Guidance Notes on
Psychosocial & Mental Health Assessment for Children in Conflict with the Law
Community Child & Adolescent Mental Health Service Project
Dept. of Child & Adolescent Psychiatry, NIMHANS
In Collaboration with
Dept. of Women & Child Development, Government of Karnataka

1. Development of the Assessment Performa for children in conflict with the law

This first step in providing psychosocial and mental health services to children in conflict with the law was to develop an assessment proforma. The objectives of the proforma are:

- To examine the (seriousness of) circumstances that the children come from and address the neglect/ abuse and trauma issues therein.
- To identify children with psychiatric and/or personality issues and implement interventions accordingly.
- To ensure restorative and transformation processes in children by:
  - holding them accountable and encouraging them to undertake responsibility for their actions.
  - helping them to understand the impact of their actions on victims/community and try and repair this harm.

The proforma was developed (through a process of iteration and revisions), using the vulnerability-pathology-consequence framework applied to understanding CICL's psychosocial issues. As per this framework, i) vulnerability refers to the risk factors that lead children to committing offence or coming in conflict with the law—these factors pertain to family dysfunction, abuse and trauma, education and academics-related issues, and individual factors such as developmental deficits and vulnerability to mental health conditions; ii) Pathology refers to mental health problems, both internalizing disorders (anxiety/ depression) and externalizing disorders (ADHD, Conduct Disorders and Substance Abuse) and the processes therein (such as emotional dysregulation, social judgment issues); iii) Consequences refer to the offence committed, including acts of aggression, stealing, and coming into conflict with the law.

This guide is designed to provide support to all who work with children in conflict with the law. It describes the purpose of various questions and variables, explaining why certain types of information need to be elicited; it also provides guidance on how to ask certain (sensitive) questions and how to interpret the ensuing responses, including what implications they have for interventions.

Information is required to be collected on ALL sections of this assessment proforma. Sections of the assessment proforma marked *(Ask Child) are to be administered to children only; information for other sections may be collected from the child or institution staff/caregiver or both.

DRAFT

2. Challenges & Considerations in Developing the Mental Health Assessment Proforma

Challenges...

- To work against a position taken by some child care workers/ service providers/ activists that no assessments should be done because... the information obtained may be used to transfer children to adult systems of trial i.e. against the best interests of CICL...or assessments may be too technical and therefore difficult for use by 'lay' persons i.e. those without formal training/ qualifications is in child psychiatry/ psychology/social work.
- To develop an assessment that is simple enough for community service providers to be able to use with the help of some training in child psychosocial care; but to ensure that the proforma is not so simplistic that the information is too broad or diluted or not nuanced enough to provide an understanding required to assist the child/ develop interventions for transformation.

How it was Developed...

- To accommodate legal concerns of using a 'validated' tool. The tool therefore includes some validated checklists and scales, mainly for diagnosis of mental health disorder. The scales and checklists provide for standardized ways to provide a diagnosis and make decisions about severity and consequences, and about medication, therapy and referral needs. Also, these checklists and scales make it quicker and easier for counselors to assess children for mental health disorders (else, they would have to learn and remember a great many signs and symptoms and would be more prone to error and inaccuracy).
- To ensure quality psychosocial assessment that provides a clear picture of the circumstances of the offence and on issues of proportionality through eliciting detailed information on children's experiences at home, in school, in the work place, of abuse and trauma and mental health problems. The tool needs to be more than a mere socio-demographic report providing some general information on the child's family and his/her education and an account of his/her offence. Thus, the tool is designed for the purposes of designing interventions i.e. all the information obtained through it helps to plan interventions for behaviour change and transformation—the main purpose of restorative justice.
- While the tool is detailed and requires some practice (following which its use becomes easier and faster), it is developed on the premise that: i) there will always be shortages of technically skilled staff in child care services and that the skills of the existing staff therefore need to be intensified and upgraded. In other words, all tools cannot be watered down to meet the under-skilled staff/ capacities of child care services, for then what would be their relevance and contribution? A more progressive view has been taken whilst developing this tool, in that we feel that the staff need to be trained and that they need to be challenged, so that they persevere to meet the complex needs of children.

