as well as interference with usual service delivery. Keeping these factors in mind, this manual has been developed to specifically guide medical officers and mental health professionals in promotion of positive mental health, prevention of illness, early identification of illnesses and to distinguish the need for referral to higher centers. It has been designed in a simple manner for quick reading and focuses on more practical aspects in relation to COVID-19 which can be readily implemented in resource-deficit settings. We hope that this book serves as a useful resource to further strengthen service delivery and overcome the challenges due to the pandemic.

We are deeply obliged to the National Health Mission, Government of Karnataka, for funding this program and helping us reach one step closer to our dream of expanding public mental health services to children and adolescents.

Editorial Team

Bengaluru

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At the outset, I would like to acknowledge the role of all our teachers at NIMHANS who constantly motivate us to do meaningful work and guide us along every step.

I am sincerely thankful to the following people from Government of Karnataka who have constantly supported and guided us at various stages:

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- Shri Pankaj Kumar Pandey, Commissioner, Health & Family Welfare Services, Government of Karnataka
- Dr. Arundathi Chandrashekhar, Mission Director, National Health Mission
- Dr. Patil Omprakash R., Director, Health & Family Welfare Services, Government of Karnataka

I would like sincerely extend my thanks to the following people at NIMHANS who have constantly motivated me and guided me along every step:

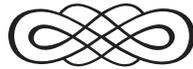
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- Mr. Yathish S., Projects Section, NIMHANS

I would like to sincerely thank National Health Mission, Ministry of Health and Family Welfare, Government of Karnataka, for funding this project.

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ABBREVIATIONS

ADHD	Attention Deficit Hyperactivity Disorder
ADL	Activities of Daily Living
ASD	Autism Spectrum Disorder
CHC	Community Health Centre
CD	Conduct Disorder
CSA	Child Sexual Abuse
DBD	Disruptive Behavioural Disorders
DMHP	District Mental Health Program
ED	Emotional Disorders
GDD	Global Developmental Delay
GOK	Government of Karnataka
IDD	Intellectual Development Disorder
ID	Intellectual Disability
IQ	Intelligence Quotient
MO	Medical Officer
NIMHANS	National Institute of Mental Health & Neuro Sciences
NIOS	National institute of Open Schooling
NTA	National Trust Act
ODD	Oppositional Defiant Disorder
PHC	Primary Health Centre
POCSO	Protection of Children from Sexual Offences Act
PCP	Primary Care Physician
RPWD	Rights of Person with Disabilities Act
SC	Self-Cutting
SI	Self-Injury
SLD	Specific Learning Disorder
SUD	Substance Use Disorder
WHO	World Health Organization



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INTRODUCTION

1. INTRODUCTION

I. INTRODUCTION TO CHILD AND ADOLESCENT MENTAL HEALTH

II. IMPACT OF COVID-19 PANDEMIC ON MENTAL HEALTH OF CHILDREN AND ADOLESCENTS

2. NORMAL CHILDHOOD DEVELOPMENT

3. PARENTING STYLES AND IMPACT OF PSYCHOSOCIAL ADVERSITIES ON DEVELOPMENT

Chapter 1

INTRODUCTION

I. INTRODUCTION TO CHILD AND ADOLESCENT MENTAL HEALTH

Harshini M, John Vijaysagar K.

Child and Adolescent Mental Health is an important public health issue across the world and especially in developing countries like India. Children and adolescents constitute approximately 40% of our national population, which is approximately 300 million. In Karnataka, 31% of rural population and 25.5% urban population are under 15 years of age and 21% population comprises of adolescents between 10 to 19 years. The ongoing Covid-19 has adversely impacted the existing systems and resources across all the units of community and the pandemic is expected to continue for a year or two.

Mental health conditions account for 16% of the global burden of disease and injury in people aged 10–19 years. Epidemiological and community-based studies in India have reported a prevalence ranging from 6– 12%. The recent National Mental Health Survey reported a prevalence of 7.3% in children and adolescents aged 13-17 years. Overall 8-13% of children are in need of mental health services. Experts predict that, Covid-19 impact will increase the occurrence of mental health morbidity among children. The huge treatment/service gap exists in developing countries like India and stigma remains as a major barrier for treatment seeking.

Mental health issues of childhood tend to have long-lasting effects in adulthood. These include future emergence of mental health illnesses such as depression, anxiety and substance use disorders. It has an adverse impact on academic performance and functional outcomes into adulthood. Violence, aggressive behaviour, child safety/abuse and excessive use of gadgets, gaming disorders etc, are the contemporary issues in this vulnerable age group need immediate public health attention.

Enabling and empowering Primary Health care services is the important approach to address the existing broad treatment gap and to address the treatment barriers. As per World Health Organization recommendation, majority of parent and child related Psycho-social (non pharmacological) interventions can be delivered at Primary care level by trained health care workers. This chapter has two sections, this first section will allude to introduction to child and adolescent mental health, the second section will address the Covid-19 pandemic's impact on child and adolescent mental health.

■ Common Child and Adolescent Psychiatric Disorders

The common child and adolescent mental health issues may be broadly classified into three groups:

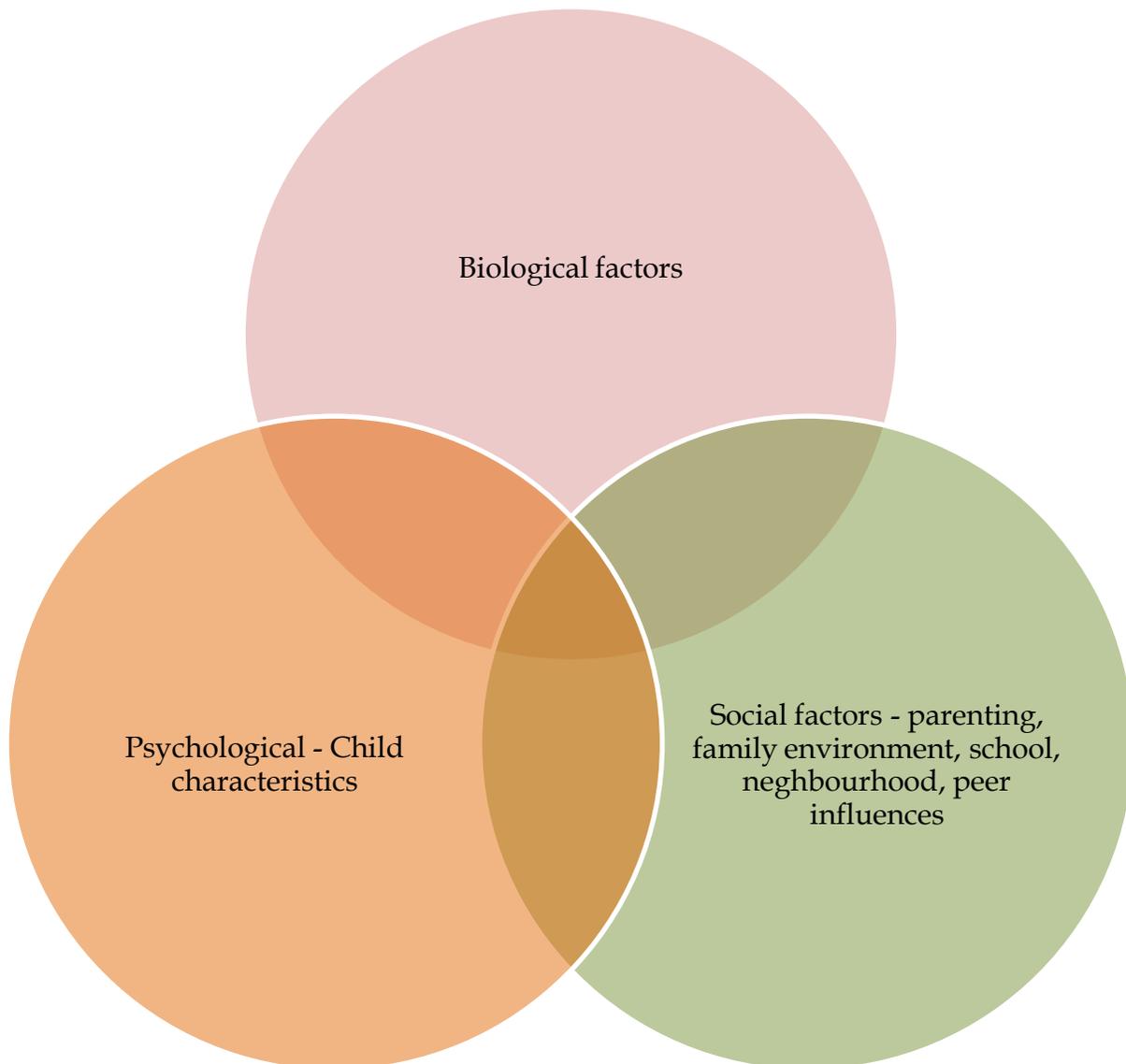
- a) *Neuro-developmental disorders*: Intellectual Developmental Disorder, Speech and language-related disorders, Autism spectrum Disorder (ASD), Specific Learning Disorder.

- b) **Emotional disorders:** Depression, Anxiety spectrum disorders (generalised anxiety disorder, separation disorder, phobias), somatoform disorders and conversion disorder.
- c) **Behavioural disorders:** Attention deficit hyperactivity Disorder, Oppositional disorders, and conduct disorders.

Comorbidity is a rule rather than an exception in child and adolescent psychiatric disorders. It usually presents with more than one comorbidity. Comorbid conditions can both medical (such as epilepsy, neuromotor impairment, cerebral palsy) or psychological in nature. Severe mental illnesses such as schizophrenia and bipolar disorder can occur during adolescence. When compared to adults, these disorders are less prevalent among adolescents.

■ **Risk factors for Psychiatric Disorders in Children and Adolescents**

Child and adolescent mental health issues are best understood from a *bio-psycho-social model*. According to this model, development of illness is determined by an interplay of biological, psychological and social risk factors.



Risk factors for the development of mental health issues in children have been divided into:

- a) **Biological factors:** pre and perinatal exposures to illness/insult, prenatal exposure to substances/ toxins like Nicotine, Alcohol etc, family history of psychiatric and developmental disorders,
- b) **Child characteristics and related factors:** sex, age, ethnicity, intelligence, thinking, coping and relational patterns/styles.
- c) **Environmental factors:** include influence of family environment, parenting style, neighborhood, school, peers, bullying, high parental expectations, *Child abuse* and *neglect* and broader community factors. *Child abuse* and *neglect* may result in a wide range of emotional and behavioral problems in children and adolescents. (*for more details, refer to chapter 3 – parenting*)

Broader contextual influences like disadvantage and poverty, natural disasters, displacement, migration, war and violence, overcrowding, institutional rearing also serve as risk factors for child and adolescent mental health issue.

Note: The ongoing covid-19 pandemic's impact on economic, social aspects, school systems and the families of the community is expected to adversely effect the child and adolescent mental health. The second section of this chapter elaborates on this aspect.

■ Current Situation and Way forward

National Policies and Programmes: A gradual shift in the focus of the national health programmes from nutrition and infectious diseases to developmental needs, life skills, and general wellbeing of children and adolescents emphasizes the need for promotive and preventive strategies. National Programmes like Rashtriya Bal Swastha Karyakram (RBSK), Rashtriya Kishore Swastha Karyakram (RKSK), Kishori Shakthi Yojna increasingly focus on developmental and mental health care needs.

The National Mental Health Programme envisioned scaling up of mental health care services in the country. With the District Mental Health Program, there is a focus on decentralization and enhancing mental health care service delivery at the primary and secondary care level. The DMHP program aims to bridge the gap in mental health and bring mental health services to the community. Karnataka state has successfully implemented DMHP program in all 31 districts, where they conduct weekly Mano-Chaitanya Clinics at taluks, do community outreach programs at school and panchayat level, and door-to-door surveys to ensure complete coverage. In association with NIMHANS, the DMHP teams in Karnataka have also received hands-on training in identification and management of child and adolescent mental health issues. At district level, taluk level and primary health care level, there should be integration of strategies to encourage positive mental health development in children and adolescents and to provide necessary mental health services.

■ Care for future Generation: Greater Role of Primary care physicians

Primary care physicians and health care workers need to play an important role in improving awareness of community regarding child and adolescent mental health issues, and in their early recognition and referral. Early identification and intervention can significantly improve outcomes, have a positive influence on the developmental trajectory and prevent or reduce the long-term adversities.

Initiation of feasible interventions with available resources at a primary care level can reduce treatment delay. Primary care physicians can empower themselves to provide brief Psycho-social interventions to child, parents, caregivers, which comprise more than half the interventions required in this domain. These brief interventions will have a long-lasting positive effect on child's health, development and his/her family functioning and wellbeing.

■ Regrading Manual

This training manual aims to sensitize the primary care physicians regarding mental health issues in children and adolescents. It will also be useful to mental health professionals working at community level. Individual chapters deal with common mental health issues in this population, assessment, and management strategies, which are feasible at the primary care level with the available resources; and points of referral to higher centers for more specific interventions. This aspects will also helpful for physicians to carry out other child and adolescent health programs like RSKS etc, The periodic training of the physicians with the manual by DMHP Psychiatrists will, in turn, facilitate effective case detection, strengthen referral systems, and ensure follow up and continuity of care in the community.

■ Conclusions

Child and adolescent mental health issues are of public health importance. Over and above the existing treatment gap, the ongoing Covid-19 pandemic is expected to affect the child and adolescent mental health adversely. Primary care physicians have greater role in the providing mental health care for children in order to bridge the existing treatment gap and also to effectively address the treatment seeking barriers like Stigma. A short time spent by them with child and parents; to educate about the condition, to give parenting tips and quick guidance about home-based interventions can go a long way in ensuring positive development in the child.

Chapter 1

INTRODUCTION

II. IMPACT OF COVID-19 PANDEMIC ON MENTAL HEALTH OF CHILDREN AND ADOLESCENTS

Vandana B. Shetty, Rajendra K. M., Rajani P.

■ Introduction

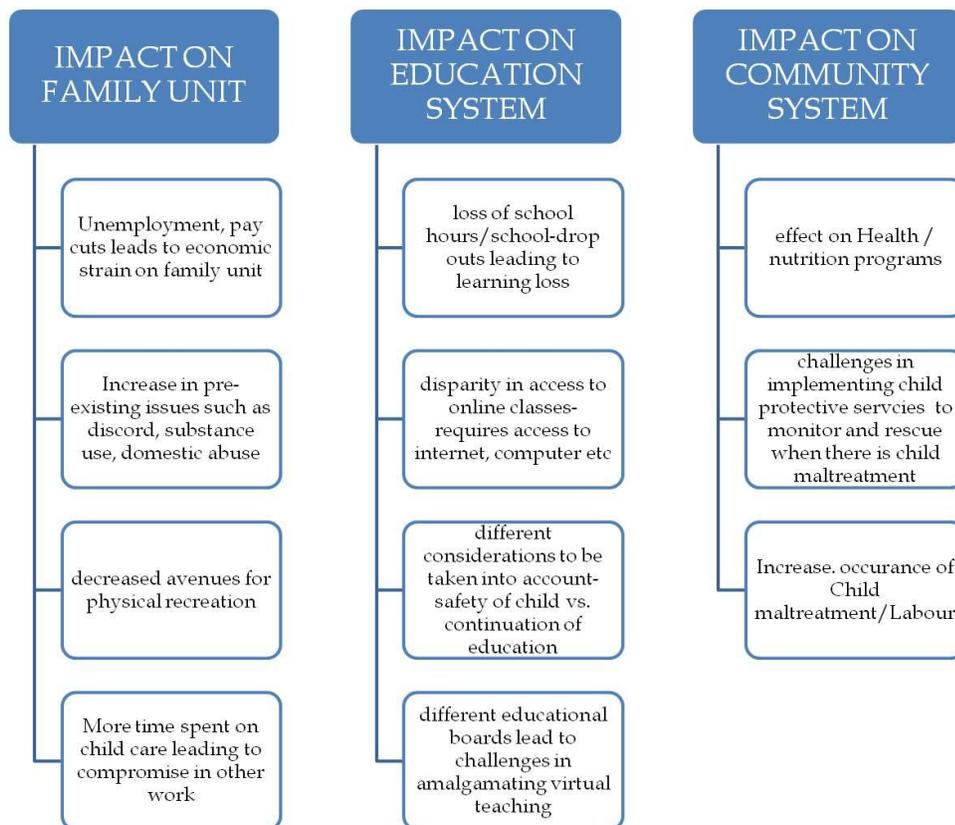
India has already recorded more than 40 lakh confirmed cases with more than 70,000 deaths by August end of 2020. The ongoing COVID-19 pandemic and the measure to control it had, and are continuing to have a global impact on all domains of community, leading to great financial strain, economic slowdown, loss of jobs, and loss of social support systems. These systemic changes and challenges are likely to have an impact on the mental health of children and adolescents due to its effect on family dynamics, educational systems, and government child welfare programs.

■ General impact

The impact on children and adolescents is closely related to the impact on important correlated systems such as family, schools and community at large.

IMPACT OF COVID-19 PANDEMIC ON VARIOUS SYSTEMS:

All these factors collectively increase stress in children



Impact of COVID-19 pandemic on family units: Demands are more than Resources

1. **Resources-** limitation of resources including social support, school systems, financial constraints, job loss.
2. **Relationships-** social isolation limits access to peer groups and trusted elders for social support
3. **Recreation-** limitation of space and activities for physical and mental recreation due to restrictions on movement and being confined to home
4. **Family dynamics-** including sharing of household responsibilities, child caregiving burden while also managing work will add to stress of family units can lead to parental burnout

■ Impact on psycho-social environment of children and adolescents

Children and adolescents are also experiencing a dynamic shift in their environment due to the pandemic. Some significant changes include:

- Mirroring family's response and coping patterns to stressors such as financial burden, lack of social support, physical health issues
- Children may tend to exaggerate and catastrophize the current pandemic situation due to information overload through various sources
- Disruption of daily routine, changes in appetite and sleep patterns
- Loneliness due to lack of peer companionship and isolation
- Relying more on digital gadgets, virtual gaming and substance use as a substitute to outdoor recreation.
- Learning loss due to disruption of school-based academic activities. This is likely to disproportionately affect children and adolescents from low income families leading to higher rates of school dropouts
- Engaging in high risk behaviour to overcome boredom- including increased unsupervised time, increased screen-time, accessing pornographic content, divulging sensitive information online to strangers
- Increased rates of abuse (physical, emotional, sexual), child marriage and child labour

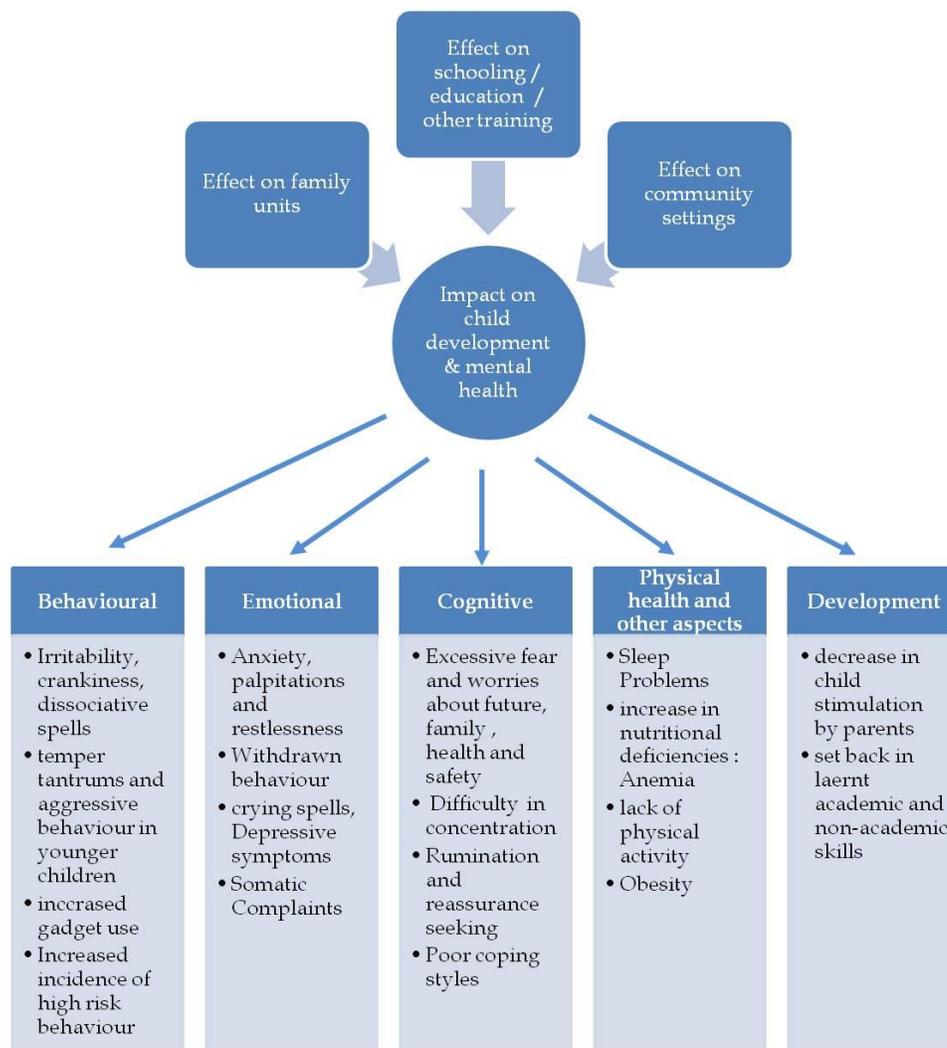
■ Impact on children and adolescents with pre-existing mental health issues or disabilities

In addition to the above mentioned factors, some additional factors which play a role in children with physical/mental disabilities and pre-existing mental health conditions include:

- Inability to express needs and poor frustration tolerance
- Impact of isolation or limited social activities- children with anxious traits will become further withdrawn
- Children with social regulation deficits or externalising traits may appear to have further **accentuation of behavioural issues**
- Difficulties in availability and access to therapeutic interventions, training and special education
- Difficulties to access to health-care, to procure medications
- Children **living in abusive environments may face increased traumatic experiences** leading to worsening of associated conditions

■ Consequences to mental health of children and adolescents

Depending upon the child's environment and his/her individual temperament and coping styles, there may be changes in the child's emotional, behavioural, cognitive and physical health.



■ How to address the concerns

To face the challenges posed by pandemic, all stakeholders and at all levels of society is need to take-up active adoptive roles. The problems are constantly evolving; therefore the solutions also have to be dynamic. Maintaining safety, ensuring development and positive mental health of children and adolescents should be a prerogative for everyone including parents, teachers, health professionals and policy makers. We have mentioned a few suggestions below which can be helpful during the coming days.

❖ *At health care level*

All medical officers, ASHA workers and other primary healthcare workers who are primary point of contacts in health emergencies should be mindful of and screen for early recognition of psychological issues. Referral to specialist mental health professionals should be considered at the earliest whenever any symptoms of psychological distress are noted. Some notable pointers are:

1. *Screen all children* who come in contact with health services for any signs of emotional distress
2. *Children may present with* change in appetite, sleep disturbances, repeated reassurance seeking, becoming withdrawn or excessive use of digital screens
3. *Children coming from difficult backgrounds are more susceptible* to psychological distress or to be victims of abuse. These include children from families with economic difficulties, parental physical or psychological illness, substance use disorder among parents.
4. For children *with pre-existing mental illness or disability*: Ensure continuity of any psychotropic medications that child is already receiving. Be prudent while introducing any new medications

For DMHP professionals:

- a) Ensure access to mental health care is available in the best feasible manner even during lockdown- telephonic follow-up with existing patients, providing helpline numbers for guidance etc
- b) Recognize and treat mental health and substance disorders in parents
- c) Family counselling should be arranged – to extend emotional support to parents, hearing out their concerns, giving practical solutions to their problems, encouraging parents to take care of their own health
- d) Enquire about wellbeing of children of persons with mental illness in clinics and provide parenting inputs
- e) Liaison with schools and social services to minimize the impact of pandemic on children as needed in cases of child abuse, child labour
- f) Empowering and enabling teachers and other stakeholders to deal with emotional problems in children through early identification and teaching life skills

Key points while counseling parents:

- Parents should be given time to express their challenges and difficulties in a non-judgemental and empathic environment
- Parents should be encouraged to pay attention to their own mental health and to speak out their distress often
- **Give practical solutions-** focus on enhancing **effective communication among parents** about family difficulties, help them **reorganising family needs and goals** with sharing of responsibilities based on available resources, encourage shared child-care time such that both parents get enough time to balance other work.
- Spend quality time with child, engaging in a joint recreational / Physical activity
- For emotional, financial, family and job related difficulties: encourage to seek help from people/systems for support

❖ *At educational level (for teachers/schools)*

Teachers and schools will continue to play a significant role in promoting positive mental health of children once academic activities resume. Some suggestions which may be useful are:

1. Taking into account learning loss and allowing for catch up learning
2. *Enhancing learning continuity-* the modes of educating children should be modified to engage children from all backgrounds at least for a few hours daily.
3. Three approaches can be considered depending on feasibility:
 - a. Offline teaching (regular school and classes) are more suited for children with limited resources.
 - b. Home-based education through worksheets and assignments may be suited where parents are educated and can spend some time in helping children with studies. Teachers can maintain continuity through periodic discussions with the family.
 - c. Online classes are suited only for children above 10 years age- the classes should be planned in an interactive manner and be time-limited
4. There can be a dedicated TV channel/other media avenues with *uniform syllabus* for children above 10 years of age
5. Schools should also be an avenue for *teaching life skills* to children. Equal importance should be given to teaching about health education, promoting positive physical and mental health of children, and stressing on the importance of balanced nutrition and regular exercise.

6. School should consider *alternative methods of evaluating students* for their curricular achievements or consider promotion based on overall abilities
7. When schools eventually re-open, teachers should *promote safe hygiene practices* in classrooms including safe distancing, educating children on modes of spread, and how children can contribute to prevention of spread

❖ *At community level*

- Community activities focused on *building resilience* among people should be considered- dissemination of information on mental health through TV, radio, internet and pamphlets; building support networks within community to promote health activities and positive coping skills; helplines for help seeking
- Since mid-day meal programs have been suspended, government should come up with alternate plans to *continue nutrition programs*.
- *Social services* aimed at *protecting vulnerable children* from child labour, child abuse and school-drop outs should be strengthened and closely monitored
- Improve access to equitable education for all - newer methods to promote community learning, increase outreach of digital learning and modifying exam evaluations should be considered in liaison with schools

■ **Suggestions to parents to promote mental health of children in home settings**

1. *Teaching healthy coping styles to children* – encourage open discussions to allay their fears, modelling calmness and positive behaviours around children, dealing with your own emotions in a responsible manner as children take cues from behaviour of adults around them.
2. *Spend quality time with children* by involving in activities which you previously didn't have time for- like board games, doing exercises together etc.
3. Developing and *maintaining a daily routine* for children and adolescents with adequate time for chores, academic work, play, interaction with peers and relatives; to have set times for meals, physical activity and sleep.
4. Limit amount and type of *screen-time*: try to set time-limits for usage of screen time with reasonable exceptions. There must be monitoring to supervise usage
5. *Avoid unhealthy coping skills while dealing with your own emotions* (such as shouting, displacing anger, substance use, violence, breaking things, attempts to harm self) as children tend to model these maladaptive methods of coping
6. *Utilize this time to inculcate life-skills in children*

7. *Seek help from mental health professionals* if you observe significant changes in your child's behaviour such as repeated reassurance-seeking, appearing worried constantly, sleep and appetite changes, tearful etc.

■ A note on COVID-19 affected children and families

Children whose families have *been quarantined* due to suspected/diagnosed COVID-positive infection may be anxious, worried for their loved one, and also face the risk of stigma. Such children are better managed with specialist interventions. Children who themselves are positive, are admitted alone without any caregiver in the hospital. This would be a time of extreme distress, loneliness and fear in the child's life. Such children will benefit from supportive therapy and periodic monitoring of mental health through specialist services.

■ Conclusions

Most countries in the world have not yet been able to contain the spread of the COVID-19 pandemic and are grappling to find solutions which can balance risk of further spread with resuming normal life activities. In such a time, both the problems and the solutions are dynamic and evolving. However, based on current experiences, some simple strategies may help to promote positive mental health in children and adolescents even in this turmoil. However, it requires active involvement and sustained effort of individuals and communities at all levels.

Key highlights of section one:

- Disorders with onset during childhood often tend to persist in adult life with varying severity and level of difficulties. Early intervention can prevent long term adversities
- Large treatment gap exists in the mental health services and stigma is a major treatment seeking barrier
- Primary care physicians and health care workers need to play an important role in improving awareness of community regarding child and adolescent mental health issues, and in their early recognition and referral
- 50-60% of counselling and home-based interventions can be successfully delivered by trained health workers at primary health care level.

Key highlights of section two:

- COVID-19 is an evolving pandemic which has impacted all domains of life and all societies. Children and adolescents are at equal risk of the psychological impacts as adults.
- Some contributing factors in children are social isolation, disruption of routine schedule, boredom, learning loss, sharing worries of family member, including economic burden, exposure to information overload

- Family counselling is important: listening to distress, encouraging the solving problems by enhancing effective communication among parents and helping them to balancing the demands and available resources.
- Impact on children can be emotional, behavioural and/or cognitive, needs to be addressed accordingly
- Children with pre-existing illness or disability are at higher risk and the continued treatment should be ensured
- Community approaches should be aimed at modifying the delivery of; healthcare services, education, and government welfare programs to ensure children's safety, health and learning.
- Mental health professionals should focus on providing psychological support to both parents and children, liaison with schools and social service agencies
- Children who are affected by COVID-19 need special support to prevent stigma, allay fears and anxieties.

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Chapter 2

NORMAL DEVELOPMENT

Vandana B. Shetty, Rajendra K.M., Chethan B.

Normal development can be defined as *an average or 'on-time' growth based on the attainment of specific physical, cognitive, language, social-emotional, and behavioural milestones across specific stages.*

Normal development is charted based on population averages; therefore there is no absolute value but rather a normal range. There will be variations based on race/ethnicity, cultural groups and contextual factors like socioeconomic status, community.

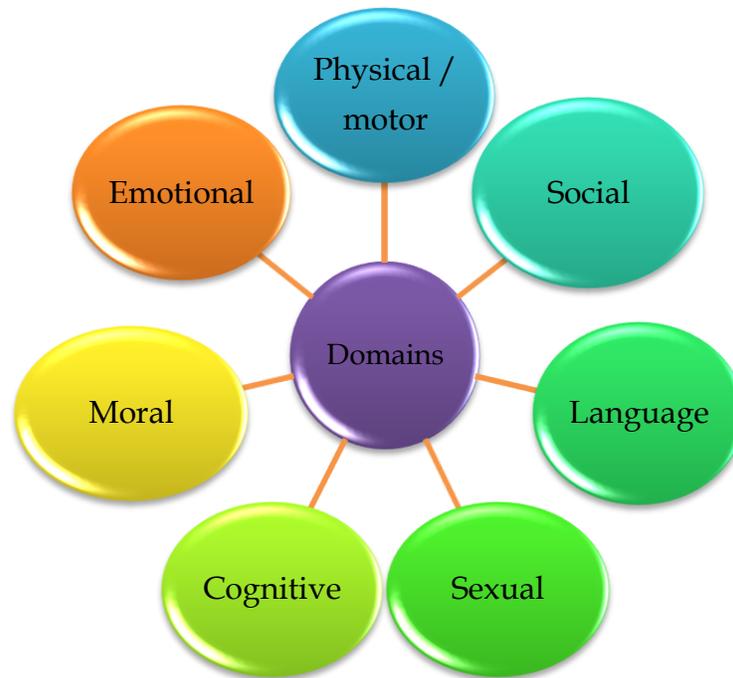
■ Factors determining normal development

Development never occurs in isolation. It is influenced by a wide array of things that happen in and around the child.