DRAFT

3. Guidance Notes

Section 1: Basic Information

Assessment done by (Name of Individual & Agency):

Child's Name: **Date of Assessment:**

Age: **Sex:**

Location/ Place of Origin:

Alleged Offence (Reasons for current institutionalization/ immediate circumstances of coming to the institution, or alleged offence for which child is in institution- according to institution staff and police complaint/FIR)

Guidance Notes

First, this section gathers basic demographic information including age, sex and location/place of origin. Although the information is gathered across the child's life span, some of it, such as emotional and behavioural problems and mental health issues, is cross-sectional in nature, therefore, the date of assessment is important to note. Location or place of origin refers to where the child currently lives or what he/she calls home, usually where his/her family is.

The alleged offence refers to the complaint in connection with which a child has been placed in the Observation Home. This information should be obtained from the child's files/ FIR or the institution staff. It may be compared at a later stage with the child's account of the offence, from which it may, at times, be different.

Section 2: Social History (Family/School/Institution/Work/ Peers)

2.1. Family Issues Identified (Child's living arrangements/parental relationships/ child's emotional relationship & attachment to parents/ illness & alcohol dependency in parents/ single-parenting, any loss experience suffered by child…)

Guidance Notes

This section on the child's social history comprises of 5 sub-sections, namely the child's family situation, school and education issues, any previous institutionalization experiences the child may have had, work experiences and peer relationships. The JJ act refers to how assessment of CICL must understand the circumstances of the offence. Merely understanding the immediate circumstances or what happened at the time of offence is not adequate; it is essential to have a longitudinal understanding of the child's circumstances, to be able to identify the pathways that led to the offence, for it is most likely that long-standing social issues rendered the child vulnerable to offence over a period of time.

Family history comprises of the family composition, including the socio-economic status of the family and the parents' educational status and occupation. It includes information on the child's emotional attachment to each parent, any illness, disability or alcohol dependency in parents or siblings; parental marital problems, domestic violence and criminality in parents must also be recorded. In case the child has suffered the loss of a parent, this must be stated, as well as the age at which the child lost the parent.

DRAFT

Socio-economic status explains the kind of deprivation that a child comes from—and in some cases, unmet needs and deprivation form the pathway to offence. The lack of emotional attachment to parents due to rejection and/or harsh and punitive parenting leads to children developing antisocial behaviours in the following ways: i) poor attachment and parent-child relationships from an early age lead to emotional dysregulation i.e. difficulty in children controlling difficult emotions such as anger and anxiety; ii) parents who are violent/ alcohol dependent/ engage in criminal behaviours serve as role models to their children who then also learn and practice these behaviours; iii) neglect and poor supervision by parents (whether due to lack of time, illness or disability) due to which children do not develop appropriate life skills.

When difficult family circumstances and dysfunctional families have been one of the causes for children's offences, there are certain implications for intervention: to validate the child's difficult family experiences and acknowledge experiences of loss and abuse; to provide family counselling interventions, including for domestic violence and substance abuse issues in other family members and discuss alternative living arrangements of the child, as part of larger social and environmental modification interventions to assist the child.

2.2. Institutional History

If the child has lived in other places than family home (where child has been/lived, for what periods of time, experiences & difficulties; include child's police station stay and experience there/ places of stay for labour as well as hostels).

Guidance Notes

This sub-section elicits information on periods of time the child has been away from home, to understand his/her experiences in those places and what (peer and other) influences may have impacted the child there. It may include the child's stay in a relative's house, in hostels and other spaces where the child may have lived in order to study or to work. This history is to be read in conjunction with the family history as usually, children leave home either due to socio-economic vulnerability in the family, forcing them to work or other family problems that cause them to sometimes forcibly and other times voluntarily leave home and live elsewhere. Being away from home and family places a child at risk of emotional and attachment issues, leaving him/her more vulnerable to adverse peer influences, and consequently to behavioural problems that potentially lead to offence.

This information has implications for social interventions in terms of living arrangements for the child, provision of educational opportunities and vocational skills training in an institution of the child's choice. Additionally, psychological interventions would also be required in case the child had experienced discrimination and abuse in these other places he had to live in.

Although the JJ Act does not permit children to be detained in the police station for more than 24 hours after an FIR is filed, and require to be produced before the magistrate or JJB, the unfortunate fact of the matter is that they often are detained in police stations for many days, during which time they are physically abused; children have also reported that they have been severely physically abused and forced them to admit an offence which they have not committed including being falsely accused when they are unable to apprehend the actual culprit.

2.3. Schooling History

(Was the child attending school/Last grade/class attended current grade/class/if child was not attending school, reasons for child not attending school, including child refusing to go to school).

Guidance Notes

This sub-section elicits information on the child's schooling and educational history. It is important to understand why children who were in school dropped out i.e. whether it was due to financial problems or motivational issues. The latter refer to children refusing to go to school because of bullying experiences or learning difficulties and/or pressure/abuse by teachers due to which they may have been afraid to go to school. This information must be elicited in a gentle, non-judgemental manner as children are often criticized for not going to school but their reasons for this decision are often ill-understood. Reasons such as being expelled or suspended also throw light on behaviour problems (such as truancy and Attention Deficit Hyperactive Disorder) which then need to be addressed in the intervention plan.

Dropping out of school is one of the pathways to offence. Whatever the quality of school and education, schools are still safe spaces for children. Considering that children spend a good part of their day there, schools provide children with routine and gainful occupation. Children who do not go to school tend to have large amounts of unstructured time to wander at will, around the neighbourhood and city, often with other peers who also do not go to school. Since they are not gainfully occupied, there is a greater risk of engaging in high risk behaviours such as substance use—which in turn lead children to other offensive behaviours such as stealing and gang involvement i.e. substance use is both a cause and consequence of other antisocial behaviours such as violence and theft.

The implications for interventions are: building motivation and future-orientation in the child, assisting child to make decisions about further education and/or vocational training depending on the child's learning (dis)abilities and treating disorders such as ADHD using behavioural and pharmacological methods; adverse peer influences and high risk behaviours that emerge in relation to truancy and school drop-out issues must also be addressed.

DRAFT

2.4. Work Experiences

(Child labour experiences: why child had to work/ how child found place of work (trafficking?)/where the child was working, hours of work, amount of remuneration received/whether this was regular, any form of abuse encountered at the place of work/ how the owner and others treated child.)

Guidance Notes

This sub-section elicits information on children's experiences in the work place (in case of any). Forced trafficking, long hours of work under difficult conditions, inadequate remuneration, violence and other forms of exploitation all amount to experiences of trauma abuse. Trauma experiences also leads emotional dys-regulation and behaviours of anger and aggression, consequently leading to offence; or trauma leads to internalized disorders such as anxiety and depression that in turn lead to maladaptive coping strategies including substance use (and offences that result from this).

Additionally, child labour contexts also expose children to older peers and young adults who engage in criminal behaviours and force children to engage in such behaviours for perverse entertainment or pleasure and/or to ensure children are caught in the act and they themselves escape punishment. Children may be far away from family have little connect with families—experience neglect/ loss of attachment relationships...making it easier for the antisocial adults around to influence them.

Thus, child labour experiences may form a pathway to offence. From an intervention perspective, this information helps to address the emotional consequences of the exploitation and trauma that the child may have faced, and to develop life skills such as assertiveness, decision-making and coping with peer pressure in various life situations.

2.4. Peer Influence

a) **Do you have a lot of friends? (Yes/No)**

b) **Which group of friends do you spend more time with?**

i. **School/ Classmates**

ii. **Family members- cousins etc.**

iii. **Friends in your neighborhood**

iv. **Others**

c) **Time spent with peers…True or False?**

i)	I spend far more time with my friends/peer group than at home/ with my family.	
ii)	I sometimes go out with my friends and stay out all night.	
iii)	I sometimes spend days with my friends without coming back home.	

d) **Age of friends?**

"Most of them are…."

i. Older than you

ii. Younger than you

iii. Same age as you

e) **What kind of activities or games you do or play with your friends?**

f) **Extent & Areas of Influence of Peers**

I will read you some statements about your relationship with friends tell me whether you strongly agree, strongly disagree or agree to some extent.

Sl no.	Statements	Strongly Agree	Agree to some extent	Strongly Disagree
i	My friends influence my decision to go to/ continue school and studies.			
ii	My friends influence my actions to do with stealing and breaking rules.			
iii	My friends influence my actions about smoking.			
iv	My friends influence my actions about alcohol use.			
v	My friends influence my actions about drugs.			
vi	My friends influence my actions about sexuality.			

g) **Consequences of peer influences**

Have you ever got into trouble with your school, parents or police/ other authorities because of your activities done with your friends? (Tell me about it).

DRAFT

Guidance Notes

Our experience has shown that negative peer influences and the lack of life skills such as assertiveness and coping with peer pressure is a critical pathway to offence by adolescents. This sub-section thus seeks to understand the nature and type of peer interactions that a child has had. The first question on whether a child has many or few friends is merely a way to open the conversation on friends and peers.