- a) **Nature vs. Nurture:** The role of genetic and inherited factors (nature) vs. role of life experiences (nurture) in the context of family, school, peers, community and culture. Current understanding is that both these dimensions interact with each other and play a role in normal development.
- b) **Nutritional status of child**
- c) **Critical periods:** A critical period is a limited time that starts and ends abruptly within which a specific function should develop. If the conditions for development are not available during this time, then it is not possible to acquire these functions later in life, e.g., language acquisition must start within the first 5 years of life. Similarly the critical period for vision development is within the first year of life. If this critical period is lost due to lack of visual stimulus secondary to cataract etc., then the vision cannot be restored at later ages.
- d) **Sensitive period:** It is a time when it is *easiest* for children to acquire certain skills. It is a time of maximum sensitivity that begins and ends more gradually, e.g., it is much easier to learn a second language before the age of 6 years even though it can be learnt at any age.
- e) **Cultural influences:** Cultural practices vary across regions and religions. Certain practices may help promote or hinder the process of normal development, e.g., traditional practice of oil massages for babies in Asian and some African cultures has shown to strengthen child's motor coordination and physical growth.
- f) **Social influences:** The child's development is also influenced by social factors such as socioeconomic status, education level of parents, parent's physical and psychological health, exposure to natural disasters (floods, migration etc.) These factors indirectly impact development by influencing the level of stimulus a child receives.

■ Domains of development

Normal development occurs simultaneously across various domains. However, for a better understanding, development can be broadly divided into the following domains:



■ Stages of development

Child development can be divided into the following stages based on age-graded milestones:

1. Infancy: 0 to 2 years
2. Toddler/Preschool: 2 to 5 years
3. Middle childhood: 6 to 12 years
4. Adolescence: 13 to 18 years
5. Emerging adulthood: 19 to 29 years (in many western cultures, this is considered to be a continuation of adolescence as part of an extended transition to adulthood)

We will briefly discuss the important milestones achieved at each stage and important warning signs to be identified for early detection of developmental delay.

1. Infancy (0-2 years)

The first two years of life are a period of rapid growth and development, which is most evident in the physical growth, language and cognitive development. Skills are achieved in an individualistic manner but are influenced by genetics, cultural practices and amount of stimulus received. The key milestones in all domains have been enumerated:

INFANTS (0-2 YEARS)					
AGE	PHYSICAL MILESTONES	SOCIO-EMOTIONAL MILESTONES	LANGUAGE MILESTONES	COGNITIVE MILESTONES	RED FLAG SIGNS
0 - 3 months	Head control fully achieved by 2- 4 months	Social smile: 6 weeks	Crying to express needs - at birth Cooing: 3 months	Differentiation of external stimuli (sounds, colour etc.): Birth to 6 months	No head control by 3 months No social smile by 3 months
3 - 6 months	Rolls from back to side Grasps objects by palm by 5 months	Attachment with primary caregivers: by 4 months Separation anxiety: 6m- 2yrs	Babbling : 6 months		Does not roll over no babbling No attachment to caregivers
7 - 12 months	Sits alone: 5-9 m Picks up pebble/cube: 6- 8m Crawls: 5-11 m. Picks up beads (smaller objects): 10m. Stands alone: 9- 16m.	Stranger anxiety : 8m- 2yrs	First word : 8-18 months Responds to own name	Memory improves consistently; delayed recall: 7-9 months Object permanence: 8- 10 months	Cannot sit without support by 9 months Cannot stand by 12 months Does not respond to name
12 - 18 months	Walks alone: 12- 17 months Builds tower of two cubes: 10-19 months	Self-awareness : 13 months First demonstrations of empathy: 18 months	Speaks single words	Joint attention Pointing at objects of interest	Cannot walk by 18 months Does not speak single word Does not point at objects
18 months - 2 years	Tries to use a spoon: 12-16 months Draws a straight line : 2 years	Play: imitation of others, parallel play with peers, and play based on gender stereotypes	Joins two words: by 2 years	Identifies body parts Pretend-play based on daily life themes	Does not imitate others No pretend play

2. Toddler/Preschool age (2-5 years)

This is the age group where the child has started to move around and explore the environment around him. Physical development moves at a slower and steady pace, whereas cognitive and social abilities develop significantly in this phase.

PRE-SCHOOL AGE (2-5 YEARS)				
	SOCIO-EMOTIONAL MILESTONES	COGNITIVE MILESTONES	LANGUAGE DEVELOPMENT	RED- FLAG SIGNS
	Temper tantrums is common between 1-3 years, reduces by the age of 4-5 years	Sociodramatic play - by 3 years	Says name, age, sex - 3 years	Frequent falls; poor hand grip Drooling of saliva from mouth or unclear speech
	Develop first friendships	Seeks out logical explanations by asking 'why' questions	Can speak 3-4 phrase sentences- 3 years Learns numbers	No interest in other children No pretend play
	Feeding & toileting self - by 5 years , almost independent in daily living skills	Memory span increases up to 4 items	Complex sentences and Narrates a story - 4 years	Extreme clinging to caregiver; poor independent skills
	Sexual curiosity & self-exploration is normative		Asks questions- 4 years	Does not understand simple instructions

3. Middle childhood (6-12 years)

By middle childhood, children have become independent in self-care skills and are able to communicate all their needs. Most children start some form of formal education by this time. This gives an increasing opportunity to children to interact with their own peer group and expands their social circle beyond the immediate family. It also gives children an opportunity to acquire knowledge and learn new skills. Some of the significant developmental milestones in this age group are:

- a) **Physical development:** occurs at a much slower and steady pace. Children progressively gain weight and height. Girls grow at a faster pace than boys. By the age of 9 years, both girls and boys will start to have growth spurt and pubertal changes. In girls, this includes breast enlargement, redistribution of body fat, pubic hair growth and eventually menarche. In boys, it includes enlargement of testes, pubic and facial hair growth.
- b) **Socio-emotional development:**
 - Develop and maintain peer friendships

- Develop self-esteem
- Gradually gain **better self-control** by delaying gratification and impulse control
- Emotional regulation develops over the years- by problem-focused coping or emotion-centered coping
- Empathy and perspective taking improves
- Develop a **sense of self**

c) *Cognitive development:*

- Able to differentiate right vs. left, categorize objects and understand time.
- Attention span improves to nearly 45 minutes by 9 years - can use selective and divided attention
- Able to use reasoning and logical thinking
- Able to understand metaphors and double meanings

Warning signs for developmental issues in Middle childhood

- Difficulty in *peer interactions* - not interested in other children; unable to make friends, social awkwardness, staying aloof
- Difficulty in *attention* - unable to focus on a task, leaves work incomplete
- *Activity levels*- either too dull or too hyperactive; cannot sit in one place, cannot wait for turn
- *Academic difficulties* - difficulties in reading, writing or mathematics
- *Poor self-esteem*, intense fear to do tasks independently; clinging to significant caregivers

4. Adolescence (13-18 years)

Adolescence is a period of transition between childhood and adulthood. It is a unique time with its own challenges.

- a) *Physical development:* The physical changes that have started towards the end of middle childhood continue onto adolescence. The age range for the pubertal changes to occur varies from 8-14 years in females and 9-16 years in males, females being slightly faster than males.
- b) *Socio-emotional development:*
- **Self-esteem** - fluctuates and is influenced by factors such as academic/work performance, peer relationships, romantic relationships, social competency

- **Identity formation** - they develop their own unique identity based on their own values, moral beliefs, position among friends and family, achievements etc
 - Fluctuations in mood are common
 - Expand social roles - take on more responsibilities in various setting such as home and school etc
 - Peer interactions - adolescents prefer to spend more time with their peers. They try to conform to peer group in order to be accepted; this may lead to peer pressure and stress
 - Develop sexual/romantic interest
 - More likely to participate in **Risk behaviours** - substance use, aggressive behaviour, bullying etc
- c) **Cognitive development:** The cognitive abilities of children continue to grow and develop such that by adolescence they are able to:
- **Abstract thinking** - adolescents are able to understand about things that they have not personally seen or experienced using their imaginative abilities
 - **Advanced reasoning** - able to implement their reasoning and logic to multiple different situations. This helps adolescents to plan for the future and make choices
 - **Metacognition** - awareness about one's own thoughts
 - **Impulsivity** is seen
 - Improvement in self-consciousness and cognitive self-regulation

Warning signs in Adolescence

Adolescents experience a range of emotions due to changes in their physical development, hormones, changes in social construct, peer pressure etc. It is common for individuals in this age groups to have mood swings, emotional outbursts, differences with authority figures as they are forming their own identity. Some warning signs warranting supervision and expert opinion are:

- Sudden change in sleep and appetite patterns
- Sudden change in academic performance or refusal to attend school
- Social withdrawal; loss of interest in all activities
- Indulging in high risk behaviour

■ A note on sexual development

Children show gender-stereotyped behaviour and attitudes right from early development which gets further intensified throughout childhood and adolescence based on influence of parenting, peer groups, play styles, sharing of roles and responsibilities, and social norms. Few key developments in this domain are:

- Gender constancy- child's full understanding of the *permanence* of his/her gender, that he/she is boy/girl usually comes by the age of 5 years. This further gets reinforced throughout different experiences of childhood and adolescence.
- Gender identity- a personal identification of one's own gender which is influenced by participating in gender-specific roles and also by connectedness with other same-sex peers. This usually occurs between 6-10 years
- Sexual development- biological and hormonal changes related to puberty start around 9-11 years in girls and between 10-12 years in boys.
- Sexual/romantic interests - develop and progress throughout adolescence (13-18 years)

■ A note on moral development

Moral development progresses slowly over the span of childhood and adolescence, as children observe and adopt the societal standards for right behaviour and good conduct by internalizing them as their own. Moral development is determined not only by the age of the child, but also the child's individual experiences, role-models, social environment and religious influences.

Moral development has an emotional component (strong feeling such as guilt, empathy), cognitive component (understanding of right vs. wrong) and behavioural component (based on people's actions). Moral development is influenced by:

- Child's age and temperament
- Parent's characteristics - positive parenting, being a role-model to child
- Parenting style- especially their method of disciplining children for a misdeed, whether inducing guilt or other forms of punishment
- Child's understanding of both the misdeed and the parent's response to it

Very young children (<5 years) make moral choices based on whether they will be rewarded or punished for their actions. As the child grows, he/she focuses on the physical consequences and self-interest in his/her moral judgement, but then slowly starts to understand other aspects such as right vs. wrong, the purpose of rules, other people's intentions and expectations. They are able to slowly self-regulate their behaviours in accordance with moral standards set by society. By adolescence, moral reasoning and behaviour strengthens and children become increasingly aware of moral aspects of social conventions and personal choice. A moral identity is formed- where the individual has a set of moral values that he/she abides by.

■ Importance of having knowledge of normal development

Every clinician and health worker dealing with children should have a thorough knowledge of normal milestones in all domains. Milestones should be noted at every opportunity, such as when the child is brought for routine immunizations, school health-checks etc.

- This will form the framework while evaluating children for any problems/delays.
- This knowledge can be used to guide parents regarding ways to create a stimulating environment and promote healthy development
- This will form a guide for clinicians to distinguish between age-appropriate normal behaviour vs. problem behaviour/red flag signs for developmental issues
- Parents of children with developmental delay can be guided on home-based stimulation techniques and progress can also be monitored by charting developmental milestones

A marginal delay in milestones by 1-2 months requires more frequent follow-up. A consistent and **significant delay** in milestones (**a delay of more than 3 months from upper range of normal**) warrants a referral to specialist for detailed evaluation and interventions. Early stimulation techniques which can be easily followed at home should be taught to primary caregivers and can prove to be the most effective interventions if followed properly. Regular follow-ups to track the progress should be arranged.

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Chapter 3

PARENTING STYLES AND IMPACT OF PSYCHOSOCIAL ADVERSITIES ON DEVELOPMENT

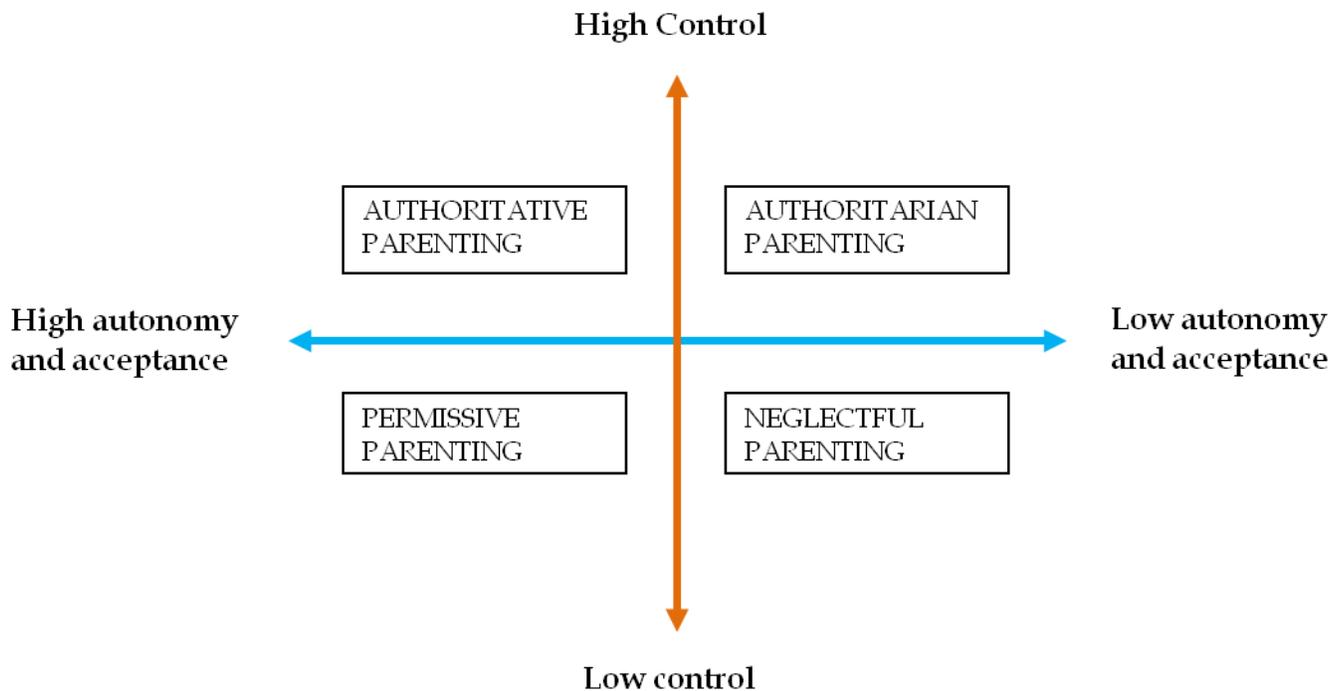
Vandana B. Shetty, Rajendra K.M.

Child-rearing styles are combinations of parenting behaviours that occur over a wide range of situations, creating an enduring child-rearing climate.

Diana Baumrind was a scientist who studied parenting styles and observed three features consistently differentiate an effective style from less effective ones:

1. **Acceptance** of the child and involvement in the child's life, which establishes an emotional connection with the child
2. **Behavioural control** of the child through expectations, rules, and supervision, which promotes more mature behaviour
3. **Autonomy granting** which encourages self-reliance

Based on these features, parenting styles can be distinguished into four main types:



■ Features of child-rearing styles

CHILD-REARING STYLE	ACCEPTANCE AND INVOLVEMENT	BEHAVIOURAL CONTROL	AUTONOMY GRANTING
Authoritative	<p>High</p> <p>Is warm, responsive, attentive, patient, and sensitive to the child's needs</p>	<p>Adaptive</p> <p>Engages in <i>adaptive</i> behavioural control:</p> <p>Makes reasonable demands for mature behaviour and consistently enforces and explains them</p>	<p>Appropriate</p> <p>Permits the child to make decisions in accord with readiness</p> <p>Encourages the child to express thoughts, feelings, and desires</p> <p>When parent and child disagree, engages in joint decision making when possible</p>
Authoritarian	<p>Low</p> <p>Is cold and rejecting</p>	<p>High</p> <p>Engages in <i>coercive</i> behavioural control: Makes excessive demands for mature behaviour, using force and punishment</p> <p>Often uses psychological control, manipulating and intruding on the child's individuality and parental attachments</p>	<p>Low</p> <p>Makes decisions <i>for</i> the child</p> <p>Rarely listens to the child's point of view</p>
Permissive	<p>High but inappropriate</p> <p>Is warm but overindulgent or inattentive</p>	<p>Low</p> <p>Is <i>lax</i> in behavioural control: Makes few or no demands for mature behaviour</p>	<p>Inappropriate</p> <p><i>Permits</i> the child to make many decisions before the child is ready</p>
Uninvolved	<p>Low</p> <p>Is emotionally detached and withdrawn</p>	<p>Low</p> <p>Is <i>lax</i> in behavioural control: Makes few or no demands for mature behaviour</p>	<p>Low</p> <p>Is <i>indifferent</i> to the child's decision making and point of view</p>

THIS TABLE HAS BEEN REPRODUCED FROM TABLE 14.1, PAGE NO. 574. BERK, LAURA E. (2013). CHILD DEVELOPMENT. 9TH ED.

Among these four styles, studies suggest that *the most effective style is the Authoritative parenting style*. Long term studies indicate that authoritative child rearing in the preschool years predicts maturity and adjustment a decade later in adolescence, whereas authoritarian or permissive child rearing predicts adolescent immaturity and adjustment difficulties. Authoritative child rearing seems to *create a positive emotional context* for parental influence.

■ Outcomes of different Child-Rearing Styles to development

CHILD-REARING STYLE	CHILDHOOD	ADOLESCENCE
Authoritative <i>Most successful</i>	Upbeat mood; high self-esteem, good self-control, task persistence, academic achievement, and cooperativeness	High self-esteem, academic achievement, and social and moral maturity
Authoritarian	Anxious, withdrawn and defiant, aggressive behaviour; unhappy mood; hostile when frustrated; academic achievement difficulties	Less well-adjusted than age-mates reared with the authoritative style, but somewhat better academic achievement and less antisocial behaviour than age-mates reared with permissive or uninvolved styles
Permissive	Impulsive, disobedient, and rebellious; overly demanding and dependent on adults; poor task persistence and academic achievement	Poor academic achievement; defiance and antisocial behaviour
Uninvolved	Deficits in attachment, cognition, play, and emotional and social skills	Poor academic achievement, depression, anger, and antisocial behaviour

THIS TABLE HAS BEEN REPRODUCED FROM TABLE 14..2, PAGE NO. 576. BERK, LAURA E. (2013). CHILD DEVELOPMENT. 9TH ED.

Parenting style has to be dynamic through the development of a child and needs changes as per the age and emotional requirements of the child/adolescent.

As the child grows and becomes more independent, parenting styles should become more engaging allowing for **co-regulation** so as to involve the child in the decision making process. As the child progresses to adolescence, parents should allow more autonomy to the child, as this builds self-confidence and self-regulation in the child while also allowing the parent to remain actively involved in the child's life.

■ Temperament and goodness of fit in parent-child relations

■ What Is Temperament?

Temperament is considered to be an innate characteristic of the child and an enduring trait relatively stable over time and contexts. Temperament is considered to be biological in origin and is present from birth. It includes the characteristic way that an individual responds emotionally to people and objects.

Thomas and Chess (1977) found **nine temperament categories**, which they believed were present at birth. These categories include the following:

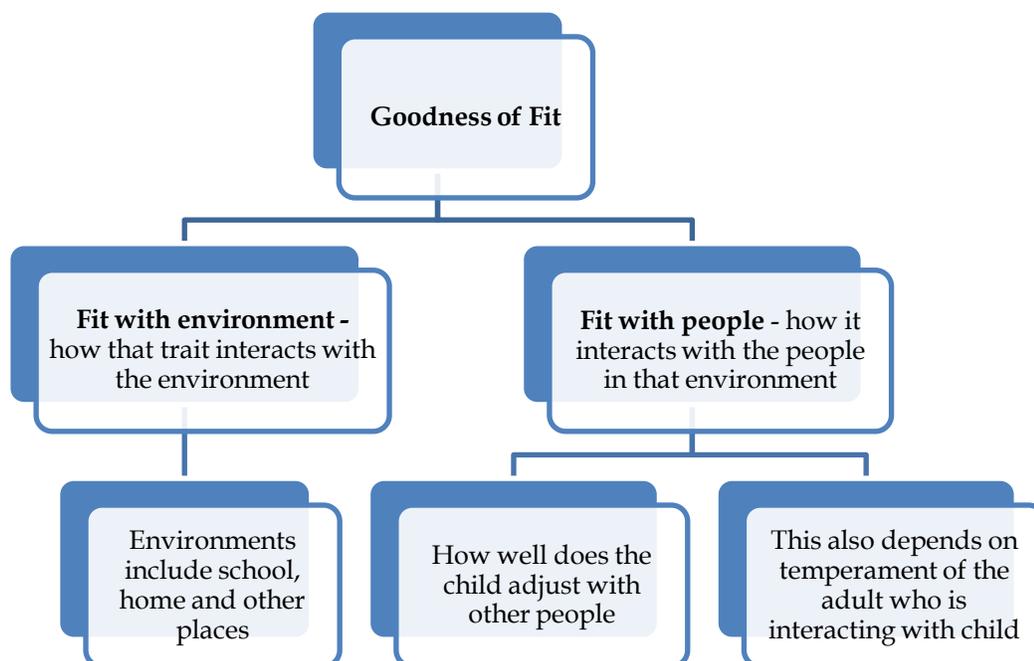
<i>Temperamental trait</i>	<i>What it means?</i>
1. <i>Activity Level</i>	Is the child mostly active or displays inactive stress?
2. <i>Rhythmicity or Regularity</i>	Is the child predictable or unpredictable regarding sleeping, eating, and elimination patterns?
3. <i>Approach-Withdrawal</i>	Does the child react or respond positively or negatively to a newly encountered situation?
4. <i>Adaptability</i>	Does the child adjust to unfamiliar circumstances easily or with difficulty?
5. <i>Responsiveness</i>	Does it take a small or large amount of stimulation to elicit a response (e.g., laughter, fear, pain) from the child?
6. <i>Reaction Intensity</i>	Does the child show low or high energy when reacting to stimuli?
7. <i>Mood Quality</i>	Is the child normally happy and pleasant, or unhappy and unpleasant?
8. <i>Distractibility</i>	Is the child's attention easily diverted from a task by external stimuli?
9. <i>Persistence and Attention Span</i>	<p>Persistence – How long will the child continue at an activity despite difficulty or interruptions?</p> <p>Attention span – For how long a period of time can the child maintain interest in an activity?</p>

Based on the type of temperament, children can be classified into one of the three groups: **easy children, difficult children, and slow-to-warm-up children.**

EASY CHILDREN	DIFFICULT CHILDREN	SLOW-TO-WARM-UP CHILDREN
<ul style="list-style-type: none"> ■ Usually positive moods and approaches to new situations. ■ Adapt quite well to change. ■ Somewhat predictable in their sleeping, eating, and elimination patterns. 	<ul style="list-style-type: none"> ■ Often experience negative moods and withdraw from things which are new. ■ Slow or non-adaptive to change. ■ Irregular sleeping, eating and elimination patterns. 	<ul style="list-style-type: none"> ■ May react to new situations in a negative but mild manner. ■ Low in activity levels and tend to withdraw in new situations. ■ More likely to warm up when approached in a way which respects their temperament traits.

■ **What Is Goodness of Fit?**

Goodness of fit is simply defined as the *compatibility between environment and a child's temperament* (Thomas & Chess, 1977).



Usefulness of knowing Goodness of fit:

Based on the nature of child, parents and caregivers need to modify their approach to the child. A child with anxious nature/slow-to-warm up needs more patient approach, frequent appreciation and more exposure to different experiences. Children who are very active need more supervision and guidance from parents.

■ Determinants of parenting

Parent-child relationships are influenced by multiple factors which determine the type of attachment security that a child develops which in turn affects other domains of the child's development.

Many of these factors *may become a barrier and pose challenges to effective parenting*. A few factors which determine parenting styles are listed below:

1. **Parental representation** (hopes, fantasies, dreams and expectations) regarding the child and their relationship.
2. **Parents' interactive behaviour** with child- better attachment with more emotional support, warm and sensitive parenting. Increased hostility towards child predicts negative attachment
3. **Parental self-regulation** - when children engage in difficult behaviour, the parent should be able to regulate his/her own emotions regarding this
4. **Inter-generational transmission of parenting** - The parent's own experience as a child plays an important role in their parenting style. Parents who were exposed to abuse, trauma or other difficult circumstances in their childhood often transmit similar styles in their own

parenting; whereas parents who were brought up in warm, supportive environments generally show better self-regulation and are able to provide a similar secure environment for their children

5. **Socio-economic factors:** parents belonging to low socio-economic status, poor social and emotional support to parents, lack of extended family. The couple relationship between the two parents also plays a significant role.
6. **Psychosocial risk factors:** like physical health of parent, psychiatric illness in parent, very low maternal age have more difficulty in parenting.
7. **Other factors** influencing are the work influences of either/both parents, religious and cultural practices also influence parenting

■ **Psycho-social adversities which negatively impact development**

Some key influences in the period of childhood can have a long-lasting and adverse impact which extends up to adulthood and influences the future personality development, risk taking behaviour and predisposes to many mental health issues. Some of these are mentioned below:

1. **Parenting styles** - as mentioned above
2. **Family environment** - A family environment where there are poor interpersonal relations between members, marital abuse, illness in one of the primary caregivers, substance use disorder, parental delinquency can adversely impact child's psychological growth. Other factors include relationship between parents (strained marital relations negatively impact the child), family structure and function (who is the key decision-maker in the family, supports from other family members, role sharing etc.), financial status etc.
3. **Child abuse** - including physical abuse, emotional abuse, sexual abuse and child neglect negatively impact the child and can lead to psychological issues. This is further determined by factors such as if the abuse is single/repetitive, by a trusted member/stranger, response of family to abuse and child's coping style.
4. **School** - Negative experiences in school include bullying, corporal punishment, peer isolation, deviant peer association etc. The impact on child depends upon the child's own temperament, moral beliefs, coping styles, and support from trusted adults such as parents and teachers.
5. **Socio-economic factors:** This includes disadvantage and poverty, natural disasters, displacement, migration, war and violence, overcrowding.
6. **Children in difficult circumstances** - Includes street children, children exposed to trafficking, kidnapping, institutional rearing also serve as risk factors for child and adolescent mental health issues.

■ Suggestions to parents to inculcate positive parenting styles

1. Create a warm and loving atmosphere for the child
2. *Be available*; listen actively when your child is talking to you and empathize with his/her problems
3. *Be approachable*; your child should feel confident to share his/her worries and desires with you. Do not brush aside his/her words or belittle him/her
4. *Be adaptive*; setting rules and taking decisions should be done in accordance with the maturity level of the child. Older children should be given a chance to actively involve in decision-making rather than the parents forcing their decision on the child.
5. *Be a good role-model*; treat everyone around with respect, model calmness and healthy coping styles around children
6. Use reinforcements to modify behaviours. Positive reinforcements and rewards should be used to encourage desirable behaviour and negative reinforcements to discourage undesired behaviours. *Punishment seldom works and should be used rarely.*
7. Both parents should maintain consistency and cooperativeness within themselves; more damage is done when one parent is too strict and other is too permissive.

■ Conclusions

Positive parenting and a supportive family environment will positively impact mental health development in children. The intensity and frequency with which children are exposed to psychosocial adversities in this vulnerable age group determines their future coping styles, problem solving skills, and adaptation to stressful life events; higher exposure to adverse life situations has a negative impact on psychological health.

Key Highlights

- Parenting styles can be of four types: authoritative, authoritarian, permissive and neglectful. Of these, authoritative parenting has been found to be most effective
- Temperamental traits are innate characteristics of the child which are biological in origin
- Goodness of fit is the level of compatibility between child's temperament and environment and people.
- A mismatch between child's temperament and parenting style can lead to significant distress
- Parent-child relations are determined by multiple factors including parent's own life experiences
- Health care professionals should understand both these aspects - from parents and child's perspective and use this information to encourage positive parenting and goodness of fit

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NEURO - DEVELOPMENTAL DISORDERS

4. OVERVIEW OF NEURO-DEVELOPMENTAL DISORDERS
5. INTELLECTUAL DEVELOPMENT DISORDER
6. AUTISM SPECTRUM DISORDER AND SPEECH-LANGUAGE DISORDERS
7. SPECIFIC LEARNING DISORDER

Chapter 4

OVERVIEW OF NEURO-DEVELOPMENTAL DISORDERS

Tess Maria Rajan, Satish Chandra Girimaji

- What are neuro-developmental disorders?
- Which disorders comes under neuro-developmental disorders?

Neuro-developmental disorders are a group of conditions characterized by

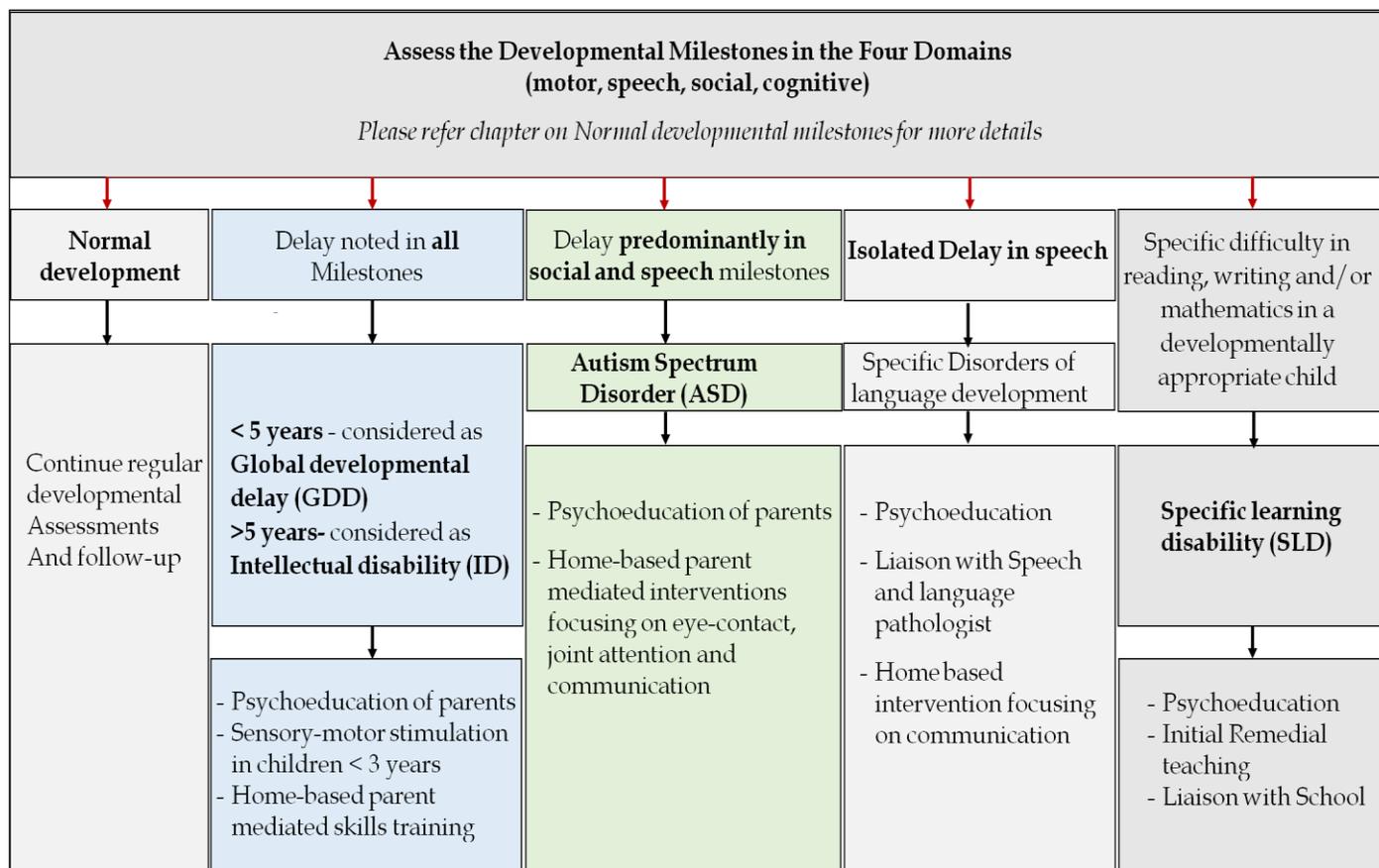
- a) Origin in the early developmental period
- b) Deficits/delay in one or more developmental domains (for example: motor/ speech/ social/ cognitive domains)
- c) Has a steady course
- d) With significant impairment in personal, social, academic or occupational functioning

Disorders which are included under neuro-developmental disorders are:

1. Intellectual Disability (ID)/ Intellectual Developmental disorder
2. Specific Learning Disorder (SLD)
3. Autism Spectrum Disorder (ASD)
4. Specific disorders of language development

1. **Intellectual disability (ID)** is characterized by a delay in *all the aspects (domains) of development*, which means a delay in motor, language, social and cognitive milestones. This is the commonest of all the developmental disorders. The child will present with a below average intellectual and adaptive functioning.
2. **Specific Learning Disorder (SLD)** is characterized by a persistent *difficulty in learning one or more* of the basic academic skills which are reading, writing or arithmetic. Unlike ID, here the developmental milestones will be usually normal and the child will have a normal intellectual and adaptive functioning.
3. **Autism Spectrum Disorder (ASD)** is characterized by a *difficulty in socialization and communication*. The child will have delay in speech and social milestones. Other milestones (motor and cognitive) can be normal or mildly delayed. But the delay in social and speech will be more pronounced
4. **Specific disorders of language development** are a delay or *difficulty ONLY in speech and language* in the absence of hearing impairment. This can be either a deficit in receptive language or expressive language; a deficit in pronunciation of certain sounds/letters or can be a difficulty in fluency of speech.