The subsequent question on who these friends are is significant in the following ways: if children's friends are school children and classmates, the chances are that the child is spending time with socially appropriately behaved peers (i.e. those who go regularly to school and engage in routine activities). If the child spends more time with friends in the neighbourhood, our experience shows that these often tend to be peers who do not themselves go to school/ are engaged in truancy behaviours, thus increasing the likelihood of children engaging in offence behaviours. However, this is not to say that peer relations will play out exactly in this manner in every case (i.e. children may have positive peer influences in the form of neighbourhood friends or negative peer influences at school too); this variable therefore needs to be read in conjunction with others relating to school and education (the child's academic performance, motivation and regularity of school attendance, for instance) and with the quality of the child's family relationships and supervision (which also determines the adequacy of the child's life skills).

Similarly, children whose friends are older should lead to alertness and possible probes on the child's involvement in gang activities. Children whose friends are (a lot) younger should lead to probes on child's intellectual abilities (in children with intellectual disability, since the mental age is lower than the chronological age, and so they tend to mingle with younger children more comfortably).

Time spent with family versus peers helps to understand the extent of peer influence a child is exposed to; children who spend extended time with their peers and more time with their peers than families are more vulnerable to peer influence. It is to be noted that staying out with friends all night and spending days outside the home with friends refers to times when the child does not inform parents or does not have parental permission for these activities (not to be confused with occasional outings with friends with the knowledge and permission of friends).

An open question on the kinds of activities and games that children engage in with their peers is asked to ascertain whether the children are part of peer groups that meet to use substance. If children do not mention substance use, a gentle probe can be used to ask whether their groups smoke or drink alcohol when they meet.

To further understand the nature of the child's relationship with his/her peers, and the specific areas in which a child is influenced by peers, there is a question with a series of statements about issues on which they are influenced by their peers—such as substance use and sexuality-related behaviours because these are some of the common high risk behaviours that lead them to offence. It is to be noted that the purpose of asking this question is to understand the child's vulnerability to peer influence in these areas i.e. even if the child does not smoke, how vulnerable is he/she to being persuaded to do so by his/her friends.

Lastly, there is a question on consequence of peer influences, in order to assess whether the child has been in trouble prior to the circumstances of coming to the observation home on this occasion i.e. has a history of getting into trouble with various types of authority, due to peer influence and actions. Children who have many times/ repeatedly had serious consequences such as complaints by teacher, suspension from school and police complaints for rule breaking is indicative that he/she has a long-standing problem, one of conduct disorder and/or Attention Deficit Hyperactivity Disorder (ADHD, both of which have treatment implications.

Section 3: Trauma Experiences: Physical, Sexual & Emotional Abuse Experiences *(Ask Child)

3.1. Loss, Death & Grief

Have you ever lost someone in your family/someone you were very close to, either through death or separation? Do you still think of this person a lot and feel very sad and upset? Tell me about it (when it happened/ how/ your feelings now…)…

3.2. Physical, Emotional & Sexual Abuse

Sometimes people behave in ways that are hurtful to children (incl. police/ teachers/ family members/ peers…). Tell me about anyone/ people who have behaved in ways that have:

a) Physically hurt you and caused you injury?

b) Said things to make you feel hurt/sad/ angry/humiliated?

c) Touched you in ways that made you feel uncomfortable or shown you sexually explicit pictures/ videos?

Guidance Notes

This section elicits information on children's experiences of trauma, mainly on loss and grief and abuse. Childhood trauma, whether due to death/loss/grief experiences or physical/emotional/sexual experiences result in emotional dysregulation leading children to then develop behaviour problems too; anxiety and depression that occur in contexts of trauma lead children to high risk behaviours such as substance use. When children are physically abused at home or in school, they learn that these are legitimate methods of coping with problems and in turn, use the same methods to deal with various life situations and problems they are confronted with. Similarly, children who are sexually abused and have received no assistance thereafter, develop a loose sense of personal boundaries and may be more likely, in some cases, to sexually abuse others. Thus, trauma experiences form part of CICL's circumstances and can be one of the pathways to offence.

However, even if there is no direct link between a child's trauma experience and the offence he/she has committed, this information is still necessary for intervention purposes; this is because conduct issues and trauma experiences are not necessarily exclusive of either i.e. we cannot assume that a child who has difficult behaviours cannot also have undergone traumatic experiences and thus cannot also have internalizing problems such as anxiety and depression. Consequently, whether or not a child has committed an offence, if he/she has undergone traumatic experiences, he/she has a right to mental health assistance to help him/her to cope and resolve issues and avert (further) negative impacts of trauma. Thus, information on trauma experiences is also gathered from a child rights perspective, on the premise that all children have the right to receive psychosocial and mental health assistance, irrespective of their problem behaviours.