■ Algorithm for diagnosing of Specific Learning Disorder and overview of management



NOTE: Detailed description of diagnosis and management of each developmental disorder is mentioned in specific chapters

■ Who are 'at risk' for neuro-developmental disorders?

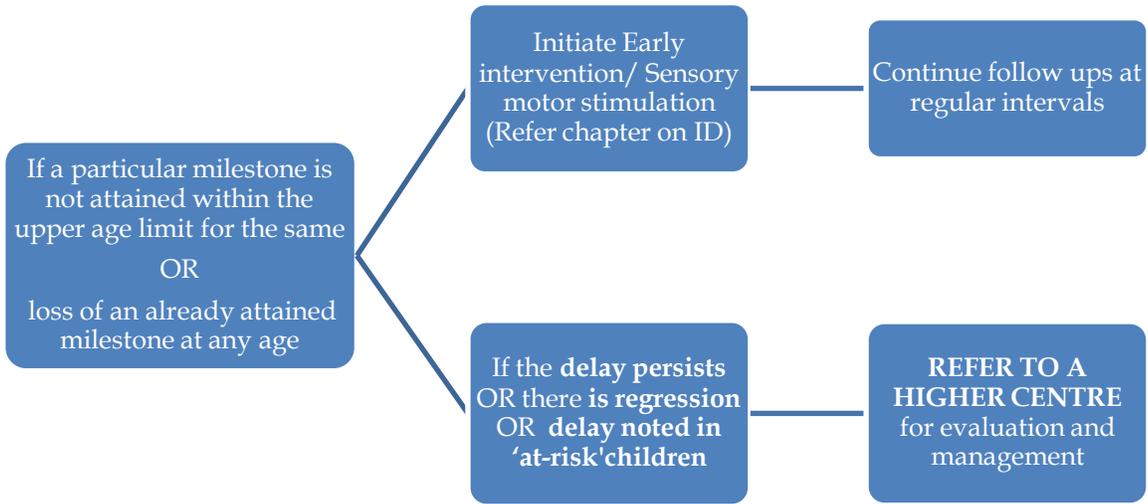
Consider children to be 'At risk' for neuro-developmental disorders if there is:

- History of premature birth, low birth weight, birth asphyxia, postnatal infection, seizures, history of Neonatal ICU admission

What to do for children 'at risk' for neuro-developmental disorders?

- Regular developmental screening to be done to note any delay in milestones
- Early intervention: Sensory motor stimulation
- If delay persists despite intervention, refer to a higher centre
- **DO NOT** advice 'Let's wait and watch'

■ When to refer to a higher centre?



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Chapter 5

INTELLECTUAL DEVELOPMENTAL DISORDER (IDD)

Tess Maria Rajan, Satish Chandra Girimaji

■ Introduction

Intellectual disability (ID) OR Intellectual development disorder (IDD) is characterized by

- a) Significantly below average **intellectual functioning and adaptive behaviour**
- b) originating during the developmental period
- c) will be etiologically diverse (ICD 11)
 - Intellectual functioning is typically measured using a standardized test of intelligence which gives an IQ score (Intelligence quotient).
 - Adaptive behaviour means the individual's ability in attaining personal independence and to take social responsibility in one or more domains of life

Adaptive behaviour is assessed in the following three domains:

- a) Conceptual domain - related to application of knowledge (reading, writing, calculation, problem solving)
- b) Social domain - managing interpersonal relationships, social responsibility, obeying laws, social judgement
- c) Practical domain - activities related to self-care, health, safety, occupational skills, recreation, use of money, transportation, use of home appliances and devices

Clinically using these three domains of adaptive behaviour, ID can be sub-typed into mild, moderate, severe and profound categories.

NOTE: ID/IDD is the new terminology for 'mental retardation'

■ Clinical presentation of children with IDD

Case Vignette 1

A 6 year old female child presents with complaints of delay in speech and difficulty in understanding. On evaluation, it is noted that the child is able to speak only 10-12 meaningful words and cannot form sentences. As per the mother's report, the child attained head control only at 9 months and began to walk only after 2 years. She can hold a pen and scribble. The child is able to follow simple instructions, and can understand and communicate through simple gestures. According to the mother, though the child is 6 years old, he has the abilities of a 3 year old only.

Approach: This is a child with delay in various developmental domains, such as motor, speech and cognitive domains. The child has abilities of a kid of a lower age. The child is able to communicate non-verbally, which rules out autism (refer chapter on ASD). This is a case of intellectual disability, moderate in severity (refer Table 1 for severity assessment).

Case Vignette 2

A 5 year old male child, presents to your clinic with complaints of frequent irritability and hyperactivity. The child does not sit in one place, is always on the go, and sometimes is unaware of safety, posing danger and injuries. The child is frequently noticed to hit himself and bang on the wall, when he wants something. The child is able to speak only 2 meaningful words, has difficulty in understanding simple commands. He cannot scribble or use crayons. He had delayed motor milestones, having attained independent walking after 2.5 years.

Approach: This child has significant delay in motor, language and cognitive milestones. The child, in addition has significant hyperactivity, impulsivity and self-injurious behaviours. This is a case of intellectual disability. But certain behaviours like hyperactivity, self-hitting behaviour cannot be explained by IDD alone.

Here the child requires a detailed evaluation by a specialist for the evaluation and treatment of the comorbidity

■ Assessment of children with IDD

a) Detailed history

Information should be gathered from multiple sources- parents, other caregivers, school reports, previous consultation notes.

A detailed history should focus on understanding about the following aspects:

1. *Reason for consultation-* presenting complaints with duration and evolution of each aspect
2. *Is there an identifiable cause for IDD in this child?-* requires detailed family history (consanguineous marriage, any other members with IDD, early deaths or spontaneous abortions, seizures)
3. *Birth history of child-* includes enquiry into pre, peri and postnatal insults (e.g.: medical illness in mother during pregnancy, exposure to teratogens; premature labour; prolonged labour; fetal distress at birth; neonatal infection; NICU admission etc)
4. *Detailed developmental history* of the child- in all domains
5. *Are there any physical/sensory/medical/psychiatric comorbidities?*
6. What is his *current functioning in various domains?* in conceptual, social and practical domain. What are the strengths of the child?
7. *Typical day of child-* the child's typical daily routine to understand adaptive level and also to gauge if child is getting adequate opportunity to learn skills

8. What are the *parents' understanding* of the child's condition? - their expectations, caregiving pattern, socioeconomic status, caregiver burden and support from extended family
9. What kind of *help/training* the child has already received? - formal therapy, special school

b) Physical examination

Every child with IDD must undergo a thorough physical examination with special focus on:

1. Head to foot assessment focusing on **hearing, vision, locomotion; any physical anomalies**
2. Look for any signs of **malnutrition or infections**
3. All the organ **system examination**- specifically looking for any focal neurological deficits, any congenital cardiac conditions
4. Any **injuries/callouses/scars** noted. (Many children with ID have self-injurious behaviours; also many of them are prone to injury due to their lack of understanding of safety)
5. An attempt can be made to look for **minor congenital anomalies** from head to toe which may help us in identifying some of the common genetic syndromes associated with ID). For e.g.: In down syndrome children present with medial slanting of eyes, short stature, flat nasal bridge, short stature, protruding tongue, simian crease

c) Behavioural observation/psychiatric examination

A well-structured behavioural observation will give us more information on the intellectual functioning of the child, his/her interactions with caregivers, any psychiatric comorbidity as well as any maladaptive behaviour.

The behavioural observation can follow the following scheme:

1. **Rapport building** (use toys, books, crayons to draw)
2. Assess **VISION** (whether child looks at your eyes, follows objects) and **HEARING** (turns head to sound, responds to loud noises)
3. **Motor Behaviour** - fidgetiness, hyperactivity, stereotypies
4. **Speech and Language** - Whether understands simple verbal or nonverbal instructions? vocabulary of the child; whether speech is clear?
5. **Mood state**- incessant crying/ irritability/fearfulness/ excessive cheerfulness
6. **Inappropriate behaviours**- self injurious behaviour; excessive aggression; disinhibited behaviour; stereotypies
7. Impression of **current developmental status of the child**; Refer Table 1

Use the following table to assess the severity of ID in the child (Table 1)

SEVERITY OF IDD	EARLY CHILDHOOD	SCHOOL GOING CHILDREN AND ADOLESCENTS
MILD	<ul style="list-style-type: none"> ■ Language - delayed; limited vocabulary and narrative skills ■ Can tell name, gender ■ Will express their needs, likes and dislikes ■ Can do simple matching and sorting tasks (match the colour/shape) ■ Follow up to 2 step instructions ■ Can recognize alphabets 	<ul style="list-style-type: none"> ■ Can communicate effectively; Can tell about past, present and future events but their narrative skills not as much as their peers ■ Can tell their age; identify their relatives; identify denominations of money and count small amounts of money; can travel by themselves ■ Can follow three step instructions ■ Literacy- can read sentence with five common words. Can do simple addition and subtraction ■ Can do their activities of daily living (ADLs) (that is- toilet needs, bathing, brushing, eating) ■ Safety concepts-most of them can follow simple traffic rules for crossing roads and follow other rules for personal safety ■ Can be trained for semi-skilled and at times for skilled employment
MODERATE	<ul style="list-style-type: none"> ■ Language- delay present; can communicate their needs; many of them express likes and dislikes through simple words ■ Can follow one- step commands ■ Can recognize symbols (not alphabets or numbers) ■ Some can understand simple opposites like 'more' and 'less' 	<ul style="list-style-type: none"> ■ Can communicate their needs effectively ■ Can identify their age and gender; Follow up to two step instructions ■ Some of them can follow road safety rules ■ Some can independently commute to familiar places ■ Literacy- can recognize own name in print, can count up to 10 ■ With adequate training can become independent in ADLs ■ Can be trained for semi-skilled employment

SEVERE

- Language- significant delay; most of them will communicate their basic needs nonverbally through gestures.
- Will attend to and respond to others
- Can stop an activity on request
- Will make gestures to indicate likes/dislikes when given options through visual aids
- Will use single words/ phrases for indicating needs. Also indicates needs through gestures
- Will require support for all ADLs
- May follow one-step instruction (if trained) and can stop an activity on request
- Can differentiate different rooms in the house
- Can express likes/dislikes when given options
- Literacy- can recognize symbols
- Requires long term training for skill acquisition in semi-skilled vocational training

PROFOUND

- Many will develop non-verbal strategies to communicate basic needs(may cry when hungry or wet)
- Respond to name call after multiple prompts
- May not attain verbal communication; may not comprehend instructions; It is difficult to get their attention
- They require constant supervision
- Use nonverbal means to communicate basic needs; may not attain verbal communication
- Most of them learn to do simple tasks with multiple prompts and aids
- Will require complete assistance for ADLs
- May not understand danger; will require constant supervision

■ When to refer a child with ID to a higher centre?

Refer the child to a higher center for evaluation and management in the following conditions:

When there is a suspected
**Physical or sensory
impairment; congenital
anomalies**

Eg: Impairment in
vision/hearing/locomotion
-Cleft lip/palate

**If any Medical or psychiatric
comorbidity**
- Seizures
-Congenital heart disease,
-ADHD, ASD, Mood disorder

**For detailed evaluation of
etiology**
-For a treatable cause
-For a genetic cause

Any recent onset change in behaviours,
New onset sleep or appetite changes
Incessant crying/ increased irritability/
fearfulness
(increased suspicion for a psychiatric OR
medical comorbidity)

**Unmanageable behavioural
problems**
-Severe Self injurious behavior
- Unmanageable aggression

REMEMBER: ALWAYS evaluate and rule out medical causes in case of any sudden change in behaviour/ increased emotional problems like irritability or crying in a child with IDD. It usually presents as a behavioural problem as the child is unable to communicate effectively.

For e.g.: ear infection, acute abdomen, and urinary infection.

■ Management of IDD

1. Psychoeducation of parents

The following aspects should be communicated to the parents

- ID is due to some damage that happened to the brain before, during or after birth
- Medicines or surgery cannot cure ID
- Teach and train the child in basic skills like – doing their self-care activities, household chores etc. will make them as independent as possible in their daily lives

While communicating the irreversible nature of ID, we can use the '*five finger example*'- If one finger is cut, it is not possible for it to grow but at the same time you can train the remaining fingers to do many things (thus emphasizing the importance of training in various domains).

- Child with ID will take time to learn even a simple task- hence repeated, systematic training for long duration will be needed
- If there is comorbidity - either medical (e.g.: seizures, Congenital heart conditions) or psychiatric (e.g.: ADHD, mood disorder), it requires opinion from a specialist and appropriate management with medications.
- Do not overprotect the child (e.g.: doing everything for him/her); Do not be too permissive; exercise limits and discipline whenever needed
- Always praise the child even for his/her small efforts
- Every child has certain strengths (things that they are good at doing) - identify it and encourage these strengths, talents and interests
- Do not blame yourself about the child's illness and never feel ashamed about your child
- Mobilize help from extended family members to avoid burn out; keep your social life intact

2. Early intervention for young children/ Sensory-Motor Stimulation (SMS)

- These techniques are for children who are *less than 2 years* of age **or** have a developmental age of less than 2 years
- Adequate stimulation of all the sensory modalities (vision, hearing, touch, smell and taste) will facilitate development; it is required even for normal development
- It should be done with a lot of love, affection and warmth from the caregiver

TECHNIQUES OF SENSORY-MOTOR STIMULATION
ROCK THE CHILD in the mother's lap with face towards the mother while softly talking to the child
<ul style="list-style-type: none"> • TICKLE THE CHILD and elicit laughter from the child • GENTLY STROKE THE CHILD
HANG COLOURFUL BALLS, TOYS, RIBBONS etc in the cradle; Toys that make sound can also be used
VOCALISATION -keep talking to the child, describing what you are doing; use a playful tone with animated gestures; sing lullabies.
GENTLY MASSAGE the child's body with oil
LET THE CHILD GRASP in his/her hands- give rattles, toys etc
PLAY PEEK-A-BOO - cover the child's face with a cloth and then remove it and say 'a-ha'
MAKE THE CHILD LAUGH - swing him in your arms, gently throw him up in the air and hold back, make him stand on your and raise the foot up and down
BE CREATIVE. Use indigenous materials and come up with more creative SMS activities

3. Home-based parent mediated skills training

❖ Teaching new skills

The following techniques may be used to teach the child his activities of daily living (ADLs) like eating, dressing, doing toilet needs and bathing

Some of the techniques to teach new skills to children include

- a) Chaining
- b) Prompting
- c) Shaping
- d) Modeling
- e) Rewarding

a) Chaining

- Break the activity into several small steps
- You do the all the initial steps for the child and **teach him the last step first** and when the child learns the last step, teach him the penultimate step and like-wise move backwards till the first step. This is **BACKCHAINING**
- Other method is **FRONTCHAINING** (reverse of backchaining). Teach him the first step first and you continue to do the rest of the steps for him. Repeat this till he masters the first step and then move on to second step.

How to teach a skill through backchaining?

For E.g.: Wearing a shirt

Steps 1. Insert the right hand

2. Insert the left hand

3. Wear the first button

From step 4. Wearing each of the buttons is a separate step

Last step: Wearing the last button

You do the initial steps for the child. Make the child do the last step with physical and verbal prompts. Once finished, appreciate the child and say ‘Good Job’.

Once child masters the last step, go one step back and make him do the last two steps

b) Prompting

Teaching through **hand-on – hand technique**

How to teach a skill through prompting?

E.g.: Task: To eat his food with spoon

1. Gently keep your hand over his hand and assist him in picking the spoon, direct the spoon to the food, assist him in taking the food with the spoon and help him reach the food to the mouth
2. At every step appreciate the child, for e.g.: say ‘Good Job’
3. Through multiple practices, child slowly starts to learn the skill- then slowly starts to fade the prompt

Fading the prompt- As the child learns the task, First hold his hand firm, then slowly hold him with light pressure, then touch his hands only with your finger-tips, then two fingers touching- then one finger and finally shadow his hand with your hand and keep increasing the distance of your arm from his hands (this progression to be made slowly over a period of time)

c) Shaping

This technique is used when the task is difficult to be broken down into smaller steps or when the task is unpleasant to the child. Therefore, the whole task is simplified and then made more and more complex (successive approximation)

Idea behind the technique is that – You appreciate or reward the child the more approximate the child reaches the target task.

How to teach a skill through shaping?

E.g.: Task: Making a child go and sit on the toilet seat

Keep rewarding or appreciating the child

1. When he comes near the toilet door
Once this step is attained, next reward/appreciate him only when
2. He enters the toilet
Once this attained, reward/appreciate when
3. He removes his underpants
And like-wise for the following steps keep rewarding/appreciating for the following steps
4. Coming near the toilet seat
5. Sitting on the toilet seat

d) Imitation / Modeling

Teaching the child by demonstrating/showing how to do a task.

Teaching through modelling

For e.g.: How to wash his plate after eating

- The mother and the child can stand side by side in a way where the child can see what the mother is doing
 - Mother to open the tap and gesture the child to do the same.
 - Mother to take a plate and keep it under running tap water gesturing the child to do it
 - Next the mother to take a plate scrubber with soap and scrub it over the plate and then gesture the child to do it
 - Then the mother to rinse the plate again with water and gesture the child
- At each step appreciate the child when he/she follows the mother's cues

e) Rewarding

The child should be rewarded for even a simple attempt/progress he/ she is making in learning the skill.

Rewards can be initially some materials that the child likes, for example- sweets, candies, biscuits. It should be paired with social rewards like – hugging the child, praising him by telling ‘very good’ / ‘good job’ etc.

❖ Improving communication skills

The following are some of the techniques used to improve the communication skills of children with ID.

TECHNIQUES TO IMPROVE COMMUNICATION

1. **Speech Stimulation** – When you are around the child, keep talking to the child. Describe what you are doing especially while engaged in daily routine like a running commentary. For e.g.: ‘See, we are in the bathroom’. ‘See the water flowing’
2. **Parallel vocalization** – paying attention to child's utterances and repeating the same
3. Speak in short sentences. Give **clear and short instructions and speak slowly**.
4. **Labeling**- While handing over the toys/food, always name it and give it to the child.
5. Keep his favourite toys or food out of his reach to encourage ‘**Pointing**’.
6. **Imitate** the sounds he makes and in turn give him new sounds to imitate.
7. **Use picture books** with familiar objects- like animals, fruits etc- point to each and name them.

❖ Teaching concepts to the child

It is important to teach the child some of the concepts mentioned below which are of use in daily life and that would facilitate the child in independent living.

Teach the child the following concepts

- Naming or pointing to body parts, colours, shapes, common objects used in daily life
(*using imitation for body parts; using matching and sorting tasks for colours, shapes etc.*)
- Concept of opposites – for e.g.: big-small, hot-cold, in-out)
(*Using picture books, showing examples at home*)
- Categories – animals, birds, fruits, vegetables through sorting, classifying, recognizing, naming
- Concept of day and night, then day of the week then date
(*using picture books*)
- Money concept- starting from small denominations to big.
(*taking the child to shops, through modeling*)
- Teaching him different rooms of the house; then, how to commute to a nearby place; then, how to comeback home from a nearby place.
- Teaching Sight words – Some commonly used words that needs to be taught include ‘DANGER’, ‘EXIT’, ‘STOP’, also to read the bus board that takes him to his house, reading his own name.
- **SAFETY CONCEPT** – The concept of safety should be taught to the child from the beginning. It includes teaching the child road safety, and then teach him certain practices like- not to go near fire, water, heights etc.
- Also, it very important to teach the child self- protection from any abuse- Not to talk to strangers, good touch and bad touch, privacy while dressing etc. This can be taught through picture books- by using words ‘This is OK’ but ‘this is NOT OK’ OR using words like ‘RIGHT’ and ‘WRONG’. But first ensuring that child understands these words.

❖ Schooling

- Sending the child to school is not just for academic achievement. School gives an opportunity for the child to have a **regular routine, peer interaction, improve his social skills and initiates the scaffolding for independent living**
- As far as possible children with ID should be send to school; If options of special school is available in the locality it can be considered (especially for children with moderate-severe/profound ID)

- Parents should have appropriate expectations in terms of academics and remember the goals of sending the child to school (as mentioned above)

❖ Vocational training

Once the child has learned most of the above said skills namely the ADLs and the important concepts for independent living, vocational training can be initiated. The type of training should depend on the **strengths and interests of the child**. Parents can be referred to a near by vocational training center for the same

4. Liaison with the school, training center, social welfare facilities

- Facilitate the IQ assessment and certification of the child
- Educate the parents about various schemes and benefits available from the government
- (disability pension, railway concession, income tax deductions, etc.)
- Give information about various training centers- speech therapy centers, occupational centers, schools for children with special needs
- Liaison with the schools, ensure child attends school on a regular basis
- For older children facilitate enrolment to a vocational training center

■ Life cycle approach in IDD

This approach is based on the principle that the developmental needs of an individual at different stages of life is different and hence the focus of training should change at each stage accommodating to these developmental needs. The following table summarizes the challenges faced by a child with ID and his/her family at each of the life stages and what should the focus of intervention should be.

STAGE	CHALLENGES	FOCUS OF INTERVENTION
INFANCY	Accepting the diagnosis, medical investigations and how to care for the child	Sensory-motor stimulation
CHILDHOOD	Schooling related issues, handling problem behaviours, poor skills in self-care and communication	ADL training, concept building, steps to improve communication
ADOLESCENCE	Sexuality related issues, menstruation in female children, safety	teaching safety concepts, initiate vocational training
ADULTHOOD	'What after me?' thoughts in caregivers; Marriage, vocation	Vocational rehabilitation, options of placement to be discussed with caregivers

■ What to do in adults with IDD?

- Provide training and opportunity for independent living. As mentioned above, providing training in ADLs, teaching concepts required for daily life (e.g.: money management, measures for personal safety etc.) and vocational training will help in independent living.
- Vocational training can be provided to the individual. The potential jobs can be manual/skilled/semi-skilled, to be decided as per the strengths, skills and interest of the person. Examples include- agriculture based works; jobs in small scale industries like bag making, candle making, tailoring; jobs as assistants in grocery shops etc.
- As problems related to sexuality might emerge- training may be provided regarding personal safety, personal boundaries and regarding the need for taking /giving consent. Use of pictures to teach these concepts might be useful
- Marriage is not a solution or cure for ID. The decision of marriage for an individual with ID should be based upon his/her independent living skills and their decision-making abilities. If done should be done only with the full consent and knowledge of the partner
- Parents/guardians of the individuals usually have the constant worry of who will take care of their son/daughter when they are no more. They should be given the option of residential care facilities available in the locality. They should be educated regarding guardianship and provisions available under the National Trust Act
- For individuals with ID who are not independent or where vocational training is not possible, the option of day care facilities or residential care facilities in the locality to be provided to the family.
- Disability certification should be facilitated. The family should be educated about the aids and benefits provided by the government for individuals with ID.

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Chapter 6

AUTISM SPECTRUM DISORDERS AND SPEECH-LANGUAGE DISORDERS

Harshini Manohar, Shoba S. Meera, Satish C. Girimaji

■ Introduction

Autism is a developmental disorder with onset during early years of the child's development. Autism spectrum disorder (ASD) is a condition where the child has impairment in

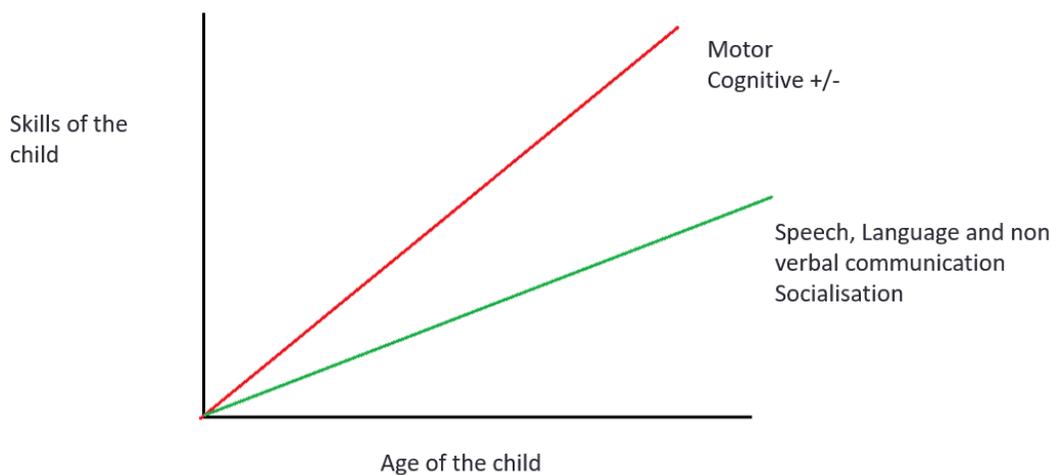
- social and communication skills, including both verbal and non-verbal interactions (poor response to name call, poor eye-to-eye contact, being solitary or in one's own world) and,
- Repetitive and stereotypic behaviours.

Children with autism engage in self-absorbed behaviour and stereotypic play. Children with autism commonly present with associated medical and psychiatric comorbidities.

■ Developmental deviance in ASD

ASD is characterized by a developmental deviance, i.e. the pattern of development is *different or deviant* rather than only a delay.

- Impairment in speech and language, non-verbal communication and social interaction, compared to normally developing children.
- The motor and cognitive abilities of the child may be appropriate for age in case of ASD, and may be delayed in case of ASD with comorbid intellectual disability.



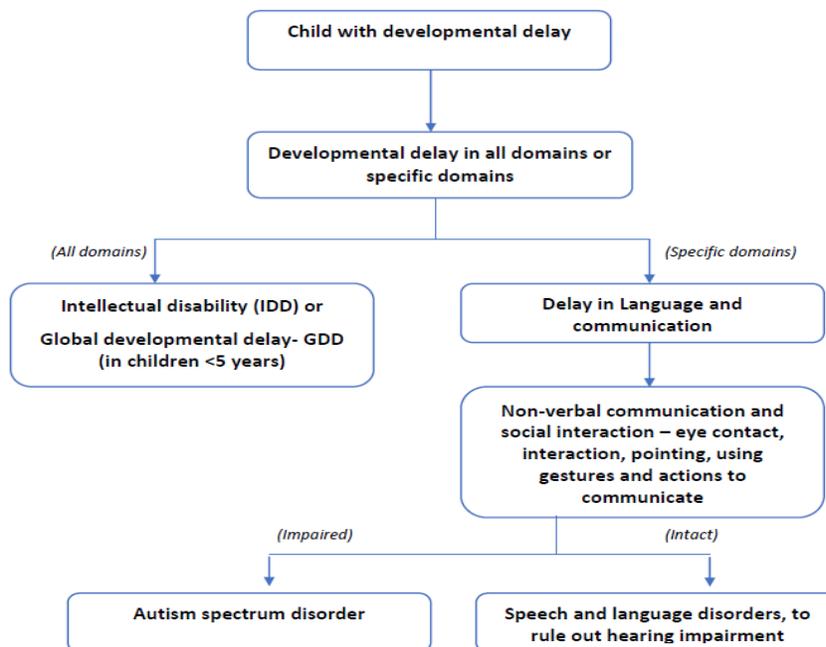
Developmental deviance in ASD

Red flags for possible ASD in Infants & Toddlers:

- No big smiles or other warm, joyful expressions by 6 months or thereafter.
- No back-and-forth sharing of sounds, smiles or other facial expressions by 9 months
- No babbling (baba, dada) by 12 months
- No back-and-forth gestures such as pointing, showing, reaching or waving by 12 months
- No words by 16 months
- No meaningful, two-word phrases (not including imitating or repeating) by 24 months
- **Any loss of speech, babbling or social skills at any age**

■ Diagnosing ASD

The below flow chart is a simple approach to diagnosis in developmental disorders.



■ Diagnosing ASD

Case vignettes

A busy pediatrician sees a 24-month-old child for routine immunization. Mother says child speaks only 2 words. The child does not respond to name call, but can show things when he needs, and can play with the mother.

Analysis: This is a child with speech delay (expected speech for 24 months – two word phrases, 40 words). Though the child does not respond to call, he can use gestures to communicate.

This is a case of Speech delay, probably secondary to hearing impairment, which needs to be evaluated.

A 4 year old male child presents with delayed speech, currently speaks only 3-4 words, doesn't respond when spoken to but runs to TV when it is switched on, , poor response to name call, limited use of gestures to communicate, increased hand flapping and jumping especially when the child is excited.

Analysis: This 4 year old child has significant speech delay, however in addition also has difficulty in using non-verbal communication. The child also has stereotypic behaviours. This is a case of probable ASD, and needs further assessment.

3-year-old female child with developmental delay presents to the clinic. The child does not interact and does not make eye contact, not interested in people, but is more interested in objects. The child is noticed to have repetitive movements of her hands.

Analysis: In children with global developmental delay (GDD), social interaction is appropriate to the developmental age of the child. This female child, in addition to delay in development, also has poor social responsiveness and poor eye contact. The child also has stereotypies. Remember that in a female child with ASD features, one need to evaluate for Rett's syndrome. This child will require referral for further evaluation.

■ Assessments and screening in primary care settings

Common complaints when children present for consultation:

- Delayed speech
- Poor eye contact
- Does not respond to name call, may respond to familiar sounds like TV ads, environmental sounds.
- Is not interested in other people.

What can be done in a busy clinic?

All toddlers who come for routine immunization may be screened for Autism using simple questions.

- Does your child look at you when called?
- Does your child interact and make eye-contact?

- Does your point to show you something interesting?
- Does your child enjoy together or joint activities?

Any toddler with **no clear attainment of these skills, or who display these skills inconsistently** may be referred for further evaluation and management.

Assessments:

M-CHAT - Modified Checklist for Autism in Toddlers

M-CHAT is a 20-item screening questionnaire for ASD, has questions with yes or no response. M-CHAT is available in multiple Indian languages and is a freely available tool. It can also be freely downloaded from <https://m-chat.org/> <https://mchatscreen.com/m-chat/translations/>

A score of <2 indicates low risk, 3-7 medium risk and 8-20 indicates high risk for autism spectrum disorder.

For example: (Critical questions from the M-CHAT)

If you point at something across the room, does your child look at it?

Does your child point with one finger to ask for something or to get help?

Does your child point with one finger to show you something interesting?

Does your child respond when you call his or her name?

Does your child look you in the eye when you are talking to him or her, playing with him Yes No or her, or dressing him or her?

Does your child play pretend or make-believe? (For example, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?)

Parents can start incorporating activities in the child's routine, which the child is currently unable to do as per the assessment on M-CHAT.

Recommendations for management at primary care settings:

1. General observation and tracking milestones of all children
2. On-going developmental screening and surveillance during routine visits
3. Autism-specific screen at 18 months and 24 months.
4. Refer to Early Intervention and specialist for formal diagnostic evaluation
5. Case management in primary care settings- initiate home-based-training.

■ Detailed assessment of children with suspected ASD

Detailed history

Information should be gathered from multiple sources- parents, other caregivers, reports of school teachers.

A detailed history should focus on understanding about the following aspects

- 1) Reason for consultation
- 2) Detailed developmental history of the child – age of attainment of developmental milestones of various domains - Assess if child is lagging behind in developmental attainments compared to same-age children. Ask the mother to estimate the mental age of child
- 3) Family history of developmental disorders, epilepsy or ASD
- 4) Is there regression / loss of social and language milestones?
- 5) Are there any behavioural problems – self-injurious behaviours, hyperactivity, sleep disturbances?
- 6) Are there any medical/psychiatric/sensory (Visual/hearing impairment) comorbidities?
- 7) What is the parents' understanding of the child's condition?
- 8) What kind of activities is the child engaged in, throughout the day? – This will help in understanding whether the child is being adequately stimulated.
- 9) What kind of help/training the child has already received?

For detailed description of various aspects of history taking, refer to chapter on IDD.

■ Clinical examination

Salient features:

- Response to name call: poor or inconsistent in children with ASD
- Eye to eye contact : poor or inconsistent in children with ASD
- Social responsiveness: Whether the child makes spontaneous eye contact or in a response to call, looks at the examiner when toys are offered.
- Joint attention: Does the child share interest in objects when pointed to? Does the child initiate spontaneous interactions or respond to interactions?

E.g.: Showing a toy and eliciting child's response – Eg: Look what I have in my hand. What is this?

- Does the child invite to play?
- Imitation: Whether the child imitates simple words like amma, appa, baba, or simple actions like clapping, waving etc, and makes eye to eye contact during the same.

- Pointing to things which he needs – toys, food, water
- Pointing to share – does the child point to share something of his interest and show it to the parent?
- Presence of any stereotypic, repetitive sounds or behaviours.

Remember: In a girl child with features of ASD, look for signs of Rett’s syndrome. Specific features: reduction or deceleration of head circumference, Loss of motor skills and language skills, loss of hand functions, stereotypic movements involving the midline of the body (hands, mouth).

- General physical status, head to foot examination, nutritional status, systemic examination.
- Focus on minor physical anomalies, stigmata of genetic syndromes or metabolic disorders– Child will need further detailed evaluation and referral to experts.

■ Management of ASD

Psychoeducation of parents

- Most essential step of management – should be done first and foremost.
- Educate regarding the developmental domains – how the child lags in social, language and non-verbal domains.
- **Need to start interventions early – ‘Earlier the interventions, better the outcome’**
- **Do not advise to wait and watch.**
- No medications to treat core symptoms of ASD, however may be used in the treatment of comorbid disorders.
- Child requires systematic, persistent and repetitive training as per the child’s ability and current symptoms.
- To enrich the child’s environment with play-based interactive activities.
- **Avoid screen time exposure as it deprives the child of social interactions and social stimulation, which are essential for normal development.** (*refer to chapter 14 for WHO recommendations for screen time in children*)
- Initiate referrals for further consultation and simultaneously encourage parents to initiate home-based interventions.

■ Components of ASD interventions



Home based interventions



Play-based joint activities



Parent-mediated intervention



Naturalistic environment and incorporating skills during daily routines

■ Home-based interventions

- Simply waiting and expecting that child will become all right with age will lead to accumulation of impairments and deficits that become more difficult to overcome later.
- Parents should be encouraged to initiate simple home-based interventions at the earliest, while referral to higher centers is being planned. These children need a lot of attention, engagement, interaction, playing talking, and teaching for them to learn social interaction and communication.

Parents should be educated to

- Develop and maintain regular, stimulating daily routines.
- Introduce joint play activities in the child's routine.
- Initiate simple home-based activities like Joint play between the mother and child.
- **What to teach:** Simple caregiver-child games which improve joint attention:
 - Peek a boo
 - Bubble games
 - Singing and dancing for simple rhymes.
 - Imitating simple sounds (ba, ga followed by simple and meaningful words) and gestures like show, give, wave Bye- bye etc.; imitating actions such as eating, drinking, sleeping (show how you eat?)
 - Pointing to objects around and naming them, 'Wow, see there is a cat!', using picture books as well
 - Pointing to an object and encouraging the child to look in that direction and then, look back at the mother
 - Sharing and turn taking games
 - Pretend play games - feeding a teddy, how the bird flies, how the dog barks,
 - Gradually introducing peer play
 - Self-care activities such as bathing, brushing, indicating for toilet needs followed by gradually taking care of self at the toilet etc.
- Parents can be encouraged to place the child in a play school or an Anganwadi centre, so that the child is engaged in developmentally appropriate activities.
- Choose natural rewards to reinforce the child's response. The rewards can be something that the child likes - small raisins, gems to social rewards such as hugging or kissing the child, saying very well, you did it. etc.

- **How to teach:** Tell and show how to do things (modeling), make the tasks simpler, break activities into simple steps and teach one step at a time, notice and praise even minor efforts and improvements (rewarding or reinforcing), using hand-on-hand techniques. Prompt and reinforce at each step. *These techniques have been described in detail in the chapter on management of IDD;*
- The responses of the child will be feeble at first, and strengthening these responses by doing this again and again will help them to understand social cues and respond appropriately to these cues, and thereby improve their reciprocal and spontaneous social behaviours.
- **The activities may be done in naturalistic settings, using play-based and fun activities, rather than like a teaching activity.**

■ Points for further referral

- Child Suspected/ At-risk/ diagnosed to have ASD.
- Severe or multiple developmental problems
- History of regression of attained milestones.
- Medical and psychiatric comorbidities.
- Complex presentation and diagnostic confusion.
- Laboratory tests and imaging if required.
- Genetic counseling
- Multi-disciplinary interventions.

■ Whom to refer to?

- Referral to pediatrician for detailed medical evaluation and initiating ASD - specific interventions.
- Referral to District Early Intervention centers for interventions.
- Give information about various training centers- speech-language centers, occupational therapy centers, and schools for children with special needs.
- Referral for IQ assessment and disability certification.
- Older children may be referred for vocational training and rehabilitation.

SPEECH AND LANGUAGE DISORDERS

Expressive language comprises of vocabulary, construction of sentences and appropriate use of language in the context (pragmatics). Receptive language refers to ability to identify, understand and comprehend what others speak. Having trouble understanding what others say is a **receptive language disorder**. Having problems sharing thoughts, ideas, and feelings is an **expressive language disorder**. It is possible to have both a receptive and an expressive language problem.

At a given time during development, receptive language skills are usually ahead than expressive language skills.

Normal language milestones: Refer to chapter on normal development

■ The most common Speech and Language disorders are mentioned below:

1. Expressive Language disorder: Children with expressive language delay will have difficulty in using language as per their age, however, will be able to use gestures to communicate and have adequate social interaction compared to peers of the same age. Children with isolated expressive language delay appear to have the verbal skills of developmentally younger children, with age-appropriate attainment of skills in other developmental domains.

Mixed expressive and receptive language disorder: There is a delay in both expressive and receptive language domains.

2. Speech sound disorders: Difficulty in pronunciation of certain sounds and words.
3. Childhood onset fluency disorders: Disturbances in fluency, resulting in difficulty in initiation, long pauses, and broken words. Also called as stuttering or stammering.

■ Evaluation and interventions

Children may have speech-language difficulties in case of

- Developmental disorders, like autism, IDD;
- Genetic syndromes, like Down syndrome;
- Hearing loss, from ear infections or other causes; or
- Brain damage, like cerebral palsy or a head injury.

Evaluation of each child should include:

- Observation of speech and language abilities and compare with normal/expected milestones checklist.
- Audiological evaluation/ hearing evaluation- to rule out hearing impairment.
- Evaluate and rule out other comorbid neuro-developmental disorders.

Interventions:

Parents and caregivers are the most important teachers during a child's early years. Children's language gets stronger if they have adequate language stimulation. Home-based interventions require active involvement of the family.

Parents can help their child learn in many different ways such as:

- Responding to the first sounds and gestures a baby makes.
- Naming things around the child.
- Talking about the things a child sees.
- Attentive listening and responding to what the child says or gestures
- Talking with the child in the language that you are most comfortable using.
- Repeating what the child says and adding to it.
- Parallel talk - Parents can watch the actions and describe it to the child, without expecting any response.

Example 1: If a child is playing with coloured blocks, a parent using parallel talk might say: "Oh, you put the yellow block on top. Good job! Now you are adding the green one. Great! It is a tall tower".

- Narrating events or explaining events as the child does.
- Using a lot of different words with the child and using longer sentences, as the child gets older.
- Asking questions and listening to the child's answers.
- Looking at or reading books with the child.
- Telling stories
- Singing songs and sharing rhymes with actions
- **Avoid screen time for children less than 1.5 years and avoid unsupervised screen time for children below 3 years of age for all children, especially those with language delay**

■ Referral to higher centers

Referral to higher centers can be considered in the following cases:

- No speech production or the child does not follow simple directions by age 18 months
- No phrases and sentences by age 2.5-3 years
- Parental concerns, especially if there is a family history of speech, hearing, or other developmental problems.
- Suspected hearing impairment.

- Suspected comorbid neurodevelopmental disorders (e.g. ASD, IDD)

The child may be referred to pediatricians, child psychiatrists and speech-language pathologists in higher centers for comprehensive evaluation and management.

■ What do speech-language pathologists do?

Speech-language pathologists evaluate and diagnose, and provide treatment for speech and language disorders. They also evaluate and treat swallowing problems, impaired cognition, and hearing problems. They treat individuals of all levels, from infancy to the elderly, by an individualized plan as per the needs of the patient. For patients who aren't able to communicate through speech, speech-language pathologists teach them alternative methods of communication, like using pictures or symbols and gestures.

■ Conclusions

Autism spectrum disorders and speech-language disorders are both neuro- developmental disorders identified in the early developmental period. Parents and primary care physicians should be alert in case of delay in milestones in specific domains such as language development and social behaviour. Intervention should be initiated as early as possible to see better results. Home-based and parent-led interventions must be encouraged at the earliest, even while arrangements are being made for referral to higher center where there is availability of specialists in this field.

KEY HIGHLIGHTS OF ASD

- ASD is a neuro- developmental disorder of early onset, with deficits in specific domains of social and communication skills and restricted repetitive behaviours.
- Clinical screening for ASD should focus on eye contact, joint attention, interest in play and communication for needs. M-CHAT can be used
- Early initiation of home-based and parent led interventions should be initiated through play activities and incorporating daily routine activities
- Referral to specialist services for more detailed evaluation and to various training centers for interventions should be facilitated at the earliest

References and further reading

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Chapter 7

SPECIFIC LEARNING DISORDER

Amrtavarshini R., Shreyoshi Ghosh

■ Introduction

Specific learning disorder (SLD) is a neuro-developmental problem which was first conceptualized by Samuel Kirk in 1963. SLD refers to a disorder in one or more of the basic brain mechanisms involved in understanding or using arithmetic and/or language (spoken or written) that may manifest itself in an imperfect ability to listen, speak, read, write, spell or perform mathematical calculations.

SLD does *not* include learning problems related to physical difficulties (visual, hearing, motor skills), emotional disturbances, cultural and environmental factors, or economic disadvantage.

The concept revolves around the theme of *unexpected academic difficulty as compared to the general intelligence levels*. It is a very circumscribed area of skill deficit rather than a generalized problem of conceptual understanding. Even though this condition is not uncommon, it is often under-recognised.

There are three subtypes defined: difficulty in reading, writing or mathematics. It is also graded from mild to severe. Other terms that are commonly used in place of specific learning disorder (SLD) are dyslexia (reading difficulty), dyscalculia (difficulty in math) and dysgraphia (difficulty in writing). Children may have a mixed form of learning disorder with difficulties in more than one of the above three areas.

SLD is heritable. Low birth weight, prematurity, and exposure to smoking, alcohol or drugs in utero increases risk for SLD and these may add to existing genetic vulnerability.

SLD is the most common neuro-developmental problem with 5-17% prevalence, characterized by unexpected academic difficulty in a child with near-normal or normal general intelligence.

It can be in the form of:

1. Difficulty in reading- most common
2. Difficulty in writing
3. Difficulty in comprehension
4. Difficulty in arithmetic

■ Manifestations of Specific Learning Disorder (SLD)

Reading problems: slowness, hesitancy, omission, substitution, reading by guessing, reading the words backwards (on for no), misreading (put for but) and not understanding printed material.

Writing problems: slowness, lack of clear understanding for even basic rules of grammar such as capitals and full stop, poor handwriting, poor organization of the writing space, poorly formed letters, words, and sentences.

Spelling problems: writing letters in wrong order, reversal of letters (b for d), inversion of letters (u for n), mirror writing (no for on), omission (wet for went); these are best elicited by asking the child to write to dictation.

Arithmetic difficulties: this is best elicited by asking the child to do simple mental arithmetic or written problems. Sole reliance on finger counting, poor sense of numbers in terms of their magnitude and relationship; inaccurate counting and calculation, failure to attend to key mathematical symbols, difficulty understanding the concept and use of “zero” or decimal points are some of the common problem areas.

■ Prevalence, comorbidity and outcome

Specific Learning Disorder is considered one of the most common neuro-developmental disorders with prevalence rates ranging from 5-17.5%. Reading disorder is the most common type of SLD, however, children can also display a combination of such difficulties.

Comorbid psychiatric disorders are a rule rather than an exception. The common conditions associated with SLD are:

- Attention Deficit Hyperactivity Disorder (ADHD)
- speech and language impairment
- emotional problems such as depression, anxiety disorders, adjustment disorders, school phobias
- externalizing disorders such as Oppositional Defiant Disorder (ODD), Conduct Disorder (CD)
- rarely substance use disorders.

Though some skills may be learnt over time, the reading, writing or mathematical abilities of adults with SLD is shown to remain below par. Factors that influence outcome are the severity of the disability, IQ, the age or grade when remedial education is started, presence or absence of associated emotional problems, socio economic status and educational level of parents, parental and school supports.

■ Clinical presentation

Direct presentations:

- Scholastic backwardness: this is the most common presentation, and may span a number of subjects especially languages.
- Cognitive symptoms: forgetfulness, poor memory, can tell everything orally but does not write answers in exam, poor attention and concentration especially while studying
- Academic skill deficits – poor handwriting, poor spelling, reads slowly, writes slowly
- Falling grades – ‘was doing well earlier, now marks are coming down’; this occurs because somehow the child was coping in lower classes, but can’t cope with academic demands in higher classes.

Indirect presentations: this is equally common, and most often occur as a secondary consequence to the underlying SLD, which is not recognized and handled properly. Some examples of indirect presentations are as follows:

- Poor motivation for studies – avoids studying, postpones doing home-work
- Somatic complaints– headache, dissociation symptoms
- Externalizing symptoms – symptoms of oppositional defiant disorder (ODD) and conduct disorder (CD) such as oppositionality, lying, stealing, and truancy.
- Internalizing symptoms: being dull, withdrawn, irritable, cries easily, tense all the time, tension before exams, exam phobia
- School refusal – severe reluctance and refusal to go to school, distress before school time or on Mondays / after holidays.

■ Clinical assessment

History:

- Major complaints: Onset, course and severity, associated emotional and behavioural problems.
- Schooling: What is the academic difficulty? Any recent change in medium of instruction? (Obtain report from school regarding academics and general behaviour.)
- Impact of these problems: In school, at home, with peers (enquire about school bullying).
- Any developmental problems? E.g., (Delay in speaking, walking etc). Ability to take care of daily needs and attend to age appropriate responsibilities? (indicative of general intelligence)
- Parents’ understanding of the problems, their reactions and solutions they have tried.

Brief assessment of child:

- Ask general questions to assess the intellectual ability of the child (check the speed of comprehension of the questions, reaction time, descriptive ability and overall general fund of information): Some suggestions are to ask the child about his place of residence, distance between known places, money concept, games played and their rules, description of hobbies which the child pursues, description of school.
- The child can be briefly assessed informally for the presence of SLD by asking him read small passages, write spellings and perform basic arithmetic calculations to get an idea of his/her abilities.
- The child should be referred for formal assessment of IQ and SLD to a clinical psychologist if SLD and or intellectual developmental disorder (IDD) is suspected.

■ Management

Whenever the medical officer suspects a diagnosis of SLD, a referral for detailed evaluation and certification should be made to the appropriate medical authorities (district hospital/DMHP/medical college) as identified under the State rules of RPWD Act, 2016. A comprehensive list of district-wise medical authority is available at www.swavlambancard.gov.in

The medical officer forms an important link in early identification and referral as well as in supportive management. Some key roles as the primary care physician include:

Education of parents:

Parents may have difficulty in accepting that their child might have SLD in the beginning, as they find the child totally “normal” otherwise. However, repeated explanations, formal assessments and interacting with other parents’ facing similar problems may enhance their acceptance. Some important points to emphasize are as follows:

- SLD is a neuro-developmental problem and it’s not the child fault and that s/he is not simply lazy.
- Avoid ridicule, comparisons, blame, humiliation, scolding and pressurizing. (The same should be communicated by the parents to the child’s teachers). Not everything is lost if the child is not doing well in school because of SLD.
- There are some great and highly accomplished people in this world that had SLD. Some examples: Einstein, Thomas Alva Edison, and Leonardo da Vinci.
- Recognize and develop the talents, skills, potentials, and assets that your child has.
- Give attention to overall personality development.

Education of child:

Listen to their problems and emphasize the following:

- SLD is not their fault; it is a developmental problem.
- State that options could be provided for alternative subjects where feasible.
- Mention that help shall be provided to alleviate the associated emotional, familial or school related problems.

Remediation:

Remediation consists of assessment of the deficit areas and structured, sequential and thorough one-to-one instruction to develop competency in academic skills. It depends on the availability of resources and special educators who are specifically trained in SLD remediation

Schooling and other educational support available

Choice of schooling depends on the severity and nature of the child's problems, the family's resources and the available facilities in nearby schools (i.e. availability of special educators or remedial training programs, resource rooms, provisions for alternate subjects, syllabus).

For example, if a child has a mild level of difficulty in math, he/she can be suggested to continue in a regular school and avail additional support in Maths from a special educator.

If the same problem is severe - then depending on the child's age, board and the formal assessment results, there can be special provisions/exemptions made for that subject.

- Disability benefits: This can be facilitated after a formal assessment to identify and certify learning disability. There are also provisions in CBSE/ICSE for children who have SLD to avail additional time during exams, exemption from particular subjects or assistance of a scribe in case of writing difficulty/disability.
- The National institute of Open Schooling (NIOS) –NIOS provides vocational, life enrichment and community-oriented courses besides general and academic courses at secondary and senior secondary level. In this scheme students are expected to choose 5 subjects with at least one language or at the most two languages with 3 or 4 other subjects at secondary level such as mathematics, science, social science, economics, home science, word processing, psychology, Indian culture & heritage, or painting. There are some schools offering these courses and a distance education option is also available.

■ Conclusions

SLD is a neuro-developmental disorder which presents with specific deficits in either reading/writing/arithmetic in an otherwise developmentally appropriate child. It is often missed/misdiagnosed due to a lack of awareness and knowledge of the condition among teachers, parents and health care contacts. It can be handled easily by raising awareness and psycho-educating key stakeholders, and supporting the child in schooling through remediation and other educational support.

Useful web resources for SLD:

- NIOS website (details of schooling options, various courses offered, syllabus, fee structure):
<https://www.nios.ac.in/default.aspx>
- Swavalamban website : To apply for UDID card for disability
www.swavlambancard.gov.in
- CBSE website (To know about concessions and exemptions for LD.):
www.cbse.nic.in , <http://cbse.nic.in/newsite/attach/CWSN%20April%202019.pdf>
- CICSE website (To know about concessions and exemptions for LD):
<https://www.cisce.org/Concessions.aspx>

Key points in management of SLD:

- Psycho-education of parents and teachers regarding nature of SLD is most important; they should avoid ridiculing child for it, identify other strengths and focus on over-all development of child
- Child's morale should be boosted and time should be given to hear out child's perspective of the problem
- Educational support in the form of audio-visual aids for learning, availing help from special educators or remedial training wherever feasible.
- NIOS can be considered if child finds it difficult to cope in structured educational boards such as CBSE/ICSE/State boards
- Formal assessment and certification will aid in seeking benefits such as exemption from subject, additional time for exams, access to scribe.

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BEHAVIOURAL DISORDERS

8. OVERVIEW OF BEHAVIOURAL DISORDERS

9. ATTENTION DEFICIT HYPERACTIVITY DISORDER

10. DISRUPTIVE BEHAVIOURAL DISORDERS

Chapter 8

OVERVIEW OF BEHAVIOURAL DISORDERS

Bikram K. Dutta, Eesha Sharma

Behavioural disorders, generally refers to a group of behavioural disturbances in children characterized by inattention, impulsivity, hyperactivity, defiance, oppositionality and conduct disturbances.

These behavioural disturbances cover three diagnostic categories –

- Attention Deficit Hyperactivity Disorder (ADHD),
 - Oppositional Defiant Disorder (ODD) and
 - Conduct Disorder (CD)
- } Together referred to as Disruptive Behaviour Disorders (DBDs)

The clinical presentations and nature of difficulties across these disorders differ substantially depending upon the developmental stage of the child. Another important consideration is that *transient behavioural disturbances can be commonly seen in young children and adolescents* at all stages of development.

For children and adolescents, while making a diagnosis of behavioural disorders, we must consider the symptoms and their duration, disruption of socio-occupational functioning and the inappropriateness to developmental stage of the child (Figure 1).

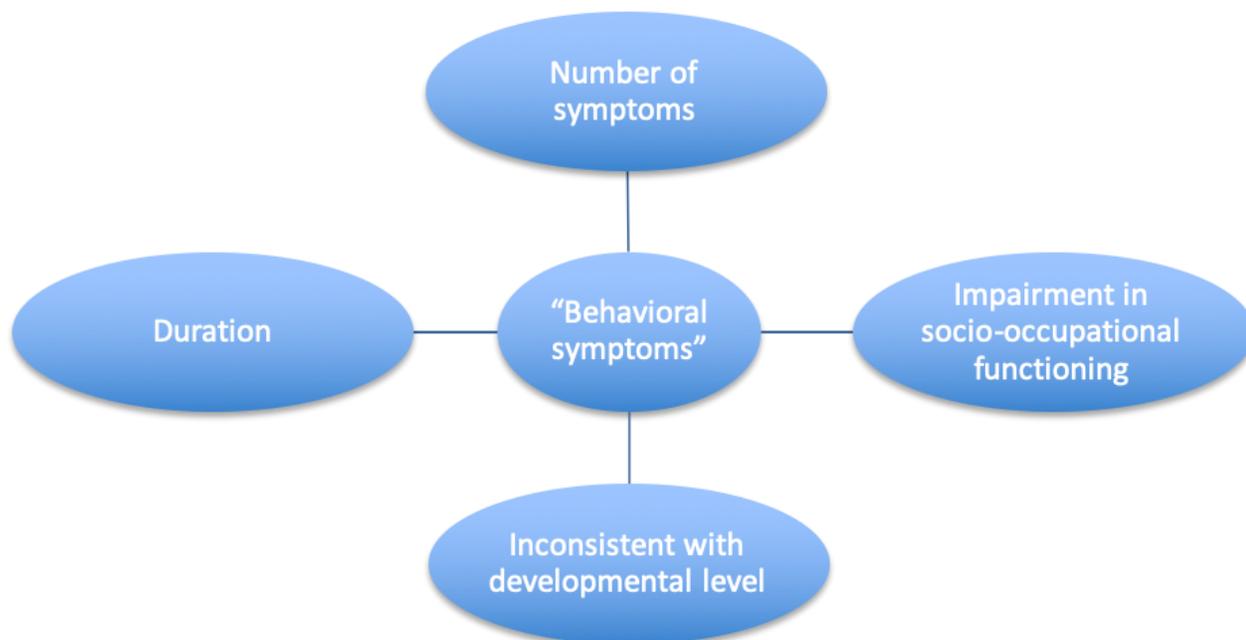


Figure 1: A diagnosis of behavioural disorder in children/adolescents

■ The need to identify and treat behavioural disorders

Any medical/psychiatric disorder is impacted by the current developmental stage of the child (eg. age-specific clinical presentations) and will in turn impact future development of the child. Children with behavioural disorders have to be looked at from a vulnerability lens. Figure 2 depicts how the presence of ADHD features can pose a child at the risk of developing ODD and CD behaviours. Longitudinal studies have shown that they are at significant risk for adverse outcomes, not only in terms of their mental health, but also in other areas of functioning (Table 1).

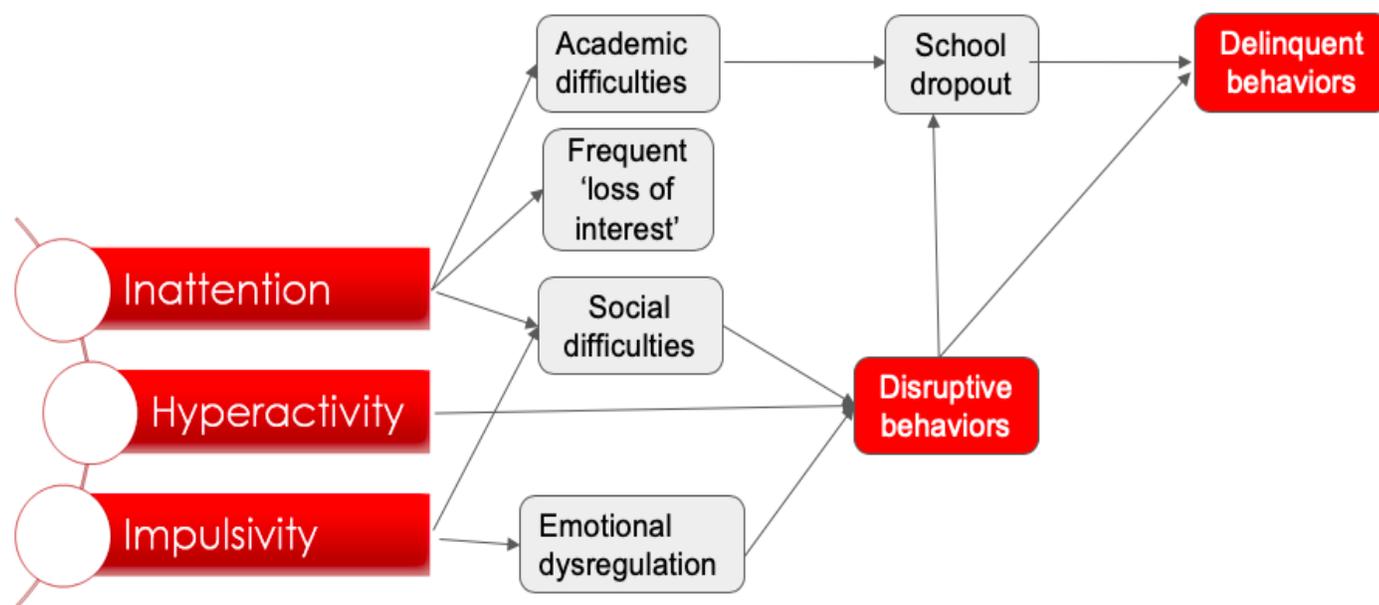


Figure 2: Impact and inter-relatedness of behavioural disorders

Table 1: Lifetime impact of behavioural disorders in childhood and adolescence

Area	Impact
Educational achievement	Lower attainment; higher rates of dropout
Occupational adjustment	Higher unemployment; frequent job changes
Marital adjustment	Higher rates of separation, divorce
Social adjustment	Less contact with relatives, friends
Physical health	Higher rates of hospitalization; mortality
Mental health	Higher rates of psychiatric disorders in adulthood
Criminality	Arrests, rates of driving while intoxicated
Inter-generational	More children with conduct problems

■ Evaluation for behavioural disorders

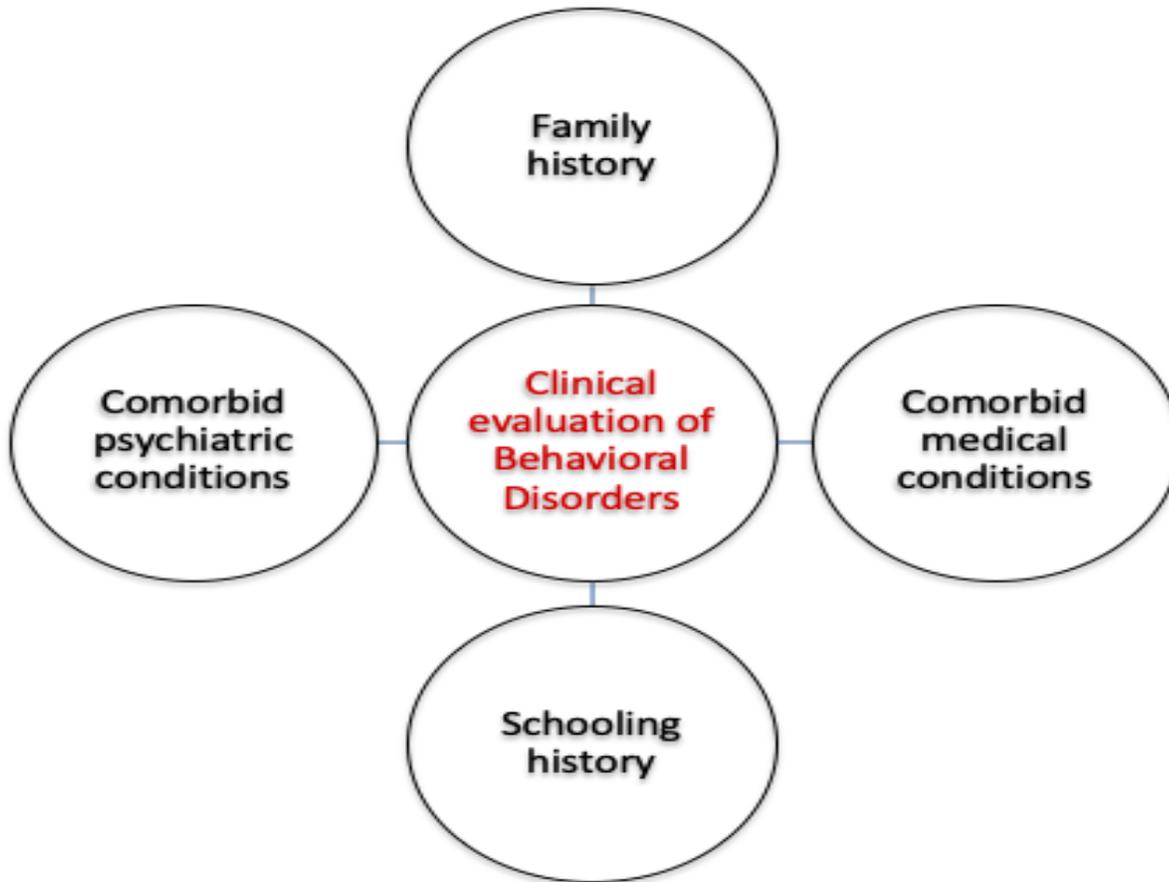


Figure 3: Areas of assessment in the clinical evaluation for Behavioural Disorders

The evaluation of Behavioural Disorders is incomplete without the evaluation of individual and psychosocial comorbidity. The possibility of comorbidity must always be considered in a child who seems to have developmental delays, ‘onset’ or ‘worsening’ of behavioural complaints, and substance use.

Common **comorbid psychiatric conditions** can include –

- a) Developmental disorders: Intellectual Disability, Autism Spectrum Disorders, Specific Learning Disability, Speech and Language disorders, etc.,
- b) Mood disorders: Depression, Bipolar disorder
- c) Substance use disorders
- d) Anxiety Disorders
- e) Impulse control disorders etc.

Comorbid medical conditions must always be ruled out in any child with behavioural concerns. e.g. behavioural changes seen with thyroid disorders or Wilson's disease.

A **family history** of psychiatric disorders also indicates a heightened risk for psychiatric morbidity in the child. Besides, the parental psychopathology can impact parenting.

School evaluation : factors which influence the environmental impact on a child's behaviour are: number of students in a class, teacher-student ratio, the sensitivity among teachers to developmental and academic issues, the capacity of the school to be inclusive, etc. Children spend almost a third of their lives in the school premises, and almost a half in academic engagement. Therefore, liaising with the school becomes an important part of any professional working with children with behavioural disorders.

■ Management of behavioural disorders

Management for Behavioural Disorders involves a combination of medication, individual and familial behavioural therapies, psychosocial interventions and rehabilitation-based approaches. Figure 4 summarizes the individual and parent-based intervention approaches for Behavioural Disorders.