Section 5: Mental Health Concerns *(Ask Child)

5.1. Anxiety

U1. (Screening Questions)
For the past six months...

Have you worried a lot or been nervous?	No	Yes
Have you been worried or nervous about several things, (like school, your health, or something bad happening)?	No	Yes
Have you been more worried than other kids your age?	No	Yes

Do you worry most days?	No	Yes

If any of the answers to U1 are 'yes', then administer U2 & U3. If 'NO', stop and proceed to next section on Depression.

U2. **Do you find it hard to stop worrying? Do the worries make it hard for you to pay attention to what you are doing?**	No	Yes
U3. **When you are worried, do you, most of the time:**	No	Yes
a. Feel like you can't sit still?	No	Yes
b. Feel tense in your muscles?	No	Yes
c. Feel tired, weak or exhausted easily?	No	Yes
d. Have a hard time paying attention to what you are doing? Does your mind go blank?	No	Yes
e. Feel grouchy or annoyed?	No	Yes
f. Have trouble sleeping ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, wakening up too early or sleeping too much)?	No	Yes

If **1** or more **U3** answers **are** coded '**Yes', then mark 'Yes' for Generalized Anxiety Disorder Diagnosis.**

Generalized Anxiety Disorder: Yes/ No

5.2. Depression Issues

C1. (Screening Question) Have you felt sad or depressed, or felt down or empty, or felt grouchy or annoyed, most of the time, for the past year?	No	Yes

If 'YES', administer C2 and C3. If 'NO', stop and proceed to next section on ADHD.

C2. In the past year OK **r**, have you felt OK for two months or more in a row? (Means not always being grouchy or free of depression).	No	Yes
C3. During the past year, most of the time:	No	Yes
a. Were you less hungry than you used to be? Were you more hungry than you used to be?	No	Yes
b. Did you have trouble sleeping ("trouble sleeping" means trouble falling asleep, waking up in the middle of the night, waking up too early or sleeping too much)?	No	Yes
c. Did you feel more tired than you used to?	No	Yes
d. Did you feel less confident of yourself? Did you feel bad about yourself?	No	Yes
e. Did you have trouble paying attention? Did you have trouble making up your mind? Did you feel that things would never get better?	No	Yes

If two or more C3 items coded 'Yes', then mark 'Yes' for Depression diagnosis.

Depression Issues: Yes/ No

If 'Depression Issues' marked 'YES', administer below 2 questions.

- Have you ever felt like you do not want to live? Yes/ No
- If yes, have you ever acted upon this thought to not live? Yes/ No

Suicidal Thoughts: Yes/ No
Suicidal Attempts: Yes/ No

5.3. Attention Deficit Hyperactive Disorder (ADHD)

O2.	**In the past 6 months...**	No	Yes

DRAFT

a)	Have you often not paid enough attention to details? Made careless mistakes in school?	No	Yes
b)	Have you often had trouble keeping your attention focused when playing or doing schoolwork?	No	Yes
c)	Have you often been told that you do not listen when others talk directly to you?	No	Yes
d)	Have you often had trouble following through with what you were told to do (Like not following through on schoolwork or chores)?	No	Yes
e)	Did this happen even though you understood what you were supposed to do?	No	Yes
f)	Did this happen even though you weren't trying to be difficult?	No	Yes
g)	Have you often had a hard time getting organized?	No	Yes
h)	Have you often tried to avoid things that make you concentrate or think hard (like schoolwork)? Do you hate or dislike things that make you concentrate or think hard?	No	Yes
i)	Have you often lost or forgotten things you needed? Like homework assignments, pencils, or toys?	No	Yes
j)	Do you often get distracted easily by little things (Like sounds or things outside the room)?	No	Yes
k)	Do you often forget to do things you need to do every day(Like forget to comb your hair or brush your teeth)?	No	Yes

03.	**In the past 6 months...**	No	Yes
a)	Did you often fidget with your hands or feet? Or did you squirm in your seat?	No	Yes
b)	Did you often get out of your seat in class when you were not supposed to?	No	Yes
c)	Have you often run around or climbed on things when you weren't supposed to? Did you want to run around or climb on things even though you didn't?	No	Yes
d)	Have you often had a hard time playing quietly?	No	Yes
e)	Were you always "on the go"?	No	Yes
f)	Have you often talked too much?	No	Yes
g)	Have you often blurted out answers before the person or teacher has finished the question?	No	Yes
h)	Have you often had trouble waiting your turn?	No	Yes
i)	Have you often interrupted other people? Like butting in when other people are talking or busy or when they are on the phone?	No	Yes

04. Did you have problems paying attention, being hyper, or impulsive before you were 7 years old?	No	Yes
05. Did these things cause problems at school? At home? With your family? With your friends?	No	Yes

If 6 or more answers are coded 'Yes' in O2 AND/OR 6 or more answers are coded 'Yes' O3, mark 'Yes' for ADHD diagnosis. (Also ask O4 and O5—for intervention purposes).