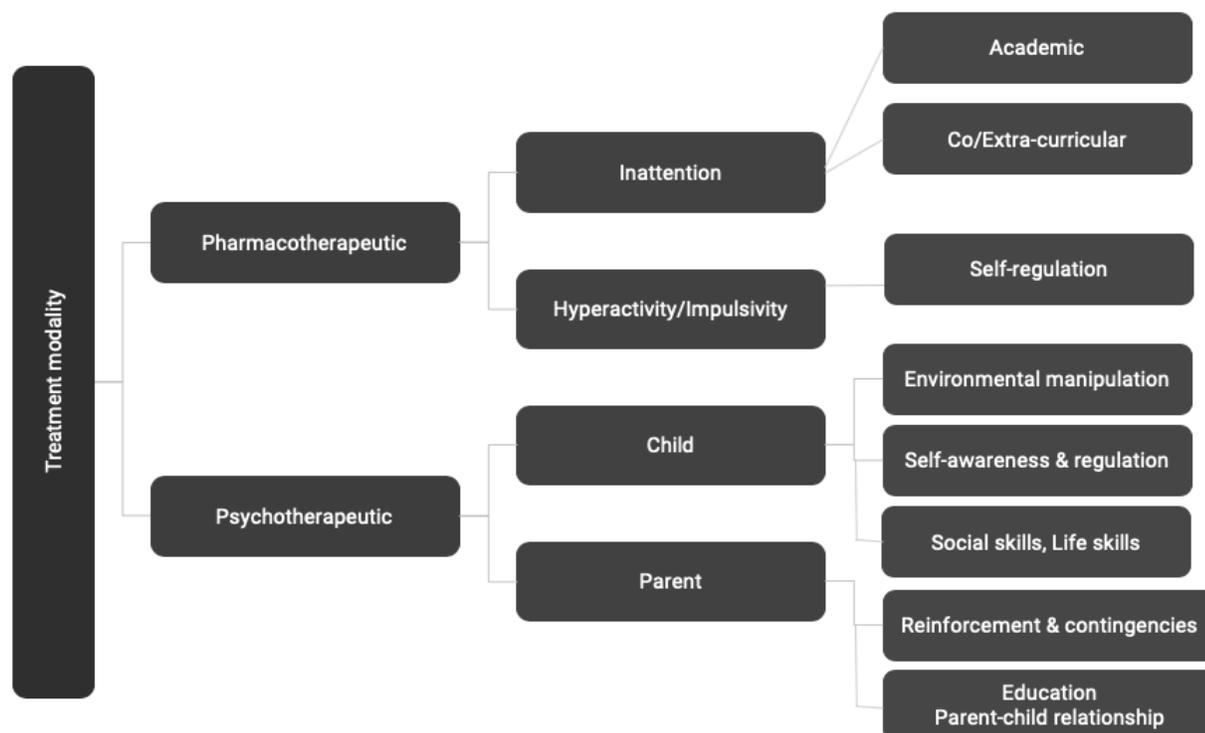


Figure 4: Management approaches for Behavioural Disorders

Chapter 9

ATTENTION DEFICIT HYPERACTIVITY DISORDER

Sowmyashree C. N., Preeti Jacob

■ Introduction

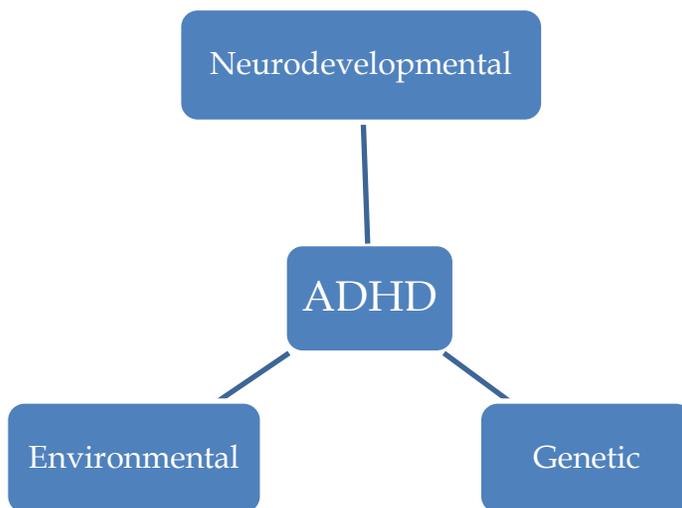
Attention deficit hyperactivity disorder (ADHD) or hyperkinetic disorder is a neurodevelopmental disorder characterized by hyperactivity, impulsivity and high levels of inattention that interfere with the functioning and development. It is one of the most commonly diagnosed psychiatric disorders in children. The symptoms begin in childhood and can persist well into adulthood. It is a chronic condition affecting many domains of life such as academic achievement, social skills, emotional life and personal relationships across the life span.

■ Epidemiology

ADHD prevalence rates vary between children, adolescents and adults. The mean worldwide prevalence of ADHD is 5.5% overall (range: 0.1–8.1%) in children and adolescents. Around 5-7% of school aged children and 2.5% of adults are affected by ADHD. Boys are more affected than girls.

■ Etiology

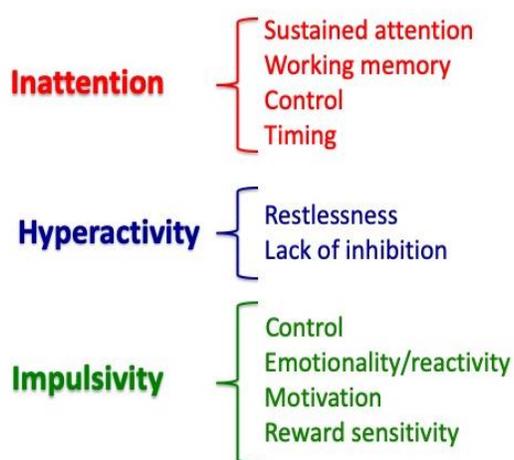
ADHD, like other neurodevelopmental disorders has multifactorial causation. It is considered to be a neurodevelopmental disorder with genetic predisposition. Environmental factors which may play a role are prematurity, VLBW, maternal antenatal smoking, Nutritional deficiency, lead poisoning.



■ Clinical features

Children present with behavioural problems which are a result of the three symptoms; *inattention* expressed as lack of attention to detail, *hyperactivity* expressed as excessive movement and *impulsivity* expressed as acting without forethought

Hyperactive-Impulsive subtype predicts aggression, rejection by peers and accidents whereas Inattention predicts poor academic function, shy and passive social behaviour in children, and lower life satisfaction in adults.



Symptoms of ADHD change as the child grows:

- **Upto 4 years:** predominantly hyperactive, appear as if ‘driven by a motor’, with decreased attention span.
- **4-11 years:** experience difficulty remaining still in class, have a decreased attention span, are forgetful and disorganised in day to day life. Impulsivity seen as blurting out answers in class, interrupting and intruding on others conversations, difficulty in waiting for turn and getting into accidents.
- **Above 12 years:** hyperactivity manifests as inner restlessness and fidgetiness. Inattention presents as difficulty organising tasks and procrastination. Impulsivity presents as high risk taking behaviours, possibly substance use and rash decisions.

■ Assessment

To gain a complete understanding of the child’s condition, history must be obtained from multiple informants, and from multiple settings in various domains. Information is collected from sources other than parents like school teachers, and in India, other family members who are involved in care giving of the child.

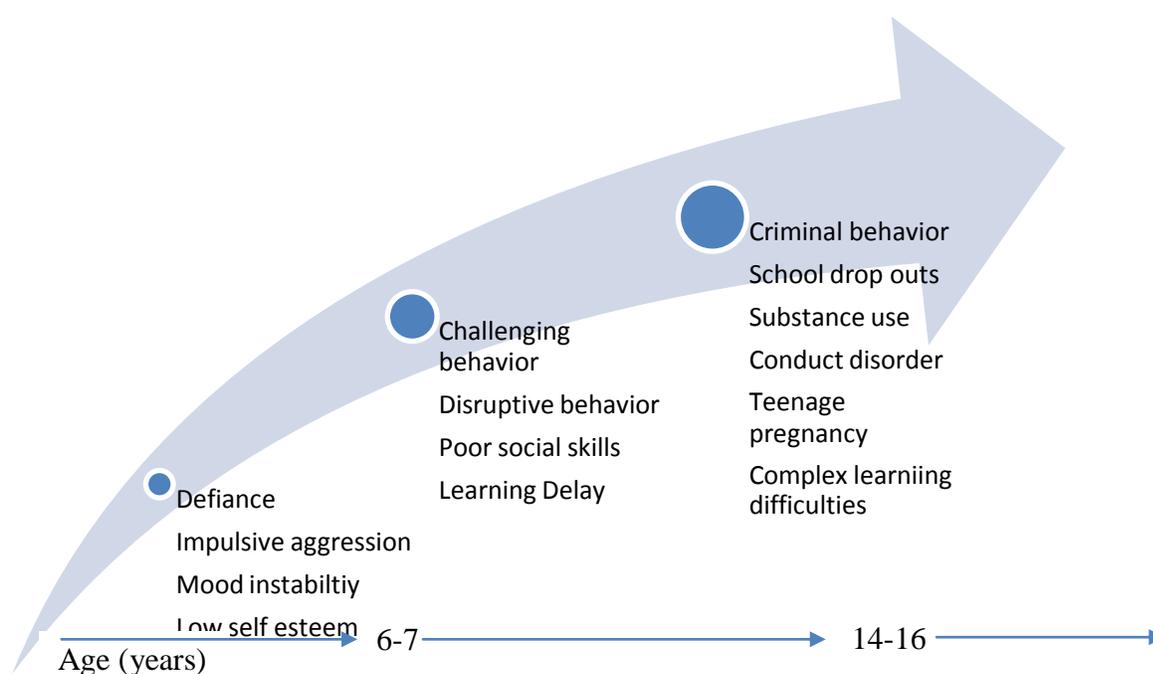
For diagnosis, the following points are important:

- ✓ child should have six or more symptoms
- ✓ which are present for more than six months
- ✓ most of the symptoms must have begun before the age of 12
- ✓ most symptoms should be present in two or more settings
- ✓ symptoms should interfere with, or reduce the quality of, social, academic, or occupational functioning

Questions to detect ADHD- INATTENTION	Questions to detect ADHD - HYPERACTIVITY - IMPULSIVITY
<ul style="list-style-type: none"> • Does the child often have incomplete classwork/homework? • Does the child frequently lose interest in activities that he/she began with enthusiasm (e.g. hobby classes)? • Does the child avoid tasks requiring sustained mental effort? • Does the child listen completely to what parents or teachers tell him/her directly? • Does the child follow through instructions and finish a task successfully? • Does the child often lose his/her belongings in class ex., pencil, notebooks etc? • Is the child bad at organization of daily routine/tasks? • Is the child forgetful? • Is the child easily distracted? 	<ul style="list-style-type: none"> • Is the child more talkative than other children his/her age? • Is the child always running, jumping or climbing around? How difficult is it to make the child sit at a place for an activity? • Does the child leave the seat and roam around in the middle of class in the presence of teacher? • Does the child have difficulty playing quietly? • Is the child impatient? Does he/she have difficulty waiting for his/her turn in play or long queues? • Does the child interrupt others in their activities?

■ Need for early identification

Early identification and effective management can significantly improve the functioning and overall quality of life for children with ADHD and their family. Those with unmanaged ADHD often experience unnecessary impairments and detrimental long-term consequences and miss out on learning opportunities in the formative years, which lead to sub-par functioning in later life.



■ Management

A comprehensive management plan is formulated *based on developmental age and the information obtained through assessment*. A good therapeutic alliance and psycho-education are the most important pre-requisites for treatment. Various treatment modalities are:

- Psychoeducation: vital to explain need for treatment to parents and to keep the child in the treatment program
- Psychosocial interventions : environment modification, parent training intervention, cognitive behaviour therapy
- Pharmacotherapy : stimulant and non-stimulant medications
- Other measures : lifestyle modification , liaison with school

■ Psychosocial interventions

Environment modification: changes made in the environment to decrease the symptoms and improve the efficiency of child's functioning:

- Day structuring through activity schedule in order to make the daily routine regular and predictable. With the help of verbal prompts and visual cues, effective implementation of the activity schedule can be carried out.
- Distracting toys and screen media like mobile phones and television should be taken off from the environment.
- A particular place is allotted for every object, especially child's belongings in the house.
- Parental supervision of boring and lengthy tasks like maths will improve the child's focus at the task. Parents can remind if the child loses focus by gentle tap on shoulder or verbal cues.
- Children should be provided with adequate break times in the middle of lengthy tasks.
- Children should be encouraged in all possible ways to channelize their energy on productive activities like physical sports e.g., cricket, football etc and extracurricular activities like yoga, dance music etc.

Box 2: Self-management strategies for children/adolescents with ADHD

- Creating time-management schedules
- Small, time-bound tasks with multiple breaks
- Eliminating distractions in the study/work area (e.g. mobile phones, TV, toys)
- Multi-modal learning (using pictorial illustrations, audio-inputs) to enhance engagement
- Identify and use rewards to keep motivation and persistence at tasks high

Parent management training

It is an evidence based parenting program for helping parents manage difficult and challenging behaviours. Specific skills are imparted to parents either in group or individual settings. The behavioural principles are:

- Setting of clear rules
- Differential reinforcement: Differential reinforcement entails use of immediate and delayed rewards following desirable behaviours and withdrawal of rewards following undesirable behaviours. Rewards can be social (appreciation) or tangible (things like chocolate), and should be proportionate to the behaviour
- Consistency: Parents should be consistent in their responses across situations, across time and across individuals (both parents should respond in the same and consistent manner at all times). Grand parents should also be included in case of joint families.
- Improving parent-child relationship through quality time: Parents must be encouraged to focus on their child's strengths and spend quality time wherein there are only positive interactions between the parents and children to develop healthy parent-child relationship.

Parent-mediated interventions for ADHD

- Facilitating and motivating the child to follow routines, e.g. morning 'getting ready' routines, nighttime 'getting to bed' routines, 'homework routines', etc.
- Using organizers for books, toys, stationary with labels/markers
- Encouraging the child to 'clean-up' routinely to further facilitate organization skills
- Discuss with the child how to break-up a task into smaller portions and work over short time-intervals
- Checklists for task completion – during classwork, homework and tests/assignments
- Engage child in multiple co- and extra-curricular activities

Liaison with school

Last but not the least, school authorities should be explained about the child's condition and special needs and school should be encouraged to implement environment modification as discussed earlier. A letter to concerned teachers with specific guidelines on how to practically help the child will be useful.

Pharmacotherapy

In children and adolescents, medications are reserved *for those with severe symptoms and impairment*, or for those with moderate levels of impairment whose symptoms have not responded sufficiently to parent management training and psychosocial interventions.

Children who require medications for the management of symptoms should be referred to a specialist (Pediatrician or Psychiatrist) for initiation of medications, monitoring and regular follow-ups.

The two main types of medications used to treat ADHD are stimulants and non-stimulants. Methylphenidate is the only stimulant available in India - it is a schedule X drug and therefore has strict regulations on its use. It can only be prescribed by a specialist doctor (Psychiatrist/Pediatrician).

Non-stimulant medications include Atomoxetine and Clonidine. All these medications are used according to body weight and tolerability of the individual child. Typically, they are continued over long-term and require monthly to bimonthly clinical follow-up. In follow-up, in addition to the clinical response of symptoms, the child's weight, appetite, blood pressure (with clonidine) needs to be monitored. There is little evidence for the use of medication for other behavioural disorders, unless there are comorbid disorders that stand to benefit from them, e.g. mood disorders.

Continuing care

Post the initiation of treatment by the specialist in secondary care set up, primary care physicians can provide valuable post-diagnostic care in terms of monitoring for improvement and side effects of medications. They can reiterate the parent management techniques and psychosocial interventions and monitor how well these measures are being implemented

Following titration and dose stabilisation, NICE guidelines recommend that continued prescribing and monitoring of medications is carried out at primary care. Medications should be reviewed at least annually by a specialist.

For children taking methylphenidate and atomoxetine, regular monitoring should include:

- Plotting height and weight on a growth chart for specialist review every 3-6 months
- Monitoring heart rate and blood pressure before and after each dose adjustment and routinely every 3 months
- Side effects and concerns to be reported to the specialist

KEY HIGHLIGHTS:

- ADHD is a neuro-developmental disorder characterized by high level of hyper-activity, inattention and impulsivity that lead to socio-occupational dysfunction.
- It has multi-factorial causation
- Clinical features depends on the age of the child- hyperactivity is more common in younger children whereas inattention and impulsivity is more common in older children
- Early assessment and intervention leads to better prognosis and overall functioning. Assessment includes reports from teachers and parents.
- Management includes psycho-education of parents and teachers, psycho-social interventions (including environmental modification, self-management strategies, parent-management training) and liaison with school
- Pharmacotherapy may be required for children with severe symptoms. Children on medications need to periodically monitored for side effects
- PCP's can help to provide post-diagnostic care and reiterate the psychosocial interventions to parents and child.

Chapter 10

DISRUPTIVE BEHAVIOURAL DISORDERS

Bikram K. Dutta, Eesha Sharma

DBDs include Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD). These are called 'disruptive' because the behavioural disturbances seen in children affected by them creates disruption in their environment, including home, school and with peers. The prevalence of these disorders, too, is recorded around 5-6%. ADHD and DBDs can frequently be co-morbid.

Children with ODD present with a persistent pattern of anger outbursts, argumentativeness and disobedience. This is usually directed at older people – typically authority figures, like parents and teachers, and also older siblings. There may also be complaints of similar behaviour with classmates and other children. Features of ODD are listed in Box 1.

Box 1: Clinical features of ODD

- Excessive argumentativeness with adults
- Refusal to comply with adult requests/ instructions by adults
- Questioning rules at school and home
- Refusal to follow rules
- Behaviour intended to annoy or upset others
- Blaming others for their misbehaviours or mistakes
- Becoming easily annoyed with others
- Frequently seen to be angry or upset
- Speaking harshly or unkindly to others
- Behaviour to seek revenge when upset by others

Conduct disorder is a far more serious clinical condition, in terms of the extent and nature of behavioural concerns. It can involve intentional cruelty to people and animals, violent behaviours and criminal activity. Children and adolescents with the disorder have significant difficulty in following rules and behaving in a socially acceptable way. There may be aggressive, destructive, and deceitful behaviour that violates the rights of others. The clinical features of this disorder are depicted in Figure 4.

Boys with CD are more likely to display physically aggressive and destructive behaviour than girls, who are more prone to show deceitful and rule-violating behaviour.

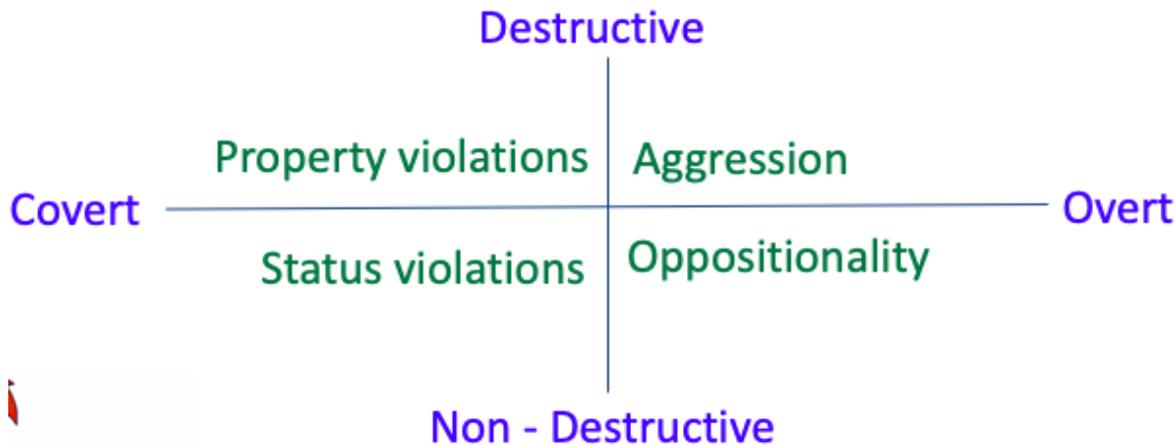


Figure 4: Clinical features of Conduct Disorder

Examples of conduct disorder behaviours

Aggression	Intimidating or bullying others Physically harming people or animals on purpose Using a weapon Arson, intentional destruction of property
Deceitful behaviour	Lying Breaking and entering Stealing Forgery
Violation of rules	Skipping school Running away from home Drug and alcohol use Sexual behaviour at a very young age

■ Evaluation of Behavioural Disorders

An evaluation for these disorders is a must in every child presenting with – academic difficulties, frequent complaints about child’s behaviour at school, temper tantrums, and other behavioural disturbances. Very often the school may initiate the referral and ask the parents to get their child evaluated. Table 2 lists questions useful in clinical elicitation of features.

Table 2: Questions to detect Behavioural Disorders during clinical evaluation

Questions to detect DBDs
<ul style="list-style-type: none"> • Does your child actively defy or refuse to comply with requests and rules? • Does your child say cruel, mean, or hateful things when upset? • Does your child argue excessively with adults and other authority figures? • Do you find that your child just doesn't take rules seriously? • Does your child bait classmates and pick fights with them by purposely doing things that annoy them? • Is your child touchy, prickly, or easily offended? • Has your child ever tried to intentionally harm/hit/intimidate younger children or tried to harm animals? • Does your child frequently lie to you/ steal money or other objects without showing any remorse for actions? • Has your child threatened to damage objects or indulged in such behaviour in case his demands are not met?

■ Management of Disruptive Behavioural Disorders:

Pharmacotherapy:

There is *little evidence* for the use of medication for other behavioural disorders, unless there are comorbid disorders that stand to benefit from them, e.g. mood disorders.

Psychotherapeutic interventions with the child:

Children with DBDs have significant difficulties with social and emotional skills. They benefit from new skills for identifying and managing feelings, managing anger, problem solve, being with other people more effectively, and strategies for making good decisions that are based on thinking rather than feeling.

Psychotherapeutic work with the parents:

Behavioural disorders, especially ADHD and ODD, most frequently present in young children. The role of parents therefore becomes very important in management. The most important thing for parents to understand is that the child has a clinically diagnosable condition and that he or she is not just 'bad'. Parents should learn to distinguish the child from the 'bad behaviour' and continue to strengthen their relationship with the child, while mutually working on the child's problematic behaviours. Certain useful strategies to be discussed with parents are presented in Table 3.

Table 3: Parent-mediated interventions for children with DBD's

- “Catch the child being good”. Use abundant social rewards – attention, praise, affection, physical proximity
- Positive, quality family time where no ‘problems’ are discussed
- Ignore mild unwanted behaviours and pay attention to alternate positive behaviours
- Clear, direct communication by looking into child’s eyes. Avoid repeating commands
- Give choices – foster a sense of control and responsibility
- Setting limits on unacceptable behaviour with consistent consequences for non-compliance
- Increase “Do” instructions, Decrease “Don’t” instructions
- School-home contract: Daily behaviour report card from teacher with home-based reward system
- Engage child in multiple co- and extra-curricular activities
- Know who your child’s friends are and how your child is spending time in and outside home. Protect from association with deviant peer groups.

Children with DBDs often fall into a vicious cycle of unwanted behaviours – negative attention from others – more unwanted behaviours. Parents need to be told that punishment, negative attention, criticality and hostility only serve to maintain behavioural problems. Instead children need to be positively engaged and their behaviours differentially reinforced.

Disruptive children, typically, only get attention when they are being problematic. This is the first thing parents need to change, and catch them being good, even if for mundane activities, multiple times a day. Seemingly annoying, unwanted behaviour (e.g. making sounds, jumping around) that does not have any real detrimental consequences for the child or others needs to be ignored. At the same time, clear limits need to be set, and consistently followed, for behaviour that has detrimental personal or social consequences, e.g. aggression in any form, violence, missing school, etc.

■ Summary

Behavioural disorders are common clinical presentations and often reflect developmental vulnerabilities that pose significant risk for long-term psychiatric morbidity. It is important to screen for them in all children presenting with academic difficulties or behavioural concerns at home or school. The evaluation must also focus on the role of family, school and comorbidities. Medications are only a small part of the interventions that must address both the individual child and his/her entire social environment.

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EMOTIONAL DISORDERS

11. EMOTIONAL DISORDERS

12. SELF-HARM BEHAVIOUR AND SUICIDE

Chapter 11

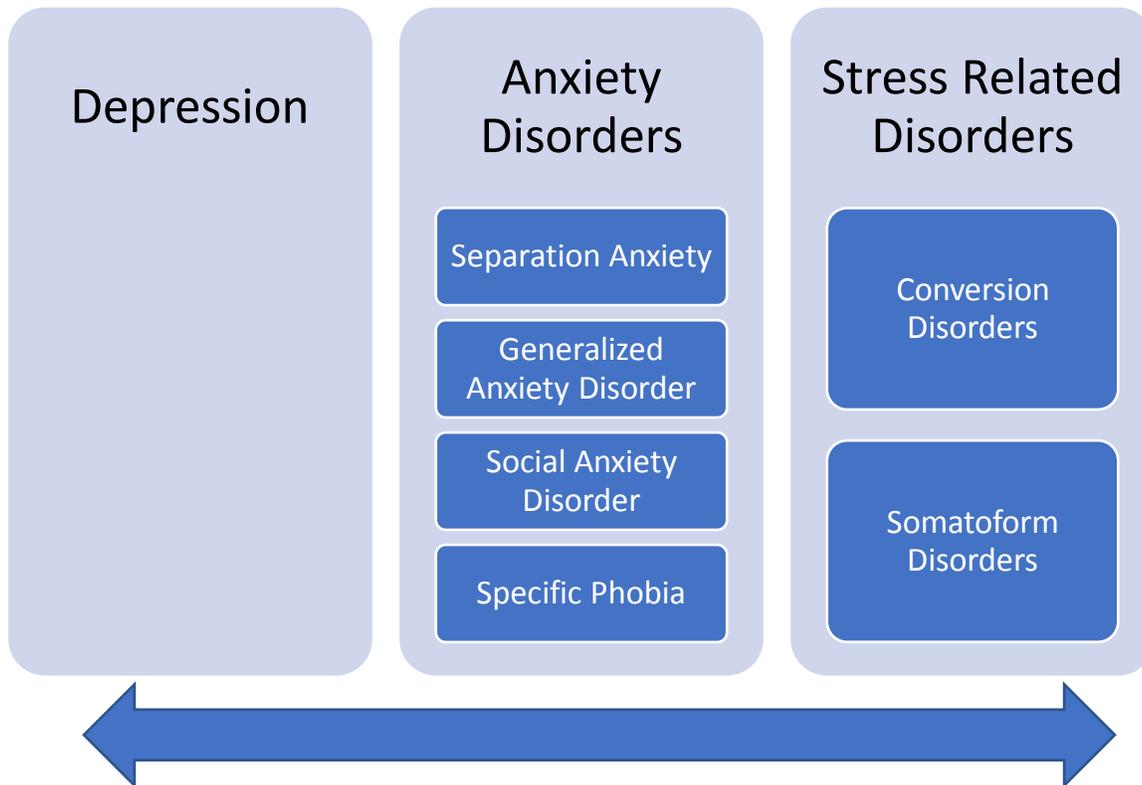
OVERVIEW OF EMOTIONAL DISORDERS

Bhagyavathi H. D., Rakesh Chander K., Rajendra K. M.

■ Overview and disorders covered

Emotional disorders (EDs) are the most common group of mental health disorders prevalent among children and adolescents. Depression, anxiety disorder and stress-related disorders are the subgroups of EDs. Children experience sadness and anxiety while facing stressful situations in life based on their innate abilities and available family care/support. In milder forms, these experiences are helpful to the child's healthy growth.

Emotional disorders are often missed or under-diagnosed during routine health checks in children. A diagnosis of ED is made if a child experiences persistent and high degree of fear/anxiety, sadness, which adversely affects his/her subjective wellbeing, social and academic functioning. As children are still learning about emotions and mastering them, they tend to have difficulty in expressing internal emotional states/feelings verbally; symptoms usually manifest as behavioural/physical symptoms. These disorders usually co-occur; with one group of symptoms being predominant and have long-term adverse events if not recognised and treated. The figure below gives an overview of three types of EDs:



■ Epidemiology

Most epidemiological studies roughly estimate that all anxiety disorders affect around 13% of children followed by depression which affects around 5% of children at any given point in time.

■ The need to identify and treat Emotional Disorders

Due to lack of clinical services, around eighty percent of EDs in children go unrecognised. Along with subjective suffering due to disorder, emotional disorders are found to be associated with adverse long term physical and mental health consequences. Children who present with other complaints such as behavioural issues or somatic illnesses can also have associated emotional disorders. The long term mental health consequences include high risk-taking behaviour, adult mental illness, substance abuse and increased risk of suicide. In addition, EDs also have negative affect on the child's academic functioning, which in turn affect social and occupational functioning even upto adulthood.

■ Causes

The complex interplay of biological, individual, environmental factors and negative life events leads to development of EDs in children. The following risk factors have been identified to have an association with occurrence of emotional disorders.

- **Biological risk factors:** History of Depressive disorder/anxiety disorder in one or both parents
- **Child (individual) characteristics:** low self-esteem, perfectionistic thinking, difficulty in emotional regulation are risk factors for depression. Shy nature, inhibited and withdrawn temperament and increased threat perception are risk factors for anxiety disorders
- **Parenting and family factors:** Harsh and over-controlling parenting, critical nature of communication, physical disciplining, excessive social and academic demands and expectations are associated with depression and anxiety disorders. Over protective and intrusive nature of parents are known to be associated with anxiety disorders.
- **Social factors:** peer rejection, victimisation, bullying experiences
- **Stressors/Negative life events:** loss of significant others, parental divorce, parental job loss, parental discord, negative events in school, academic setback.

■ Clinical features

1. **Depression:** When a child is experiencing sadness/irritability for most time of the day and/or has loss of interest in pleasurable activities for two weeks or more, we need to consider the possibility of depression. The symptoms of children can be divided as follows:

<i>Major symptoms</i>	<i>Associated symptoms</i>
<p>i. Low mood/sadness</p> <p><i>Note: In children low mood clinically manifests as crying, appearing dull at most times, poor frustration tolerance, irritability and tendency for emotional outbursts</i></p> <p>ii. Loss of interests in previously pleasurable activities</p> <p><i>Note: In children loss of interest clinically manifests as being disconnected, withdrawn and spending time alone</i></p> <p>iii. Lack of drive, easy fatiguability</p>	<ul style="list-style-type: none"> • Cognitive: poor concentration/ attention, indecisiveness / hesitation • Reduced self-esteem, low self-confidence, worthlessness • Inappropriate feelings of guilt, self-reproach • Hopelessness, death wishes , Suicidal thoughts/plans, suicidal behaviour • Disrupted sleep: decreased sleep duration/ sleeping for more time, even in daytime • Loss of appetite <i>or</i> increase in appetite with change in weight

2. Anxiety disorders :

When a child is experiencing excessive fear/anxiety in general for most of the time, or in specific situations for four weeks or more we need to consider the possibility of anxiety disorders.

Major and minor features of the anxiety disorders		
Disorder	Major feature and duration of symptoms	Minor features
Separation anxiety disorder	<p>Fear that something bad will happen to him/her or to the attachment figure when separated.</p> <p>Reluctant to be alone or without major attachment figures.</p> <p>Duration of 4 weeks or more</p>	<p>Repeated nightmares involving the theme of separation</p> <p>Refusal for sleeping alone, for going to school</p> <p>Worries about the consequences of separation; fear of being kidnapped/ hurt while apart, fear of possible harm to/losing the attachment figure (hurt/injured/killed)</p> <p>Physical symptoms- headaches, stomachaches, nausea, or vomiting</p>
Generalized anxiety disorder	<p>Repeated and excessive worries about a variety of topics, events, or activities</p> <p>These worries are uncontrollable</p> <p>Duration of 6 months or more</p>	<p>Excessive worries regarding various domains of life; such as school work, academic performance, self and family health/finances, and minor day-to-day issues.</p> <p>Tendency to seek reassurance from parents or others about worries.</p> <p>Negative news and worries of making mistakes.</p> <p>Physical symptoms(muscle aches/tiredness), sleeplessness, and irritability</p>
Social Anxiety Disorder	<p>Fear and avoidance of social interactions/situations</p> <p>Strong belief that others will negatively judge/evaluate him/her</p> <p>Duration of 4 weeks or more</p>	<p>Avoidance of a range of social activities or situations including, speaking or performing in front of others, meeting new people, talking to authority figures such as teachers</p> <p>Fear of being the center of attention in any way</p> <p>Worries about negative evaluation by others ;feeling of being perceived as unattractive, stupid, or odd</p> <p>A limited number of friends and difficulty making new friends</p>
Specific phobias	<p>Fear and avoidance of range of <i>specific</i> cues, situations, or objects.</p>	<p>Some common fears in children include:</p> <ul style="list-style-type: none"> • Animals such as dogs • Insects or spiders • Darkness • Loud noises like thunder • Blood, illness, injections

3. Conversion Disorder:

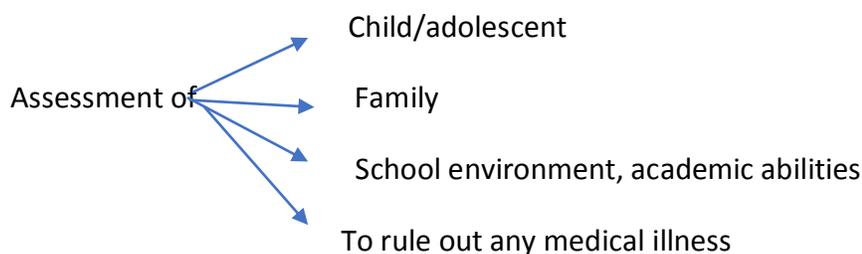
Conversion disorder refers to a clinical condition in which the child presents with loss of function, *or* altered function *or* dysfunction of one or more bodily parts with **no explainable medical cause**; rather associated with a psychological cause. This is a common condition among children and adolescents in India. The most common symptoms are pseudo-seizures, fainting spells (attacks of unresponsiveness), and abnormal movements (shaking of the limbs, tremulousness, hyperventilation). Motor weakness, aphonia, amnesia and possession attacks are less common clinical presentations.

4. Somatoform disorders:

Somatoform disorders are characterized by recurrent physical symptoms (gastrointestinal, pain related, neurological) that cannot be explained by a medical condition. The most common somatic symptoms are head-aches, recurrent abdominal pain, and musculo-skeletal pain. These conditions are usually associated with psychological/emotional issues; however they are not intentionally produced by child.

■ Assessment of Emotional Disorders:

It involves a detailed assessment of the presenting emotional condition - onset, course, severity and effect on child's routine, academic and social functioning. Further, assessment of family situations and academic related assessments need to be carried out to understand the strengths of the child and contributing factors to the current presentation. Lastly, assessment should focus on ruling out medical conditions which can present with emotional symptoms. Asking the child a simple question such as "how are you feeling?" or asking the parents "how is your child doing?" can reveal a lot, and is rightly called the sixth vital sign.



Assessment of child/adolescent: Both clinical interview and observation of the child are necessary in assessing for mood state/ irritability/ fears / anxiety / psychological wellbeing and overall nature of the child.

- Is often feeling sad and irritable, easily annoyed?
- Is often unhappy, dejected or tearful?
- Has lost interest in or enjoyment of activities?
- Has many worries or often seems worried?
- Has many fears or is easily scared?
- Often complains of headaches, stomach-aches or sickness?
- Avoids or strongly dislikes certain situations (e.g. separation from parents, meeting new people, or closed spaces)?

Note: The clinician must always assess the risk for suicide in all children (refer to chapter 12 for details regarding suicide assessment)

Assessment of family and related risk factors:

- Poverty and parental job loss
- Family dysfunction / Marital discord in parents / divorce / Single parent
- Parental mental illness: History of mental illness, substance abuse
- Relationship between child and parents: Parent–child conflict, poor communication
- Significant loss: e.g., death of a parent, sibling, or friend; separation from parents

Assessment of school environment/academics/peer groups and related risk factors:

- School refusal / academic difficulties / high academic expectations
- Bullying, corporal punishment and discrimination etc.
- Conflict with peers; romantic relationship issues, experience of insult
- Academic setbacks, upcoming exams

Assessment to rule out medical/ physical conditions:

Rule out any signs/symptoms suggestive of:

- Thyroid diseases/ other endocrine disorders
- Nutritional disorders: Anemia, vitamin deficiencies
- Chronic medical conditions
- Malnutrition and any other medical/neurological conditions

■ Management: psychiatrist/mental health professionals

Psycho education of child and parents:

Psycho-education should be done early and thoroughly. The parents and child should be psycho-educated regarding the nature of illness, diagnosis, severity, factors contributing to the occurrence of disorder and management plan. For milder form of EDs, only psychological interventions are provided. For moderate to severe condition, both pharmacological and psychological interventions are preferred. The treatment process usually lasts for weeks to few months and most children with these disorders recover well.

Pharmacological management:

Selective serotonin reuptake inhibitors (SSRI's) are safe to use in children above 12 years and adolescents. Fluoxetine and Escitalopram are most commonly used for treating anxiety disorders and depression. The child and parents should be explained regarding the treatment targets, effects, and side effects. The symptom severity should be assessed at baseline, and progress should be monitored during follow-up- to look for response and side effects.

Child-focused psychological interventions

Cognitive behavioural therapy (CBT) is the preferred psychological intervention for EDs, especially for depression and anxiety disorders. In this, the therapist helps the child to recognize and unlearn unhealthy behavioural and thinking patterns, which lead to occurrence and maintenance of negative emotional state. Further, the child will be guided to learn healthy thinking patterns and healthy behaviours. In Indian context, parents can also be involved in the therapy process as co-therapist(s) to impart necessary training to the child. Especially in adolescents who lack emotional regulation and interpersonal sensitivity, dialectic behavioural therapy has been found to be effective. These psychological therapies are conducted by psychologists/ psychiatrists.

Importance of identification and referral in primary care setting

Children and parents almost always approach primary care physicians (PCPs) for all types of health concerns. PCP's need to consider the possibility of emotional issues when children present to them with recent onset emotional/behavioural change, sleep/appetite concerns, memory/concentration problems, or medically unexplained recurrent somatic symptoms. Such children should be referred to nearby psychiatric services. This process will not only help child and family to get early treatment and faster recovery but also has a positive effect on the child's further development and his/her future. PCP's can also help in follow-up care for the child by monitoring for side-effects, refilling medications and provide supportive care to the family in liaison with the psychiatrist.

■ Guidance to parents and children: during referral and follow up at primary health care setting

The primary care physician can guide the family to get a better understanding of illness to help them deal with it better. Some general guidance includes points as mentioned below:

- Explain that emotional disorders are common and can happen to anybody. The occurrence of emotional disorders does not mean that the person is weak or lazy.
- Children also experience stress due to developmental demands or stress from different domains such as school, peer relations, family situations. A few children may develop emotional problems which needs medical attention.
- Emotional disorders can cause unjustified thoughts of hopelessness and worthlessness. Explain that these views are likely to improve once the emotional disorders improve
- Early diagnosis and treatment by a mental health professional can help the child to recover faster and resume functioning. Overall the treatment process usually takes few weeks. These disorders to tend have good prognosis.
- The child may have difficulty in expressing his/her concerns, and may need time to recover from the emotional disorder when it is severe. Parents can help the child to overcome the emotional state over time by being supportive, encouraging and patient.
- Make the person aware that if they notice thoughts of self-harm or suicide, they should tell a trusted person and come back for help immediately.

■ Specific guidance tips during follow up:

For Depression/ Anxiety disorder:

- The child should be provided with adequate opportunities to face and master age-appropriate day to day life challenges
- Child's self-esteem should be promoted through positive self-appreciation, learning useful skills, and developing better interaction abilities
- The child should be guided on ways to deal with fearful or anxiety-provoking situations gradually in a step wise manner
- Regarding academic achievements, parents should encourage the child to appreciate his/her own efforts rather than the scores/achievements
- School can be resumed in a graded manner depending upon the readiness of the child. Any concerns that the child may have should be addressed.
- The child should be encouraged to share his/her personal or interpersonal troubles with parents.
- The child should be encouraged to adopt healthy practices such as maintaining a routine, eat and sleep on time, practice relaxation activities like yoga, sports, reading etc
- Ensure the continuation of medications for period as suggested by psychiatrist

For Conversion and Somatoform disorder:

- Family should be educated that child has real symptoms and sufferings, but the reasons could be psychological and not physical
- Reassure parents/ caregivers- educate caregivers about non-life-threatening nature of illness
- Parents should be guided to acknowledge the child's symptoms and to reassure the child
- Encourage the child to return to normal daily activity and school.
- Encourage the child to talk to his parents about his feelings, thoughts and concerns.

Conclusion

Emotional disorders include anxiety spectrum disorders and depressive disorders. Even though emotional disorders are common among children, 80% cases are unrecognized/ not treated. These disorders have long term adverse physical and mental health consequences. Primary care physicians can play a major role in early recognition and referral of these children to psychiatric services. This will not only help the child and family in short term, but it will also have positive impact on child's further development and future. Primary care physicians can provide follow up services to these children in liaison with mental health professionals.

KEY HIGHLIGHTS:

- Emotional disorders include anxiety spectrum disorders and depressive disorders
- ED's in children and adolescents are difficult to identify as children may not be able to vocalise their problems and many problem behaviours may just be an exaggeration of normative behaviours.
- Some warning signs which should alert the caregivers and primary care physicians are a sudden change in behaviour, school refusal, inconsolable crying, avoiding people.
- The clinician should screen every child for emotional disorders. Asking a simple question "How are you feeling?" is akin to checking the 6th vital sign.
- Management should focus on psychosocial interventions such as psycho-educating caregivers, parental support, psychological interventions with child to promote self-esteem and coping, liaisioning with school, promoting strategies for positive well-being of children
- Pharmacotherapy should be used only in children above 12 years with moderate-to-severe illness where psychological interventions have failed.

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Chapter 12

SELF-INJURY AND SUICIDAL BEHAVIOUR IN ADOLESCENTS

Vandana B. Shetty, Rajendra K. M.

■ Self-Injury

Self-injury (SI) means deliberate destruction or alteration of body tissue *without* suicidal intent". It can also be described as Non-suicidal self-injury. **Self-cutting (SC) is the most common method of SI**; other methods are biting, carving, scratching, pinching, burning, head banging and hair pulling. It is more common in females than in males.

■ Course and types of SI

Self-injurious behaviour most often starts between 12 to 14 years of age. It has a high prevalence- studies from across the world have reported life time prevalence of one episode in 17 to 18% of adolescents in the community. It tends to increase in early and mid-adolescence and tends to decrease from late adolescents to young adulthood. It is more common in females than males.

■ Consequences of SI

1. Long term consequences: in a small number of adolescents the SC behaviour may become repetitive and persistent. This group of children need continued care from mental health professionals.
2. **Medical consequences-** Increased risk of blood-borne disease transmission in adolescents who attempt self-cutting, especially with shared use of sharp objects
3. **Impact on parenting:** Caring for an adolescent indulging in SI behaviour is difficult and tends to have huge negative emotional impact on caregivers. Negative emotions like sadness, shame, embarrassment, shock, disappointment, self-blame, anger, and frustration are common among parents, due to their child's SI behavior. SI in adolescents affects parents' employment, their usual life style, and family dynamics in a negative way.

■ Reasons for indulging in SI

The most **common triggers** for adolescents engaging in self-cutting/ SI can be summarised as:

Situational triggers:

- *Family/parents related:* marital discord between parents, poor family environment, conflict with parents, exposure to abuse (physical, emotional or sexual)
- *Peer related:* insecurities or conflicts in friendships, perceived insults, rejection in early romantic infatuations/relationship, as a challenge or threat to others
- *Personal:* failure to resolve conflicts, failure to achieve expected goals, poor help-seeking is distressing situations

Pre-disposing psychological factors: low frustration tolerance, poor problem-solving, inability to tolerate criticism from significant others, poor emotional regulation, impulsive nature

Functions of SI:

Individuals, who engage in self-injury, **usually do not have any intention to die**. The functions of self-cutting are

- a. **Emotional regulation:** Anxiety, anger, frustration and sadness
- b. **Control of thoughts or memories:** Distraction from problems, Stopping suicidal thoughts
- c. **Interpersonal:** Secure care and attention, Influence others
- d. **Self punishment**

■ Management approaches for adolescents engaging in self-cutting

ASSESSMENT: An assessment of the antecedent events that led to self-injurious behaviour is needed along with an understanding of the pre-disposing personality factors and immediate triggers.

Even though self-injury is without the intent to die, adolescents who engage in self-injurious behaviour are still at risk for suicide. *Because of this fact, all individuals who attempt SI need to be assessed for suicide risk. This behaviour cannot be taken lightly.*

Immediate management at primary care setting and referral (within the first 36 to 48 hours):

Immediate care can be provided in the primary care setting.

- i. Ensure safety and vary close monitoring of the individual- provide immediate first-aid for injury, medical evaluation and treatment including Inj.Tetanus toxoid if required
- ii. Providing emotional support in an empathetic and non-judgemental manner
- iii. *In case of risk of imminent suicide, a referral should be made to the psychiatrist at the earliest.*

Short-term management at primary care setting (in the first week; 1 or 2 brief counseling sessions):

- i. Validation/ motivation of the adolescent's emotional state
- ii. Psycho-education of both parents and the adolescent- to create awareness about SC behaviour
- iii. To help the adolescent understand the behaviour by connecting it with the emotional experience- as a faulty coping to stressful situation
- iv. Helping the adolescent take a firm view regarding avoiding future self-injury
- v. Education regarding medical consequences

Long-term management at primary care setting (over 1-2 months: 2 or 3 brief counseling sessions):

These interventions aim to slowly help the adolescent deal with predisposing risk factors.

- **Emotional regulation training-** to use more adaptive ways to control intense negative emotional states. The adolescent should be trained to recognize the intensity of the negative state and use appropriate response: either distraction, delaying response, or displacing negative emotions
- Teaching solution-focused problem solving
- Improving inter-personal interaction skills- to reduce rejection sensitivity
- Building self-esteem and resilience- thorough task mastery, self-appreciation and motivation
- Encourage child to reach out to significant adults to seek help

At any point in treatment, if the primary care doctor feels that there is risk of suicide or further self-harm, then referral to a mental health professional is warranted.

SUICIDAL BEHAVIOUR AMONG ADOLESCENTS

Suicidal behaviour in children can be differentiated from other forms of self-injury by the *presence of intent to die in suicide*.

Suicidal behaviour includes *suicidal ideation* (pervasive thoughts of engaging in behaviour intended to end one's life) ; *suicide plan* (formulation of a specific method through which one intends to die); and *suicide attempt* (engagement in potentially self-injurious behaviour in which there is intent to die)

The prevalence of suicidal risk is less in children and adolescents; when compared to youths and adults. However, the NMHS survey of 2016-17 indicated that among adolescents prevalence of moderate to high suicidal risk is about 1.3%.

Risk factors for Suicide among adolescents:

Suicidal behaviour in adolescents cannot be pinpointed to a single cause. It is rather due to interplay of multiple biological and psycho-social risk factors in a vulnerable/ stressful situation. Some risk factors are summarized below:

RISK FACTORS		
Biological	Psychological	Social
Family history of suicide	Impulsivity, novelty-seeking	Academic difficulty
Parental history of depression, substance use disorder	Difficult temperament- poor emotional regulation, low frustration tolerance	Family conflict- parental marital discord, family violence, abuse
	Perfectionist traits	Peer conflict- peer pressure, romantic breakups
	Low self-esteem, self-criticism	Poor social support- neglectful parenting, loss of parent, lack of friends
	Early childhood trauma- including physical or sexual abuse	Bullying
	Mental illness- such as adjustment disorder, depression, anxiety or substance use disorder	Financial difficulties in family

Protective factors against suicide

There are a few factors which may be protective against suicidal behaviour even in a vulnerable adolescent.

These are focus areas which should be strengthened to reduce the risk of suicide. Some of these include:

- 1) Positive family environment- with positive regard, warm and loving environment, healthy parent-adolescent interaction
- 2) Good social support- including friends, teachers and community support
- 3) Good problem-solving skills and conflict resolution
- 4) Access to mental health care services - providing opportunity for psychological support and early management of depression, anxiety and substance use disorder
- 5) Cultural and religious beliefs which discourage suicide

■ Management of suicidal behaviour

Assessment at primary care setting: An emergency assessment of the suicidal adolescent would include:

- Risk assessment: evaluate the risk based on the following factors: hopelessness, death wishes, suicidal ideas, suicidal plans or attempts and level of family support.
- Evaluation for underlying psychological disorders: including adjustment disorder, depression, anxiety disorders

Immediate management at primary care setting and referral (within hours):

It should focus on crisis intervention and ensure safety of the child. Immediate first-aid and medical management should be provided as needed. The primary care physician should engage both the caregivers and adolescent in psycho-education regarding suicidal behaviour. A referral should be made to the Psychiatrist/DMHP professionals for emergency evaluation and treatment.

Psycho-education for suicidal behaviour:

Caregivers should be explained that:

24/7 close eye to eye monitoring and safety precautions are required in the early weeks.

Suicidal behaviour is a result of underlying psychological disorder/distress

Underlying disorder/distress is treatable with medications/counselling and adolescent will recover

Refer to close psychiatry services for emergency evaluation and treatment

Primary care physicians are vital as suicide gatekeepers in the community. They form an important link in prevention and early identification of suicidal behavior among children and adolescents. Gatekeeper trainings are frequently conducted at NIMHANS to develop skills required for suicidal behaviour management. Interested persons can contact NIMHANS to avail such trainings.

■ **Psychiatric Management of Suicidal behaviour**

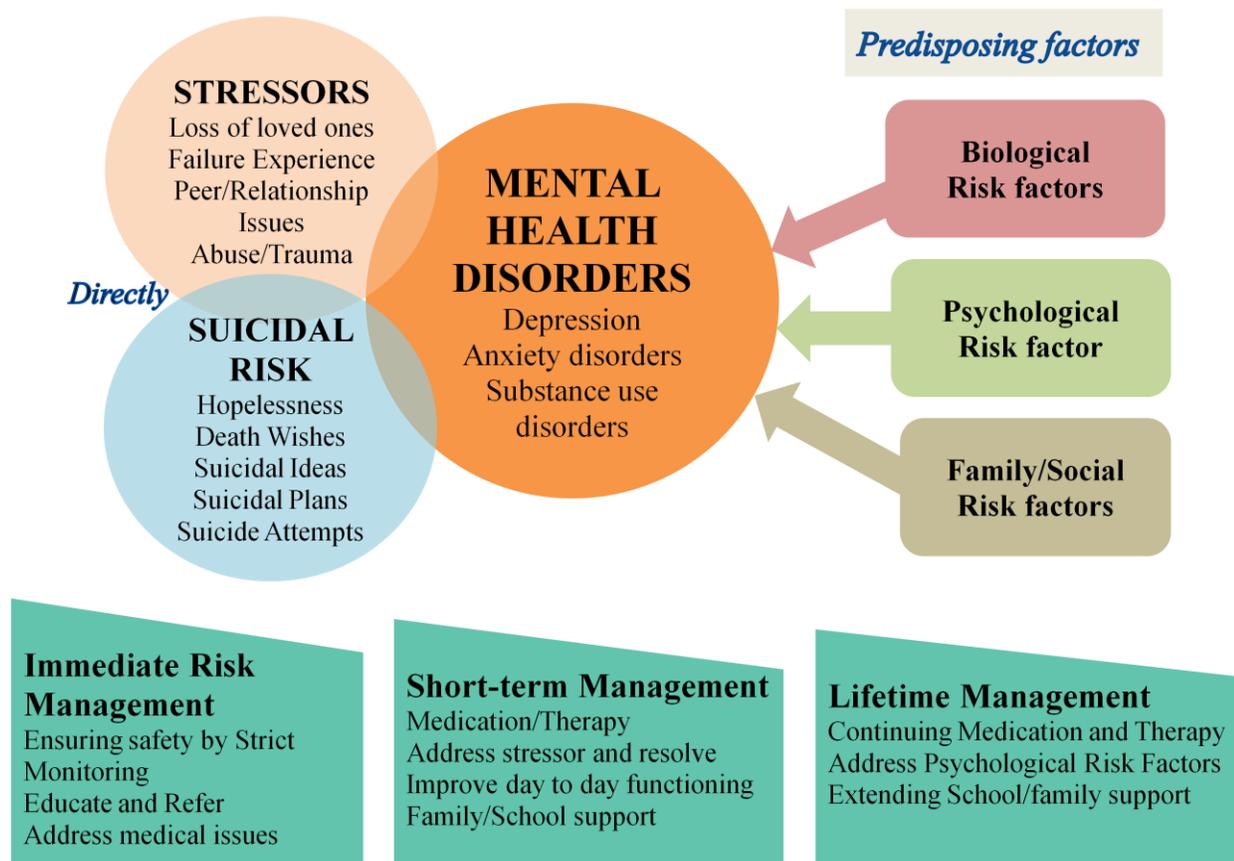
The treatment at higher centre in psychiatric service setting will happen in the following two stages:

1. Risk management and Short-term management (upto 4weeks):

- Assessment of suicidal risk and its management in inpatient/outpatient setting
- A detailed psychiatric evaluation to identify any underlying mental health illnesses and predisposing risk factors.
- Psychological support to be provided in a non-judgemental and empathetic manner. Initial sessions should focus on building rapport with the adolescent and helping her/him to resolve the crisis.
- Medications can be considered for illnesses such as depressive disorder, anxiety disorders and substance use disorder
- Counseling will initially focus on enhancing family support and improving adolescent's day to day functioning. The sessions will also try to identify faulty thinking patterns and coping styles which may lead to depression/anxiety disorder.
- Further counseling sessions will focus on preparing the adolescent to resume academic activities; including liaison with the school.

2. Long-term management (up to 3-6 months):

- Long-term counseling and psychological support by psychiatrist/ psychologist focuses on modifying predisposing psychological issues like: emotional regulation issues, perfectionism, interpersonal skill deficits, poor self-esteem etc.
- Psycho-social factors which contribute to adolescent's mental health issues needs to be addressed- this includes engaging family in therapy to resolve conflicts, improving communication styles
- Continued liaison with school to ensure the on-going support
- Identifying and strengthening social support systems



At-risk adolescents usually need continued long-term psychological support by mental health professionals; along with support from school and family. Medications are usually continued for 6 months to 1 year. *Primary care physicians/medical officers, in liaison with psychiatrist, can provide follow-up care for the adolescent at PHC- including monitoring for side effects, refilling the medication prescription, and providing supportive counseling to family and adolescent.*

■ Conclusion

Self-injurious behaviour is prevalent among adolescents; primary care physicians should have a basic understanding of contributing factors and consequences of SI. They should be able to engage the adolescent and family in two or three brief counseling sessions to help them adapt better coping styles and to prevent the recurrence of such behaviour. Primary care physicians should be able to distinguish SI from suicidal behaviour in adolescents. Suicidal behaviour is more serious and requires early identification and referral to psychiatric services. Primary care doctors have a major role in liaison between mental health professionals and adolescents; they can also provide long-term follow up care to these adolescents under the guidance of a psychiatrist.

Key highlights:

- Self-injury is a type of self-harm without intent to die. It is also called Non-suicidal self-injurious (NSSI). Self-cutting is the most common form; it is more common in females
- Suicidal behaviour is self-injurious behaviour with an intent to die. It usually results from exposure to a stressful situation in a child with bio-psycho-social risk factors for suicidal behaviour.
- Immediate interventions focus on ensuring safety of child, providing first-aid, and emotional containment of crisis
- Short- and long- term management focuses on modifying risk factors, developing healthy coping styles, and treating psychiatric comorbidities.
- Primary care physician plays a key role in liaison with mental health professionals – for referral services, providing follow-up care and conducting brief counselling sessions with family and adolescent.

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MISCELLANEOUS ISSUES OF CLINICAL SIGNIFICANCE

13. SUBSTANCE USE IN CHILDREN AND ADOLESCENTS

14. HEALTHY USE OF DIGITAL TECHNOLOGY

15. CHILD SEXUAL ABUSE

Chapter 13

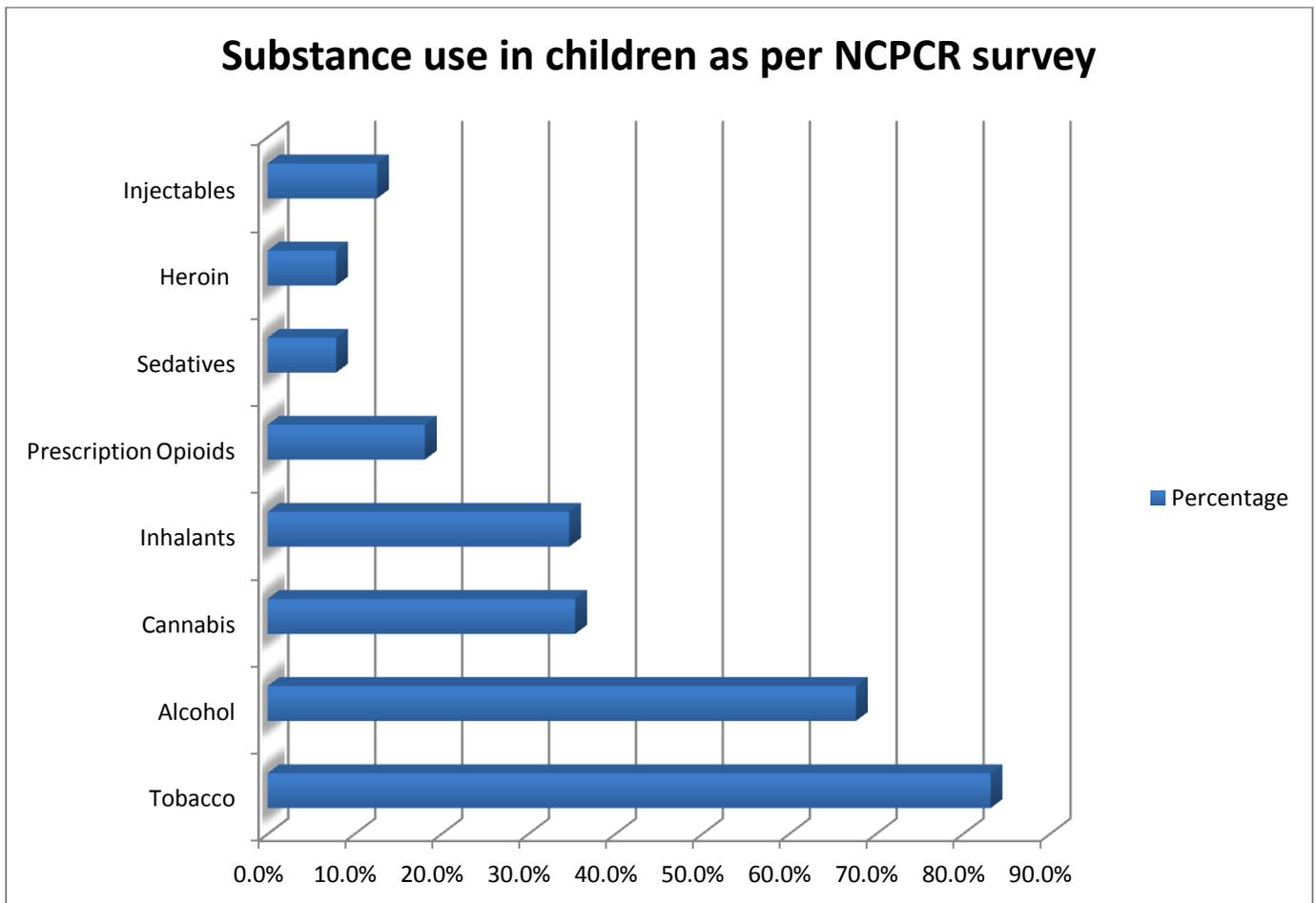
SUBSTANCE USE IN CHILDREN AND ADOLESCENTS: EPIDEMIOLOGY, DIAGNOSIS AND MANAGEMENT

Kamaldeep Sadh, Arun Kandasamy

■ How big is the problem?

According to 2011 census, there are 243 million adolescents in India, which constitutes approximately 20 percent of population. World Health Organisation (WHO) has estimated that globally, 25 to 90 percent of children and adolescents have ever used at least one substance of abuse.

National Commission for Protection of Child Rights did a survey on nearly four thousand substance-using children and reported that 72% of the substance users had initiated their first substance before completion of 20 years. The most common substances ever used by children in this study were Tobacco (83.2%) and alcohol (67.7%), followed by cannabis (35.4%), inhalants (34.7%), pharmaceutical opioids (18.1%), sedatives (7.9%) and heroin/smack (7.9%). A significant proportion of injectable substances (12.6%) were also found. Children have a higher percentage of inhalant solvent use compared to adults.



■ Why Adolescents are more vulnerable?

Childhood and adolescence are critical periods in the development of an individual during which the individual acquires important skills in order to live a healthy life. They are one of the vulnerable sections of the society. Factors which increase vulnerability are:

- Genetics- high family loading increases risk of early-onset usage
- Environmental factors- easy availability, peer pressure, poor interpersonal relations with family members.

Adolescents are more vulnerable to use of gateway drugs, i.e. experimental use of a less harmful drug, which eventually makes them more vulnerable to the use and abuse of other drugs. Common gateway drugs are tobacco, alcohol and inhalant solvents which are easily available.

■ Effects of early onset of substance use

- Early experimental use increases risk of dependence/ addiction and SUD in later life.
- Results in unintentional injuries, death, suicidality, infections and long-lasting changes in brain.
- Risk of poor response to treatment.
- Adolescents are reluctant to seek treatment and come late to treatment set up. The substance use often gets unrecognized until the appearance of serious consequences. Hence, it is very important to be aware and vigilant in order to identify and treat the substance use in this population.

■ How to approach?

There are various approaches which have been used to identify and treatment of substance use disorder in children and adolescents. We will discuss one of the approaches, Screening- Brief Intervention- Referral to Treatment (SBIRT) which has been tested and found to be effective in the community settings.

Intervention starts with identifying children who are at risk with the help of screening and taking appropriate measures to prevent progression of substance use. So, it can be done in the following ways -

■ Screening:

It is the most essential part of early intervention because it can help to identify high risk children *before* they develop behavioural problems. Screening can be done by simply asking children attending health care facilities for use of substances. Common point of contact for screening could be various centers like Primary Health Services, emergency services, contact with other health care services. All irrespective of their gender, socio-economic status should be screened for

substance use. It can also be done with structured assessment tools which are easy to administer and take few minutes. For example - CAGE Questionnaire for Alcohol Use Disorder.

For brief screening for Alcohol use disorder - CAGE Questionnaire

- Have you ever felt you should Cut down on your drinking?
- Have people Annoyed you by criticizing your drinking?
- Have you ever felt bad or Guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

Scoring - Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.

The following protocol can also be used for screening and intervention.

■ Brief Intervention

Brief Intervention is designed to be conducted by health professionals who do not specialize in addictions treatment. It can be summarized by the acronym FRAMES.

Assessment of an adolescent for substance use includes evaluation of associated behavioural issues, any psychiatric or medical comorbidity, school/ college performance, occupational history, consequences of substance use, family history, child's childhood experiences or temperament and environment. We should ensure that we have a good rapport with them and focus on understanding their needs.

Brief Intervention for Substance use Disorders (FRAMES):

F- Feedback- feedback to personal risk, for example, drinking may lead to stroke or hypertension

R- Responsibility of the patient; emphasizing that drinking is by choice and patient has personal control

A- Advice to change; to stop or reduce drinking

M- Menu of alternative goals and strategies to reduce drinking

E- Empathy

S- Self efficacy; encouraging patient to attain the goals of abstinence

Brief intervention can be provided to prevent progression of substance use, whereas, children who already have developed substance use disorder and its consequences should be provided with specialty interventions.

■ Specialty Interventions

Children who have already developed substance use disorders need more intensive intervention by a trained psychiatrist or a substance use health care provider.

Treatment follows a multimodal approach which consist of:

- use of various anti-craving agents like Naltrexone, Baclofen etc for Alcohol use disorder, Nicotine replacement therapy for Tobacco use disorder etc;
- Treatment of complications due to substance use like infections, injuries, abscess etc.
- Management of comorbid psychiatric illness and neurodevelopmental illnesses like ADHD, mood and anxiety disorders.
- Psychosocial interventions are also equally important - which includes interventions like MET (Motivational Enhancement Therapy), RPT (Relapse Prevention Treatment) as well as intervention with family of the adolescents or necessary interventions.
- Special emphasis should be given to skill building and promoting social integration.

Often, treatment at a specialized center is preferable for the specific treatment.

■ Referral services

When to send? - Whenever there a red flag signs indicating problematic use

RED FLAG SIGNS WARRANTING REFERRAL / TREATMENT BY SPECIALIST:

1. Drinking and driving
2. Using alcohol with other drugs
3. Use of intravenous drugs
4. Unplanned or unprotected sexual activity under influence of drugs
5. Sudden change in behaviour- getting more angry or irritable as his/ her usual self, spending more time alone in room or with friends
6. Decreasing grades at school

■ Where to send?

It is better to make a list of local child and adolescent substance use treatment centers including nearby tertiary care centers or rehabilitation centers and keep copies with you and your colleagues. It is a good idea to keep good working relationships with these resources and professionals in order to ensure better continuity of care. It is also important to maintain long term follow-up with such children to prevent relapse.

■ Handling the challenges in treatment-

Adolescents are usually resistant to seek treatment for their substance use. They may not open up, may completely deny using any substance or may get angry or irritable while confronted. The following key points need to be noted while interviewing a child or an adolescent

- Talk to the adolescent **first**
- Assure confidentiality
- Non- judgemental attitude
- Active listening
- Establish mutual trust/ Rapport
- Speak the language of the child or adolescent
- Engaging the family
- Sustain engagement- arrange follow up
- Identify common treatment goals
- Positive addiction/ alternative behaviour- encouraging the child/ parents to help child to have a positive alternative behaviour which he or she is passionate about.

■ Parenting related interventions

Here are few parenting techniques or suggestions that can be used/ applied while communicating with the children and adolescents –

- Communicate early and often
- Model desired behaviours
- Monitor sleep, stress and behaviour
- Encourage positive risk taking
- Know where your kids are, whom they are with and what they are doing
- Return to the basics- family meals, spirituality, nutrition, exercise, outdoors

■ Community level Interventions:

The following are the community-based prevention strategies that can be used to promote well-being and social integration-

1. Caring neighbourhood and communities- involvement with neighbours.
2. Encouraging or becoming a community that values youth- youth will benefit from knowing that a community supports the health and well-being of young people.
3. Encourage youth to give services to others, for e.g., spending one hour a week in teaching younger children or extending help for a function etc
4. Encouraging extra-curricular activities- creative activities like music, theatre; sports etc
5. Religious activities or programs

■ FOLLOW UP-

The following flow chart discusses the techniques to be used while following a child or an adolescent who has been on treatment for substance

KEY HIGHLIGHTS:

- Children and adolescents are vulnerable for substance use. It is determined by genetics and environmental factors
- Early onset of substance use leads to poor prognosis and poor response to treatment
- All high risk children should be screened for substance use whenever they come to health care facilities with the help of simple screening tools
- Brief interventions can be conducted by primary care physicians and other health workers to prevent progression of occasional substance use
- Specialty services by psychiatrists are required for established cases of substance use disorder or problematic use. Such cases should be referred to higher centers.
- Family and community interventions are essential for prevention of substance use among children

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Chapter 14

HEALTHY USE OF DIGITAL TECHNOLOGY FOR CHILDREN AND ADOLESCENTS

Vandana B. Shetty, Chethan B., N. Manjunatha, Naveen Kumar C.

■ Introduction

Digital technology use is spread far and wide. The commonly used portals for accessing digital media are hand-held mobile devices (mobile phones, tablets), laptops and computers, & televisions.

Of these, mobile phones are now a common commodity in most households owing to their easy portability and affordable costs. In India, there are at least 800 million mobile users of which 36% use smart-phones.

■ Current trends of mobile phone usage in adolescents

In *developed countries*, children have access to mobile phones by 10 years age and about 60% own a mobile phone handset by 13 years. Adolescents spend 3-4 hours per day on their phone, of which atleast 2 hours is spent on social media apps. The average user unlocks his/her mobile phone atleast 63 times in a day, which is once in 15 minutes in a 16-hour wake cycle.

In *India*, 95% of Indian children live in a household with mobile phones and atleast 76% of children in the range of 7-11 years have access to mobile phones². Most adolescents own their own handsets by the age of 16 years. Indian adolescents use mobile devices for atleast 2 hours a day.

■ Positive impacts of digital technology

- Tool for communication with family, friends, and improve social connections. It has provided a platform to make new friends, overcome social rejection and anxiety related to interacting with strangers. It can increase confidence in some individuals due to the perceived anonymity of their identities.
- Many educational apps and videos have made it simpler for students to understand basic concepts and find useful information especially for practical work and projects.
- As a medium to supervise the child's whereabouts and can be immediately contacted in case of any emergency, thus providing a sense of safety.

■ Recommended Screen-time

Screen time includes total number of hours exposed to ANY screen, including TV, computer and mobile.

Families should *negotiate screen time limits with older children* based upon:

- the needs of an individual child
- purpose for which screens are used (homework vs. Online games)
- interference with other physical and social activities and sleep.

Recommended screen time (total hours exposed to ANY screen, including TV/computer/mobile phones)

0-2 years: No screen time

2-5 years: half hour under supervision

6-11 years: one hour under supervision

11-18 years: two hours of high quality content for recreational use

Among adolescents, slightly longer screen-time can be permitted if necessary; for example, to complete a school assignment. But parents should always monitor the activity in discussion with the child.

■ Negative impact of digital technology

Children and adolescents are vulnerable; and therefore at higher risk for negative effects of overuse or unsupervised use of TV, internet and mobile phone. This can affect both physical and mental health of children, and cause problems in relations with family members (frequent fights, isolation), with peers (lack of real friends, poor socialization in real world), and school (lack of concentration, poor grade).

Digital technology has also led to new styles of crime, like kidnapping, rape, online theft through online banking etc.

Physical health risks	Mental health related risks
Back and neck stiffness due to constant stooping position , wrist and finger pain due to constant usage	Lack of concentration and easy distractibility
Visual problems- eye strain	Mood symptoms- easy irritability, aggression, anxiety, depression, suicide
Hearing problems- mild to moderate hearing impairment if used continuously for more than 2 hours for voice calls, music	Engaging in risky behaviour-contact with strangers, sexting (sending nude photos through digital media)
Somatic symptoms- headache, fatigue	Access to age-inappropriate information such as pornographic content

Decline in physical health, lack of physical activities, obesity	Body image issues, low self-esteem, seeking validation
Increase in road traffic accidents- especially due to texting and using phone while driving	Cyber-bullying (repetitive, deliberate digital cruelty)
Sleep disturbances - fragmented sleep, late to bed	Privacy issues- higher risk in adolescents as they may be unable to judge how much and to whom they divulge sensitive information

■ Promotion of healthy use of digital technology- Guide for parents

1. *Encourage positive conversation-* encourage face-to-face conversation with your children where you can discuss about online activities, online-safety and any other problems. It is okay to set rules but avoid being too restrictive and strict as this will discourage children from sharing their genuine problems with you.
2. *Joint decision-making:* You should discuss beforehand about the acceptable number of hours that a child can spend on phone and what all apps he/she can use.
3. *Set media-free times* (during meals, during family time) and *media-free places* (like bedroom, bathroom)
4. *Good role-model:* Children always tend to copy the elders around them. It is wise to limit your own mobile usage around them; and to demonstrate other ways for leisure instead (eg: playing games together etc)
5. *Educate children regarding online safety:* Educate children regarding the dangers of sharing important information online to strangers, like their location, ATM card number etc.
6. *Parental control of devices:* Use of online apps by parents through which they can monitor and control child's digital device. One example is the Google Family link for Parents.

■ Management of mobile over-use/addiction

Clinicians at Primary Health Centre/Community Health Centre level should be able to identify children who are at high-risk and who have excessive use so that these children can be referred to higher centers for appropriate help. Referral to DMHP or to closest tertiary hospital with an established psychiatry set-up must be considered for problematic overuse.

Who are high- risk individuals for Over-use/addiction?

1. *Psychosocial risk factors-* low socio-economic status, marital issues between parents, frequent fights at home, very strict parenting style where the parent- child interaction is not expressive , adolescents who face social rejection and victimization in their real lives

2. *Personality traits*- Persons who are constantly looking for new experiences, want attention from peers and want to escape from their realities are more at risk.
3. *Comorbidities*- Children with poor academic performance, difficulty in concentration and behavioural problems
4. Vulnerable adolescents with *negative self-image and low self-esteem* spend more time viewing others' lives and comparing it with their own
5. *Shy adolescents* are at high risk cyber-bullying and may be at risk of sharing private information online to potential fraudsters, or may become victims of sexual crimes.

The chart below summarizes steps of evaluation and management which is feasible at ground

EVALUATION AND MANAGEMENT OF EXCESSIVE/HARMFUL USE OF DIGITAL TECHNOLOGY- AT THE LEVEL OF PHC/CHC

<div style="background-color: #0070C0; color: white; padding: 5px; border-radius: 5px; margin-bottom: 10px;">Evaluation</div> <ul style="list-style-type: none"> •Number of hours spent on phone/TV, pattern of usage (>2 hours is problematic) •Is phone usage interfering with homework and studies? Is there a decline in grades/complaints from teacher? •Is phone usage interfering with playtime and family time. Does child refuse to go out and plays on phone instead? •Does the child look distracted and has poor concentration? •Does the child get angry/voilent if denied phone, and is restless till he/she gets the phone? •Are you aware of the apps/games that your child uses and people he/she meets online? Is your child open to discussing how they use their phone time? •Type of parenting styles , parent-child interaction and other family conflicts (marital issues, financial issues etc.)
<div style="background-color: #0070C0; color: white; padding: 5px; border-radius: 5px; margin-bottom: 10px;">Referral to DMHP</div> <ul style="list-style-type: none"> •If child is in high-risk category for over-use/addiction •If there is problematic overuse on evaluation (based on above questions) •Poor family support
<div style="background-color: #0070C0; color: white; padding: 5px; border-radius: 5px; margin-bottom: 10px;">Management</div> <ul style="list-style-type: none"> •<i>Family</i> re-education: to set boundaries and appropriate expectations •highlight importance of positive interactions, limit setting and being good role-models •Family conflict needs to be addressed •Counselling child regarding harmful effects of over-use, imprtance of discussing with significant elders •creating public awareness about healthy use of digital technology

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Chapter 15

CHILD SEXUAL ABUSE: CONSIDERATIONS IN COMMUNITY SET-UP

Apoorva M. Dharmendra, Priyanka Nambiar, Kavita Jangam, Preeti Jacob

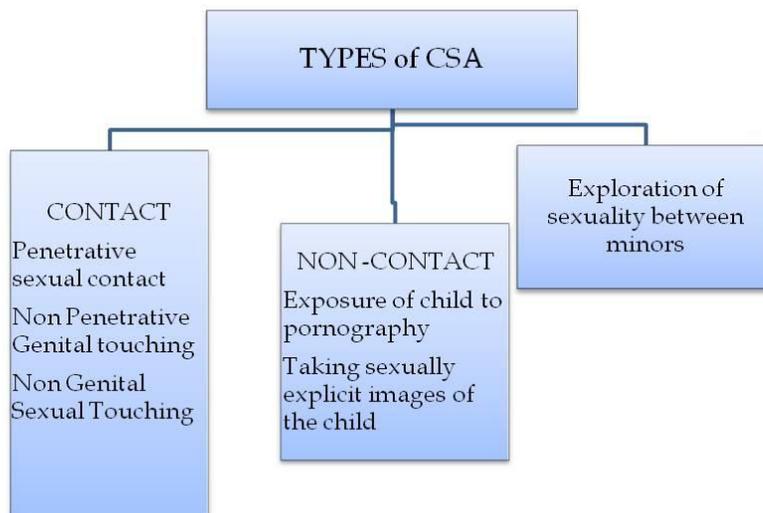
■ Introduction

Child sexual abuse (CSA) is a lived reality for many children and adolescents in India today. Studies have shown a high prevalence rate of CSA in India ranging from an estimated one fifth to one half of the under -18 population. The impact of CSA upon a growing child can be significant and may have short- and long-term consequences especially with regards to their psychological health.

CSA is complex and sensitive in nature and therefore it is important for childcare service providers to be able to recognize signs of abuse, sensitively interact with a child victim and provide appropriate support for the victim and their families.

■ What is CSA?

The involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, *or* for which the child or adolescent is not developmentally prepared and cannot give consent, *or* that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility or trust or power over the victim. It includes incest which involves abuse by a family member or close relative. Sexual abuse involves the intent to gratify or satisfy the needs of the perpetrator or another third party including that of seeking power over the child.

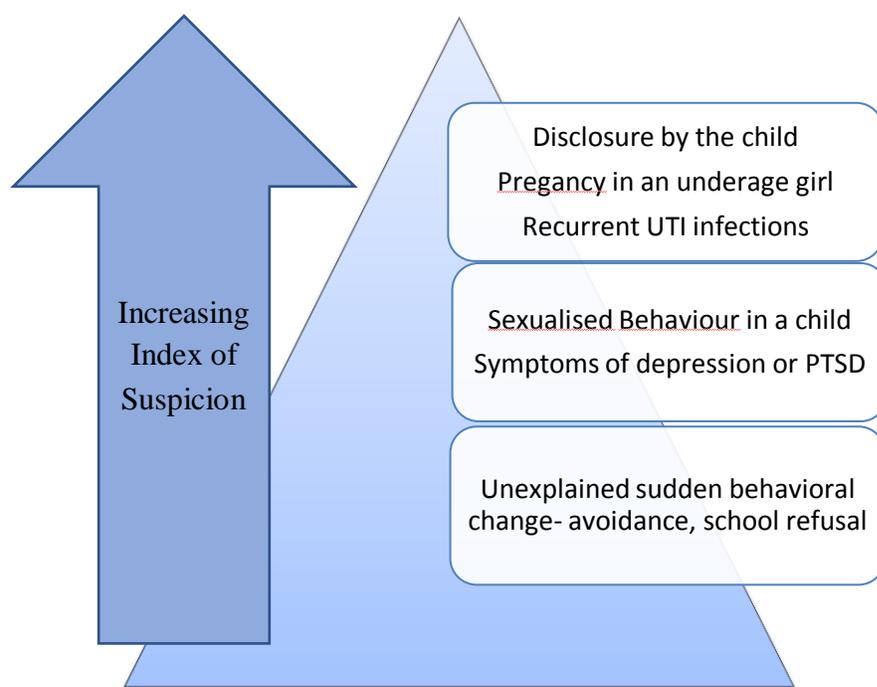


It is also important to highlight that CSA can also occur within families, once or repeatedly over time, and that often the perpetrator is a person whom the child trusts or who is responsible for the care of the child. This is one of the reasons for the reluctance to disclose abuse as it affects the child's closest family members as well.

■ When do we suspect CSA?

Children or adolescents can either be brought to a child care service provider (such as a mental health professional) in one of two ways

- 1) CSA has been previously established or disclosed: - The child is brought with a referral from agencies such as Police /NGO's or with their parent or guardian seeking mental health intervention
- 2) CSA has not yet been disclosed: The issue of CSA becomes evident during clinical interview or examination in the following ways



The disclosure of CSA by a child and the presence of physical signs such as pregnancy (a sure sign) or genital injury is to be treated with the **highest index of suspicion**

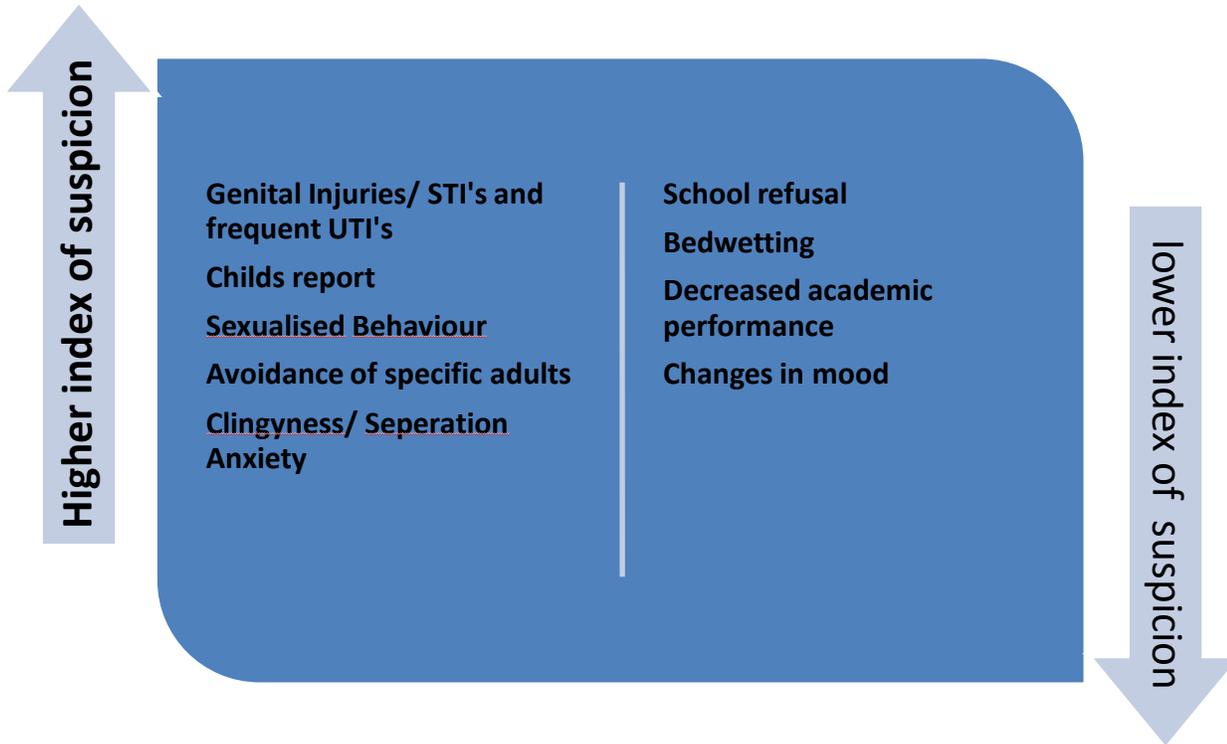
The behavioural changes and emotions reported by a victim of CSA can vary with the age of the victim.

Older Victims: Will be more likely to report depression, symptoms associated with PTSD, anger, anxiety and engage in self-harm behaviours. They may also engage in high risk -taking behaviours; increased sexual activity or substance use to help cope with the difficult emotions that come about due to the trauma

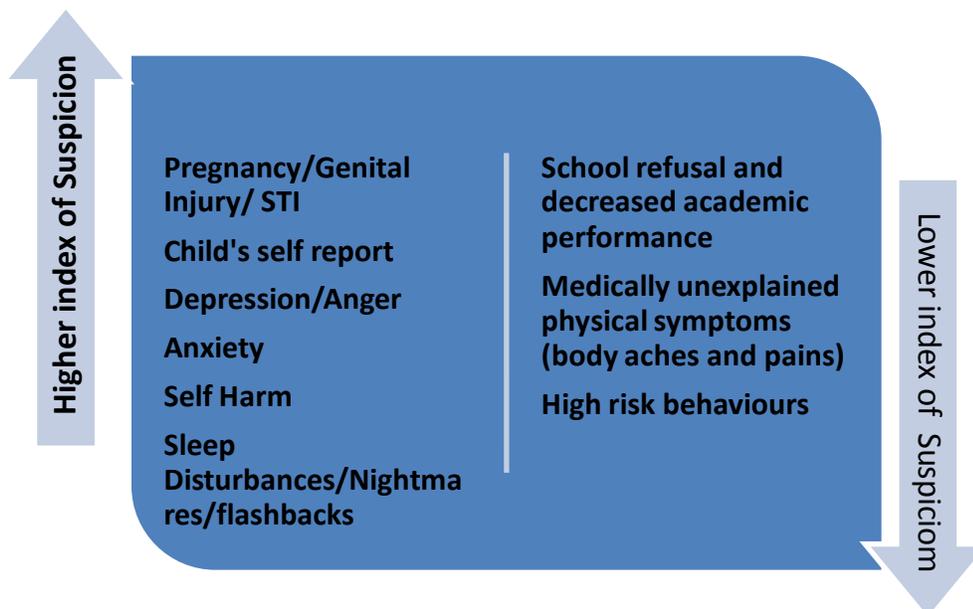
Younger children may show sexualized behaviour, school refusal, excessive clinginess or complain of multiple physical complaints.

■ Behavioural and emotional responses to CSA

■ Young Children



■ Older Children/Adolescents



■ Psychological Impact on the Victims of Child Sexual Abuse

The clinical practice and review of literature have shown that victims of child sexual abuse experience significant emotional distress and dysfunction. As the trauma is experienced in a life stage when their understanding of self, others, and the world are being formed, it is seen to have immediate as well as long term consequences on the psychological health of the victim. The typical behavioural and emotional indicators of CSA have been mentioned earlier; however, it is important to mention that the child or adolescent may be also experiencing some of the following cognitions:

- Confusion (What **happened to me? What does this mean?**)
- negative self-evaluation (e.g. **I am stupid for letting it happen**),
- Insecurity (How **can I be safe? What If it happens again?**)
- Self-estrangement (e.g. **Who am I? I am damaged, worthless**) which should be the long-term focus for healing

■ Psychological Impact on parents

Being aware or suspecting their own children of have been sexually abused can be extremely distressing for any parent. This could be even more agonizing if the perpetrator is found to be a family member or known person. This can take a toll the parent's mental health. The parents experience a range of emotions such anger on the perpetrator for harming the child, anger on self for not being able to protect the child, frustration on your child for not disclosing about the abuse, anxiety in dealing with the emotions of the child or the relationship with a known abuser. In cases of intra-familial abuse, the non-offending parents may be fearful that the child could be harmed again, or in denial and disbelief of the occurrence of the abuse. Hence, knowing that the abuser was a person you know, and trust could have severe mental health impact on the parent as it results in conflict of interest, guilt, financial instability, marital breakdown and sense of loss of a family member who is the abuser. It's crucial for the parents to seek help to deal with these feeling of betrayal, shock, disbelief, shame or self-blame in order to focus on assisting the child and creating a safe protective space for the child.

■ Approach to a Child with history of CSA

■ ASSESMENT IN CSA

A child or adolescent who presents with a history of alleged Child Sexual Abuse is to be considered an **Emergency** and should be handled with sensitivity. A thorough and detailed history must be taken and should be done keeping in mind at all times the child's level of comfort. A child must be able to provide a narrative for an interview to take place, therefore, very young children or those with intellectual disability or speech and language deficits must be assessed as to whether they will be able to provide a narrative before being taken up for interview

(Ref: Clinical Practice Guidelines for Child Sexual Abuse, Seshadri et al 2019)

■ Role of Mental Health Professionals

- Mental Health Professionals should have knowledge about The Protection of Children from Sexual Offences (POCSO) Act which is mentioned in detail further on. As per the POCSO Act, mandatory reporting of sexual offences against children to the concerned authority is a must and also applies to any persons who in their professional capacities come to know of such offences that have been carried out.
- Carry out detailed Mental Health Evaluation: It comprises of a detailed psychosocial assessment of the child and family as well as collateral information from school, relatives and neighborhood with details on school performance, developmental assessment, past and current history of emotional and behavioural issues in familiar and school contexts.
- Treatment and interventions: Based on the mental health assessments, in depth understanding of the child's narratives on the experience of the abuse, the child's psychosocial context and present mental health issues, a trauma focused model to be incorporated in therapeutic intervention.
- Future Therapeutic goals to include life skills, personal safety, awareness about POCSO and education on sex and sexuality.

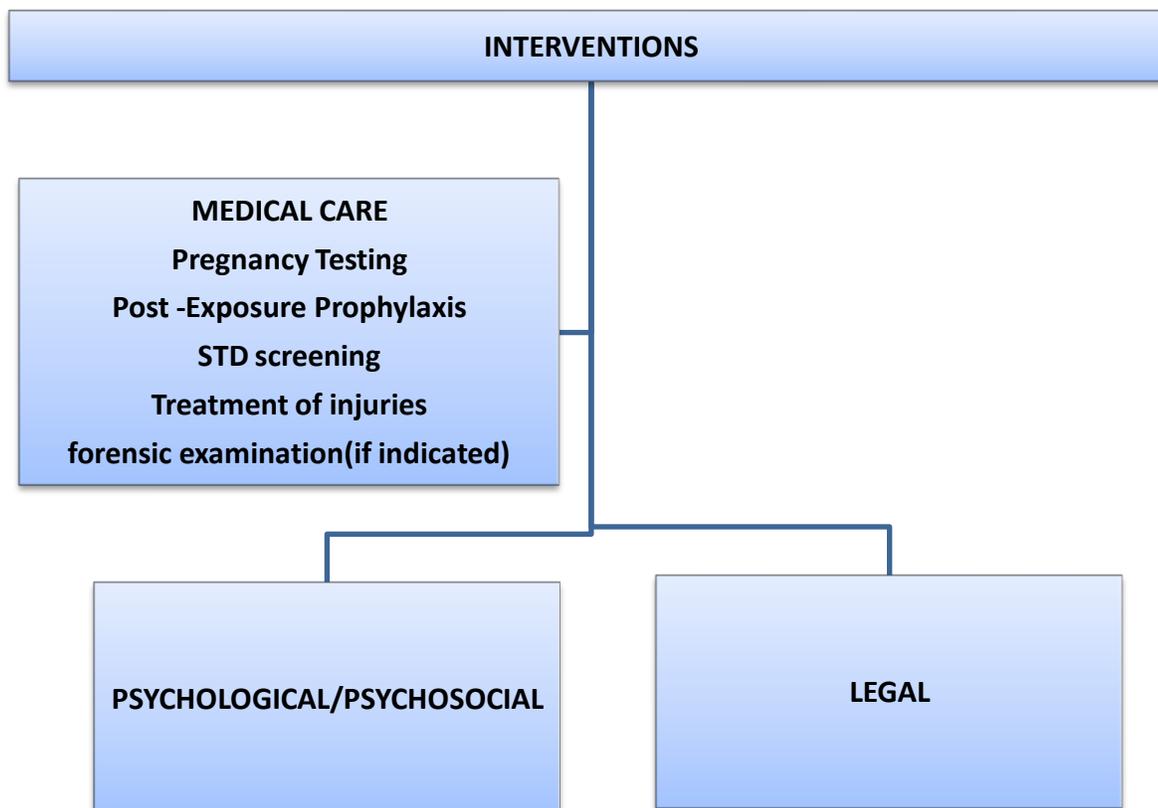
■ Pointers for interview with children/adolescents

- Introduce yourself to the child and explain why you are here
- Ask if the child is aware of why they are here
- Build Rapport
- Use short simple sentences
- Use concrete terms and proper names for description of body parts when asking questions
- Ask if the child is able to understand the questions asked and clarify if needed
- Option of writing down or drawing answers to be provided
- Ask about a description of the event
- Clarify about the description of the event
- Ask about physical symptoms, if any
- Ask about the child's concerns and fears
- Reassure the child
- Stop the interview if the child is too distressed and give adequate time for recuperation
- After interview, thank the child and acknowledge the efforts made by the child during the interview
- Information may not be obtained in a single session. Go at the child's pace.

(Ref: www.aacap.org)

The following information must be taken:

- A. **Demographic details:** Name, Age, Sex, Education, Place of residence, Who the informant is and their relation to child. If the informant is someone like a social worker or police officer who is working with the child in an official capacity; it is important to also note down their place of employment and employee details.
- B. **Referral:** Agency referral letters should be filed and names of persons accompanying the child should be noted with the relevant contact details
- C. **Initial account of abuse:** From the caregiver and child (**if child is willing**) should include all details about the circumstances of alleged abuse; including name of perpetrator, nature of the abuse, location where abuse has occurred, the duration and the number of times the abuse has occurred, how and by whom disclosure was made, current whereabouts and safety of the child. Relevant information from agencies involved with the child and information from other sources (Police and CWC) should be recorded.
- D. **MEDICAL AND PSYCHIATRIC HISTORY:** Note should be made of physical complaints including the nature and duration as well as psychological symptoms/behavioural symptoms reported
- E. **PAST HISTORY, FAMILY HISTORY AND SCHOOLING HISTORY:** Including previous level of function, family relationships and academic performance should be noted down
- F. **PHYSICAL EXAMINATION AND MENTAL STATUS EXAMINATION:** Should make note of 2 ID marks and look for signs of subjective distress: clinging, crying, reactions to touch. Mood, speech and thought should be evaluated; to look for acute psychiatric risk factors such as thoughts of self-harm or suicide



First priority should be given to necessary medical care, if a child has not already been seen by and evaluated by a pediatrician or gynecologist especially in cases of ‘Contact -CSA’ then a referral should be made.

■ Psychological interventions

Psychological First aid:

It is about providing immediate relief and comfort to the victim

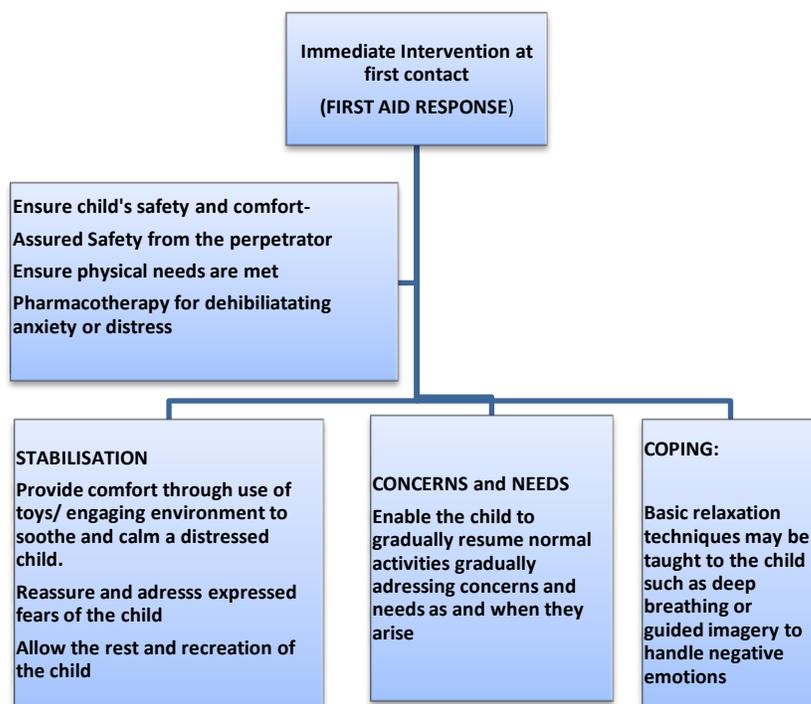
Psychological First Aid (PFA) is the primary support which can be provided to a child going through a distressing event. It is a sensitive manner of responding to children that can reduce the initial stress. It can help prevent short term and long-term mental health issues.

PFA enables the practitioner to establish contact with the child, assess whether child is feeling safe and comfortable, and if not, to stabilize the child, understand their needs as well as provide practical assistance.

- 1) **Contact and Engagement:** To initiate contact with trauma victims in a compassionate and helpful manner
- 2) To ensure the physical **safety** and **comfort** of the child
- 3) To **Stabilize** the child: To calm and orient the child to the current environment
- 4) Gather information on **current concerns and needs**- this may be done with caregiver or child
- 5) Offer practical support tailor made to those **concerns and needs**
- 6) Provide connection with social supports
- 7) Information on coping
- 8) Referral to other needed services

(Ref: www.ntcsn.org)

How does this apply when working with children?



These interventions should happen in tandem with support provided to the caregivers of the children- education regarding CSA and how best to support the child

- Enable them to accept, or even believe the child's experience of abuse.
- Help them understand abuse dynamics i.e. how and why child sexual abuse occurs (and the processes by which it has occurred in their child), including the importance of not blaming the child.
- Explain to parents the child's mental state and how they need to provide supportive, reassuring responses to the child.

The **long-term psychological interventions** require a trained therapist and will take place over many sessions with the goal of the sessions to help the child reflect upon, process and resolve the abuse experiences and needs to be tailor made considering the age and developmental stage of the child. It should also incorporate training in personal safety and abuse prevention in an age appropriate manner

■ Laws against Child Sexual Abuse Offences in India and Guidance on Mandatory Reporting

To deal with child sexual abuse cases, the Government of India enacted The Protection of Children from Sexual Offences (POCSO) Act in 2012. The POCSO Act, 2012 is a comprehensive law to provide for the protection of children from the offences of sexual assault, sexual harassment and pornography, while safeguarding the interests of the child at every stage of the judicial process by incorporating child-friendly mechanisms for reporting, recording of evidence, investigation and speedy trial of offences through designated Special Courts.

The Section 21(1) of the POCSO Act, 2012 requires mandatory reporting to the police or magistrate by anyone who has received information about child sexual abuse during professional or personal relationship with the child. It applies to everyone, particularly, parents, medical and para medical professionals and school personnel. The failure to report a suspicion of child sexual abuse is therefore a punishable offence under the Act. The objective of mandatory reporting, under POCSO Act, is to ensure that sexual offences against children are prosecuted, thereby ensuring personal safety, protection and justice to the abused child and prevent any further harm. At the same time, however, there must be an attempt to obtain the consent of the parents and child by educating them about the act and assuring confidentiality to particularly those families who are reluctant to report due to underlying fears of stigma and discrimination.

■ **Therapist issues and Dilemmas during therapy**

It is common for the therapist to feel personally overwhelmed while handling cases of child sexual abuse, particularly in cases of intra-familial abuse. However, the therapist must maintain professional boundaries and not form an enmeshed or unhealthy relationship with the child. The gender of the therapist also plays a vital role in the process of rapport building and establishing therapeutic alliance with the child. Also, in case of therapists' own personal history of trauma, it must be resolved in order to maintain a non-judgmental stance. In such cases, peer supervision and support can aid the therapy. This will in turn help the therapist to be empathic and child-focused and pace the therapy based on each individual child.

KEY HIGHLIGHTS:

- CSA has a high prevalence but is usually under-reported.
- The behavioural and emotional responses to CSA depends upon the age of the child.
- CSA has a significant and long-lasting psychological impact on both the child and the parent, leading to significant emotional distress
- CSA should be considered as an emergency and handled with sensitivity. It requires a multi-disciplinary approach with involvement of multiple sectors (health care, child care services, law enforcement)
- Mental health professionals have a role in providing psychological first aid, conducting a detailed mental health and psychosocial evaluation, and providing trauma focused therapy
- POCSO Act, 2012 is a comprehensive law dealing with sexual offenses against children. As per the Act, mandatory reporting of sexual offences against children to the concerned authority is a must.

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www.aacap.org

COMMUNITY ASPECTS OF CHILD AND ADOLESCENT PSYCHIATRY

16. SCHOOL MENTAL HEALTH PROGRAM

**17. LIAISONING IN RUNNING A COMMUNITY CHILD AND
ADOLESCENT MENTAL HEALTH PROGRAM**

Chapter 16

SCHOOL MENTAL HEALTH

Utkarsh Karki, Shreyoshi Ghosh

After the home, schools are the best place to promote mental health. Research has shown that school mental health programs are effective in improving learning and mental well-being and in reducing the stress on children with mental health disorders, thus achieving improvement in their conditions. Teachers are an important resource to deliver school mental health programs and can serve as gatekeepers to mental health issues among students. It is important to create a good network between teachers and mental health professionals for effective delivery of services. Some of the salient issues pertinent to school mental health are discussed in this chapter with a special emphasis on life skills training.

School mental health programs aim at mental health promotion strategies at school.

Who will train? - Initial training to sensitize teachers regarding mental health issues and capacity building can be imparted by local medical officer/mental health professional under DMHP in a structured manner once in 3 months.

Who will implement? - Teachers can eventually implement strategies within the school hours on a regular basis.

How often? -Some strategies can be implemented on a day-to-day basis within the school hours. Specific activities like life skills training can be taken up once a month

Strategies for mental health promotion-

- Creating positive classroom environment (cooperation over competition)
- Fostering self-esteem and agency (realistic expectations from students, praising for good behaviour/work, focusing on a student's strengths and assets)
- Life skills education- communication skills, social skills, cognitive skills, emotional skills
- Anti-bullying programs
- Sensitizing students regarding mental health issues- early identification and intervention where necessary

■ Management of academic difficulties in school

Academic difficulties can be due to below-average intelligence, specific learning disorders or due to external causes such as psychological distress.

Children with below-average intelligence may have difficulty in either only academics or additionally in other extra-curricular activities too such as sports, creative work etc. Teachers need to evaluate for areas of difficulty in school settings and can refer for detailed evaluation of IQ to district psychologist. Children with mild difficulties may benefit with extra teaching time, attending classes in smaller groups etc. Teachers should focus on strengths of the child in other areas to encourage holistic development and promote self-esteem.

Children with learning difficulties may have problems in only domain such as reading, writing or mathematics or a combination of these. Teachers may notice that the child has difficulty in specific abilities such as reading passages (may skip words, wrong pronunciation), or has poor handwriting, or can follow oral classes very well but himself cannot read and understand etc. If a child's overall performance is average, but he/she has such specific difficulties, then the teacher should consider referring such a child for detailed evaluation of SLD (more details in chapter 6).

■ Classroom management of emotional problems in youngsters

Increasing awareness about mental health problems amongst youngsters by organizing talks/discussions/film screenings, effecting changes in the home and school environment wherever possible, providing individual support to the young person with supportive counseling focusing on problem solving.

Example: Adarsh, a 14 year old boy in class 9, has been very dull and sits by himself during lunch-break since a few days. On noticing this, the teacher calls him aside and asks if everything is alright. He reluctantly tells her that his friends have been leaving him out of plans and avoid him after he had an argument with one boy while playing cricket. Even though it was a small fight, all friends supported the other boy. The teacher listens to him without any judgement, and discusses why the situation has bothered him so much. She also discusses different possible solutions to his problem and encourages him to talk to his friends and resolve the fight.

■ Management of behavioural problems in school

Ways to increase expected behaviours: Reinforce desirable behaviours immediately and consistently, clear briefly worded instructions, star charts

Example: whenever a child completes his classwork without mistakes, teacher puts a star on his notebook and praises him.

Ways to decrease problematic behaviours: Explain the rationale behind undesirable behaviours, establish consequences (time outs/taking away points or privileges)

Example: While playing, one child snatches the ball and pushes his classmate away. The teacher takes him aside and gives him a 10-minute timeout and explains why she is doing so. At the end of time-out, she also discusses how he can improve his behaviour by asking politely next time.

■ School bullying

Bullying is very common in many schools throughout the world. It is most common at 8-10 years. Boys are more likely to be involved in hitting and beating up other children; girls are more likely to use words to hurt other children, either face to face, electronically or through online forums. Being bullied is one of the most common reasons why children do not want to go to school. Many children who are bullied may suffer from depression and anxiety as well.

Schools should be encouraged to have a zero-tolerance policy towards bullying. Playgrounds should be well supervised and a system can be in place wherein children can report episodes of bullying anonymously. (e.g.: a dropbox). If bullying is identified, the bully should be talked to very seriously about his behaviour and the effect it is having. Punishment may need to take place but should not involve any kind of public humiliation.

■ School refusal

School refusal can be a result of any of the above mentioned factors alone or in combination- academic issues, emotional disorders, behavioural problems, being a victim of bullying, issues outside school which cause distress to child (poor family environment, abuse). Evaluation for school refusal should consider the child's perspective of the problem. School refusal should be managed by counseling the child and also sensitizing parents and teachers.

■ Relationships and sexuality

Sexual drive is present from birth, although there is a marked increase in this drive during adolescence. Before puberty sexual drive varies greatly. It mainly shows itself by:

- Sexual curiosity- boys and girls noticing the physical appearance of adults and examining each other's genitalia
- Masturbation or self-stimulation of the genitalia

Both of the above are considered normal activities. Many adolescents feel extremely guilty about masturbation because they have been brought up to believe it is harmful and wrong. It is in fact harmless.

Children develop in their sexual thoughts and ideas in three main ways.

1. Gender Identity: By 2-3 years of age most children have a strong sense of gender identity, and think of themselves as either male or female. A very small number of boys and girls have a gender identity which is the opposite of their anatomical sex.

2. Gender role behaviour: In most but not all societies, boys and girls behave in different ways. However, there are considerable differences between cultures in how important these differences are thought to be. It is not uncommon for girls to be tomboys and boys to be effeminate.
3. Sexual orientation: This refers to a child's preference for the same or opposite gender when attaining sexual arousal.

It is important to remember that gender identity, gender role behaviour and sexual orientation may be fluid entities and may change over the course of childhood and adolescence. Thus, it is important to avoid gender stereotyping and allow the child's identity and preferences to develop as he or she wishes.

Many adolescents enter into romantic relationships in adolescence. It is important to educate adolescents about safe sexual practices, consent and boundaries in intimate relationships and responsible decision making. Research has shown that sex education delays the age of coitarche (age at first intercourse). Adolescent girls should also be educated regarding the importance of menstrual hygiene.

No matter what the attitude to sexual promiscuity, homosexuality and transgender individuals in the community, the health professional must not make moral judgements about whether such behaviour is right or wrong. He/she should provide whatever help she can in a supportive and understanding way.

■ Life skills training

The World Health Organization (WHO) defines Life Skills as ““adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life.”¹

Core life skills for the promotion of CAMH include:

Social skills	Cognitive skills	Emotional skills
<ul style="list-style-type: none"> • effective communication • interpersonal relationship • empathy • self awareness 	<ul style="list-style-type: none"> • problem solving • decision making • creative thinking • critical thinking 	<ul style="list-style-type: none"> • coping with stress • coping with emotion

For whom - All children are meant to acquire life skills. Imparting life skills is not only for curative purposes, i.e. to address particular problems that children may have, but also for preventive purposes i.e. to address issues that adolescents may be contending with, but that have not reached a problem or pathology level.

By whom - It can be used by all persons who work with children, including doctors, teachers, counselors, child protection staff, special educators i.e. persons working with children in education, health and welfare agencies.

Note: Imparting life skills should not follow a didactic approach i.e. simply putting across one's opinions, viewpoints and convincing the adolescent to adopt the same beliefs. Individuals should participate in a two-way dialogue thereby creating a space for debate and discussion so that children or adolescents can come to their own conclusions on what might be the best course of action.

Life skills education should entail:

- Dynamic teaching and dynamic learning
- Working in small groups and pairs
- Brainstorming
- Role - plays
- Experiential learning
- Games and debates
- Home assignments, to further discuss and practice skills with family and friends.

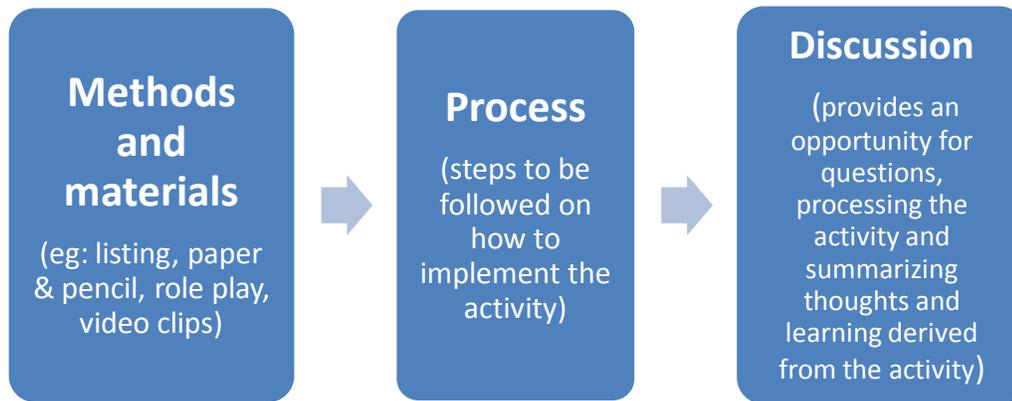
■ Objectives:

The specific objectives of Life Skills training are:

- To allow for sharing of experiences and narratives around children's daily realities and past experiences so as to take perspectives on them for the future.
- To address life skills domains (as outlined by the WHO) covering the broad areas in which children need to acquire skills in order to tackle their situations and experiences.
- To enable children to develop specific skill sets through various creative and process-based activities.
- To thus triangulate life skills, contexts of application (situations/experiences) and methods of learning (experiential activities).

■ How to impart life skills:

A single topic may consist of up to 3 to 4 activities. Each activity should consist of the following:



Developing life skills in interpersonal settings, managing various negative emotions and communicating effectively is of vital importance for today’s children and adolescents. A multitude of factors, especially the rapidly changing socio- economic and cultural factors in contemporary society puts adolescents at a great disadvantage and contributes to the mental health problems that we see among school going adolescents. The learning of life skills enables children and adolescents to handle life more effectively and makes them “fit for life”.

EXAMPLE: Coping With Emotions i.e. anger (2 activities)

Activity 1: When I get angry-

- a) **Methods:** Listing, Role play
- b) **Materials:** Paper and pens
- c) **Process:** Introduce the session: All of us have a world of emotions. There are feelings that make us feel good—like happiness and joy. And then there are some uncomfortable feelings such as fear, sadness and anger. Anger is a feeling that most of us experience at some time or the other. We feel angry for many reasons, such as people not behaving properly with us, when we do not get what we want or when we feel unfairly treated. We also show our anger in very many different ways, either verbally or with actions or with aggression. Anger affects us physically and emotionally. It affects our relationships. If we learn better ways to deal with our anger, we would not only feel calm and in control of the situation, we would also feel healthy.

In this session, we are going to examine the reasons/ situations in which we get angry, how we respond, the consequences of our anger and ways to manage our anger better.

- Do a listing and analysis exercise to examine anger using the following framework as an example:

- Get the children to generate a list of situations and reasons for anger.
- Ask them how we respond to each situation/ time when we get angry.
- Ask them to demonstrate or act out anger actions/ expressions.
- Ask them to state the consequences of each response...what happened next or as a result of the response?
- Then, ask them to evaluate the responses in terms of whether the consequences (to themselves and/or to others) were helpful or not.
- Now ask children to look at those responses that they judged to be unhelpful and suggest alternative ways to i) express the anger; ii) resolve the issue/ conflict.
- Ask them to demonstrate or act out the alternative ways to resolve the conflict situation.

Situation/Reason for provocation	Anger response	Consequences	Response helpful or not?	Generating alternative ways to express anger /resolve the issue

d) Discussion:

- During the process, point out strategies to manage anger –such as walking away, going to sit in a quiet place on your own until you feel calmer and ready to return to the situation, letting the other person know you are angry verbally (instead of physical aggression)
- Also point out conflict resolution strategies such as negotiation, persuasion, seeking external/ additional help and intervention from caregivers or teachers.

Activity 2: Evaluating anger responses-

- a) **Materials:** Picture cards, problem narrative
- b) **Methods:** Narrative, perspective-taking
- c) **Process:** Show pictures of and share the following narrative with the group.

Nikhil's mother packed a large slice of chocolate cake for his tiffin to school. He was very excited about his tiffin and was waiting for break time. As soon as the bell went, he rushed to eat his cake. As he was about to take a bite, Manish came running up and snatched it from him. "I want some," he said, eating half the piece and dropping the other half on the ground, so that it got muddy. And so Nikhil was unable to eat any of the cake. He was very angry. What should Nikhil do?

- Now, ask if it is alright for Nikhil to feel angry and upset. (Legitimize and validate Nikhil's anger – as being natural for anyone to feel that way in that sort of situation).
- Next, ask what Nikhil should do – how should he respond? Present each of the picture cards showing possible responses/ actions by Nikhil, one by one and ask the children which response (there can be more than one) Nikhil should select:

Nikhil should...

- Grab Manish's tiffin and eat his food.
- Give Manish a slap.
- Tell Manish: "I am really upset with what you did...I would have been happy to share the cake with you if you had asked me first. But I am angry that you just snatched it and ate it without my permission."
- Take a deep breath, walk away and make sure that Manish never sits next to him again.
- Tell teacher what happened so that she can talk to Manish.
- Wait until later and tear up Manish's notebook and break his pencil box.
- Go home and punch his pillow when he feels like he wants to hit Manish.

d) Discussion:

- Ask children to consider the consequences of each of the above responses – 'what would happen if Nikhil...' and ask them to judge whether it is a helpful/ desirable or unhelpful/undesirable consequence.
- Finally (based on the discussions), what advice would they give Nikhil about managing his anger?

A complete manual for life skills training for children and adolescent is available at www.nimhanschildproject.in. Please click on the intervention section once you see the home page.

■ Role of parents in promoting school mental health

Parents and caregivers have a significant role to play even in the promotion of school mental health. Parents must be actively involved in school activities and educated about common problems faced by school-going children and importance of non-academic teaching such as life skills training, sexual health education etc. Any myths and misconceptions held by the parents must be addressed to gain their full confidence and support. Involving parents also helps in continuing the process of learning at home. It also serves to instill hope and remove stigma in parents whose children are facing problems.

■ Conclusions

After home, children spend most of their time in school. It is an important platform for children to expand their social skills, interact with peers and learn both academic and other skills. Children have to face various challenges in their school years. Promoting mental health, teaching children life skills, and early identification of problematic behaviours must therefore be prioritized in school settings.

Key highlights:

- School mental health programs are aimed at promotion of mental health well-being
- This should be imparted on a regular basis by school teachers within school hours. Mental health professionals can guide schools in the initial stages.
- Some strategies include – creating a positive environment, fostering self-esteem, sensitizing children regarding mental health issues, reducing stigma
- Anti-bullying programs are needed in schools to prevent bullying which has an adverse effect on psychological health of children.
- School mental health education should include sex education and healthy sexual practices
- Life skills education includes communication skills, social skills, cognitive skills,
- emotional skills. Life skills training should be imparted to all children in a dynamic way through active participation.

References

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Chapter 17

NETWORKING WITH STAKEHOLDERS FOR COMMUNITY CARE

Patley Rahul, Varsha S., Rajani P., Naveen Kumar C., Suresh B. M.

The importance of psychological well-being in children and adolescents is well recognized. There is increasing evidence of the effectiveness of interventions aimed to improve resilience in children and adolescents, promote positive mental health and treat mental health problems like developmental disorders, emotional and behavioural disorders.

WHO and CDC report shows that One in every 5 children has a mental health issue. If we invest in identifying the problems early and intervene at the right time, it will be more cost effective, as we will be preventing further breakdown and avoid an adult treatment-and-rehabilitation programme which is much more expensive.

Currently, mental illnesses are predominantly managed in hospital settings at tertiary care centers. However, such tertiary centers are not available uniformly throughout the country. Even where such services are available, they are largely geared for therapeutics and aim at treatment and rehabilitation; rather than preventive and promotive aspects. A large gap exists in the area of prevention, mental health promotion and early intervention programmes.

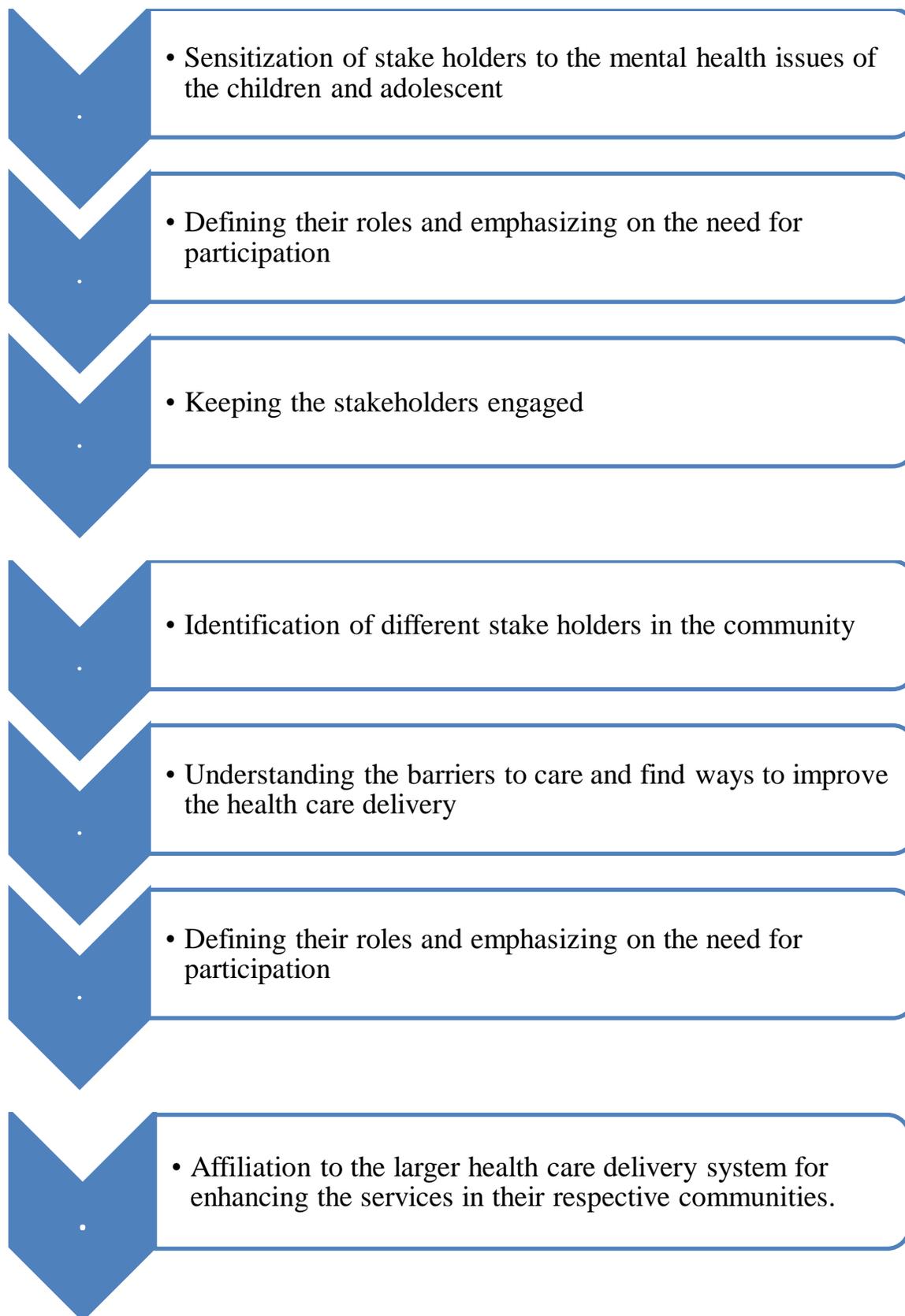
Child and adolescent mental health services and service providers are limited in India. Mostly such services are restricted to urban areas. Access to mental health services for children with a mental, emotional or behavioural disorder is substandard, not provided early enough and accessible only to a limited fraction.

■ Need for liaison

Everyone in a community has a role to play in ensuring that the environment in which children are growing up promotes their mental health. Since there is huge gap in the access to mental health services for the child and adolescent at the local level, it is important to have a strong local network and liaison with available resources in the community to plan, strategize, evaluate and implement the health services in the community more effectively.

Child mental health is a shared responsibility, and for any intervention to be effective there should be a synergy between efforts being made by different stakeholders to address the issues. All the stakeholders must be involved in every stage of delivering care to the children. For this to be successful, definitive strategies with clear goals has to be followed (as described below)

■ Strategies for delivering care to children at community



■ Services to be provided at the community level



Child Mental Health services should include all the above services for holistic care at the community level. Liaising of different services is the most important step to achieve this. Training should aim at consolidating the existing knowledge, enabling the staff to recognize and manage child and adolescent problems at an early stage. Supervision, which is primarily educative, will aim to improve the delivery of care by improving the skills and knowledge base of the staff. All the interventions and research should be appropriate to the developmental level and cultural context of the child and adolescent population of that community.

■ Sources of liaison at the community level



Fig: Stake holders involved in child mental health care at the community level

There should be liaison between these available sources and stake holders to promote the mental health and to meet the needs of all children and adolescent with established problems. This system should be present at the village, block, district and state levels to ensure the early identification/detection of the problems, timely referral to the integrated, high-quality, multi-disciplinary mental health services delivered by the staff with appropriate skills and competencies.

■ Source of liaison at the village level

Fig: Role of ASHA worker

At the grass-root level, the Community Health workers like ASHA/ANM have an important role to play as they are already involved in maternal and Child care. They can liaise with schools, Anganwadi centers, local officials and other agencies, which will result in early identification and referral to appropriate services.

The following table shows the Mental Health issues in Child and Adolescents and sources of liaison and the indications for referral to Mental Health Team

Mental Health issues in Child and Adolescent	Source of Liaison	Referral to Mental Health Team in case of
IDD	School teachers School counselors Disability Board	Aggression Self-Injurious tendencies
ASD/SLD/ADHD	School teachers School counselors Disability Board NGOs	Aggression Self-harm
Emotional and Behavioural problems	School teachers School counselors NGOs District Child Protection Unit	Aggression Hostility Substance use Self-Harm

IDD - Intellectual Developmental Disorder, ASD - Autism Spectrum Disorder

SLD - Specific Learning Disability, ADHD - Attention-Deficit/Hyperactivity Disorder

■ Departments catering to Children

■ Government sector

MINISTRY/DEPARTMENT/PROGRAMME	DELIVERED BY
Ministry of Health and Family Welfare <ul style="list-style-type: none"> ➤ National Health Mission-Rashtriya Bal Swasthya Karyakram (RBSK) 	Medical officer (PCD), ASHA workers, Community Nurses
Ministry of Human Resource and Development	Teachers, Block Education officer, District Education officer
Ministry of Women and child Development <ul style="list-style-type: none"> ➤ Integrated Child Development Scheme ➤ Integrated Child Protection Scheme (ICPS) <ul style="list-style-type: none"> ▪ Child Welfare Committee (CWC) ▪ Juvenile Justice Boards (JJB) ▪ Special Juvenile Police Units (SJPU) 	Anganwadi worker and helper, Child Development Project officer (CDPO) Outreach workers, Social worker, Counselor, District Child Protection Officer
Ministry of Social Justice and Empowerment Department of Empowerment of Persons with Disabilities (Divyangjan) <ul style="list-style-type: none"> ✓ National trust Act ✓ Rights of Persons with Disabilities Act,2016 	Disability Board members, Tahsildar Hospitals

■ Non-Government Organizations (NGO)

NGO are involved in

- Childcare
- Special Children care
- Training of children and Caregivers/parents
- Special homes

■ PRIVATE ORGANISATION

- Schools
- Sports Organization

■ COMMUNITY

- Panchayat Raj institution
 - Gram Panchayat – Adyaksha and Upadakshya (Panchayat Development officer)
 - Mandal Panchayat – Sarpanch
- Independent families

The coordination and networking of all the departments and organizations of Government, Private, NGO's and Community will help formulating holistic care for the children.

The ways of achieving this are

- ✓ Public private partnership
- ✓ Intra and inter-sectoral coordination
- ✓ Convergence of the National Programs involved in childcare and integration of their activities
- ✓ Involving NGOs in training, service delivery and filling up of gaps
- ✓ Revitalizing the local/community resources

Along with the above measures, establishing cross referral system and extending the services of the District Mental Health Program will strength the network system and will lead to incorporation of these services into day to day clinical care. Strengthening the mutual liaison between all the possible service delivery systems and taking an interdisciplinary approach as followed in case of District Early Intervention Centers (DEIC) will serve as a model for catering the diverse and specific needs of each individual child and achieving the ultimate goal of provide care for children at the community level.

■ Conclusions

The incidence of children needing mental health services is high. However, large gap exists in this area and the resources to meet the mental health needs of children, manpower, as well as preventive, diagnostic and treatment services are extremely limited. There is a need to stimulate a sustained and long-term improvement in children's health by focusing on the mental health and psychological well-being. We need to embrace all those services that contribute to the mental health care of children and adolescents, whether provided by health, education, social services, or other agencies in order to achieve this. What we need a multi-disciplinary team or service working in a community mental health clinic providing a specialized service for children and adolescents with effective partnerships and liaison between agencies at the local bodies at the community, social service organizations and educational institutions. This will serve as an effective service delivery model for child and adolescent mental health.

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1) SCREENING PROFORMA FOR MEDICAL OFFICERS

Motor development:

DOMAIN OF DEVELOPMENT	Average age of development (months)	Age at which achieved in this child
<i>I. Gross Motor</i>		
Lifts head when on stomach	3 months	
Head control fully achieved	4 months	
Sits alone	6- 8 months	
Crawls'	9-10 months	
Stands alone	11-12 months	
Walks forward	12-15 months	
Walks backwards	24 months	
<i>II. Vision and Fine Motor</i>		
Reaches for objects	4 months	
Grasps objects	5 months	
Picks up cube/pebble (bigger objects)	6-8 months	
Picks up beads (smaller objects)	10 months	
Scribbles	12 months	
Tries to use a spoon	15 months	
Draws straight line in imitation	2 years	
Thumb and finger snap test	2.5 years	
Draws circle in imitation	3 years	
<i>Hearing, Language and Concept Development</i>		
Responds to sound	1 month	
Babbles	6 months	
Points to objects	10 months	
Follows simple commands (no, come here)	10-12 months	
Says one word	12-15 months	
Points to atleast two body parts	15-18 months	
Says two words together	20 months	
Pretend play/ make- believe play	2 years	
Can tell a short story /recite events of the day	3 years	
Can name colours	3 years	
Concept of big and little	3 years	
Concept of heavy and light	3 years	
<i>Self Help Skills</i>		
Tries to feed himself with hand/spoon	12-15 months	
Drinks from cup or glass	18 months	
Self-feeding with minimal mess	2 years	
Bladder control during day	2 years	
Bladder control during night	2.5 years	
Brushes teeth	3-4 years	
Dresses self without help	5 years	

APPENDIX

IV. SOCIAL -EMOTIONAL DEVELOPMENT EVALUATION:

A delay in any of the above by more than three months *or* a loss of an already established skill raises concern and warrants referral.

Social behaviour	EXPECTED AGE	Age of achievement in child
Social smile	2 months	
Follows moving objects with their eyes	3 months	
Makes and maintains eye contact when you engage the child	6 months	
Attachment to caregiver	6months	
Separation anxiety	6 months- 2 years	
Stranger anxiety	8 months- 2 years	
Plays Peek-a-boo	9 months	
Imitates others / pretend play	18 months- 2 years	
Points to objects of interest	18 months	
Shows interest in other children	1 year	
Plays with other children/ shares toys	2-5 years	

V. BEHAVIOURAL DEVELOPMENT EVALUATION:

If the answer to any of the below questions is YES, it is considered as a behavioural concern and warrants referral for specialist evaluation.

BEHAVIOURAL PROBLEMS	YES/NO
Small children- Inconsolable crying and irritability	
Bursts of aggression- hitting self or others, biting, headbanging	
Repeated unusual behaviour - hand flapping, rocking, toe walking, spinning	
Highly sensitive to change in environment (going to new places, change of room setting etc.)	
Child appears restless/ is unable to sit at one place	
Child is inattentive/ distracted/ unable to focus and complete given task	
Child appears anxious most of the time/ is very fearful of common things	
Child keeps complaining of headache/stomach pain/ weakness even after the doctor has checked and confirmed that child is healthy	
Change in behaviour- Child is very dull, doesnt interact with anyone, always talks negatively about self and life	
Regression- normally developing child has gone back to previous stage of development (eg. Bedwetting, loss of speech etc.)	

VI. SCREENING FOR LEARNING DIFFICULTIES:

Learning difficulties can be evaluated at home and school environments separately.

A. Evaluation based on household activities:

If the answer to any of the above questions is YES, it indicates a difficulty in learning home-based life skills and warrants further evaluation.

EVALUATION THROUGH PARENT/CAREGIVER AT HOME	
Is the child independent in activities by age of 5 years?	
<p>For children between 5-10 years: Is the child help in routine household activities like- folding clothes, cleaning house, etc if guided appropriately</p> <p>Does the child understand concept of self-hygiene and dressing appropriately?</p>	
<p>For children between 10-15 years: Is the child able to make small purchases if given a list of items (grocery shopping)?</p> <p>Is the child able to bring back the correct amount of change (money calculation)?</p> <p>Can the child cook small dishes and understand proportions of items if guided (make tea for 4 people by adding right amount of milk and powder etc.)?</p> <p>DOes the child know how to behave and dress appropriately in front of others, maintaining physical distance with others etc?</p>	

APPENDIX

B. Evaluation based on school activities:

EVALUATION THROUGH TEACHER/SCHOOL	
Current class level	
Does the teacher feel the child is slower than other children?	
Does the child have difficulty understanding concepts even after being explained individually?	
Reading difficulty - Does the child omit words/add new words/guess the words while reading	
Does the child struggle to read simple passages in familiar language	
Writing difficulty - Does the child make many spelling mistakes inspite of repeated correction	
Does the child replace alphabets, use both upper case and lower case together?	
Difficulty in mathematics - Does the child have difficulty understanding common symbols in Maths (Addition, subtraction, division, multiplication)	
Does child have difficulty performing simple maths problems which were taught in earlier classes?	

REPORT OF EVALUATION/FURTHER REFERRAL:

Domain	Problem noted (either delay of more than 3 months OR answer to any one question was YES)	Referral needed (Yes/No)
Motor development		
Language and concept development		
Self-help skills		
Social development		
Learning difficulties		
➤ Home/caregiver evaluation		
➤ School evaluation		
Behavioural concerns		

Summary of concerns:

Concerns and need for further evaluation explained to family (Yes/No): _____

Referral made for further evaluation to _____

on _____

Declaration:

I have clearly explained to family that based on the screening tool, we can only identify domains with concerns/problems which will benefit from further evaluation. I have not labelled the child with any diagnosis and have clarified all doubts of parents which was feasible at first reponse.

Name: _____

Sign: _____

District/Taluk: _____

Date: _____

REFERENCES FOR LEGISLATIONS- VISIT www.ncpcr.gov.in

- **Juvenile Justice Act**
- **Prevention of Child Sexual Offences Act**
- **Right to Education Act**