DRAFT

Attention Deficit Hyperactivity Disorder (ADHD): Yes/ No

5.4. Conduct Disorder

P2. In the Past Year...	No	Yes
a. Have you bullied or threatened other people (excluding siblings)?	No	Yes
b. Have you started fights with others (excluding siblings)?	No	Yes
c. Have you used a weapon to hurt someone? Like a knife, gun, bat, or other object?	No	Yes
d. Have you hurt someone (physically) on purpose (excluding siblings)?	No	Yes
e. Have you hurt animals on purpose?	No	Yes
f. Have you stolen things using force? Like robbing someone using a weapon or grabbing something from someone like purse snatching?	No	Yes
g. Have you forced anyone to have sex with you?	No	Yes
h. Have you started fires on purpose in order to cause damage?	No	Yes
i. Have you destroyed things that belonged to other people on purpose?	No	Yes
j. Have you broken into someone's house or car?	No	Yes
k. Have you lied many times in order to get things from people? Or Tricked other people into doing what you wanted?	No	Yes
l. Have you stolen things that were worth money (Like shoplifting or forging a cheque?)	No	Yes
m. Have you often stayed out a lot later than your parents let you? Did this start before you were 13 years old?	No	Yes
n. Have you run away from home two times or more?	No	Yes
o. Have you skipped school often? Did this start before you were 13 years old?	No	Yes

If in P2, 3 or more answers are coded 'Yes' with at least one present in the past 6 months, then mark 'Yes' for Conduct Disorder Diagnosis.

Conduct Disorder: Yes/ No

Guidance Notes

The Mini-International Neuropsychiatric Interview (M.I.N.I.) is a short structured diagnostic interview, developed jointly by psychiatrists and clinicians in the United States and Europe, for DSM-IV and ICD-10 psychiatric disorders. With an administration time of approximately 15 minutes, it was designed to meet the need for a short but accurate structured psychiatric interview for multicenter clinical trials and epidemiology studies and to be used as a first step in outcome tracking in non-research clinical settings.

The Mini-International Neuropsychiatric Interview for Children and Adolescents (MINI-kid) was developed for children and adolescents; it is used in screening 23 axis-I DSM-IV disorders. For most modules of MINI, two to four screening questions are used to rule out the diagnosis when answered negatively. Positive responses to screening questions are examined by further investigation of other diagnostic criteria.

DRAFT

For the purposes of this assessment proforma, we have drawn questions from 4 parts of the Mini Kid tool, to evaluate children for common mental health disorders—anxiety, depression, Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder (CD).

Anxiety and depression are internalizing disorders, which refer to negative behaviors that are focused inward or problems that people keep within themselves. They include fearfulness, social withdrawal, and somatic complaints1. ADHD and CD may both be considered as externalizing behaviours i.e. disruptive, negative behaviours that are directed at the environment.

Anxiety and depression have been selected because they can lead to emotional dysregulation and substance use and other high risk behaviours (especially in when they occur in the backdrop of trauma experiences), consequently leading to offence. Severe anxiety and depression may lead to self-harm and suicidal behaviours which institutional care systems need to be especially alert to; custodial death is a serious matter and there would be serious consequences for the management staff of a child care institution if they have failed to recognize severe mental health problems that led to death of a child. Severe anxiety and depression may lead to severe sleep and appetite problems, dysfunctionality and inability to perform daily self-care and routine activities and/or self-harm thoughts and behaviours; in such instances, a child should be referred to a tertiary health facility or specialized mental health facility for further assessment and care, including pharmacotherapy.

ADHD is a neuro-developmental disorder is one of the most common childhood disorders, affecting between 8 and 10 percent of children and teens. It is a childhood disorder that is characterized by restlessness, difficulty focusing or concentrating, difficulty sticking to & completing tasks and haste in making decisions. In both children and adolescents, it results in uncontrolled aggressive behaviours and poor emotional regulation; if untreated, as children and adolescents grow, it manifests in the form of poor social skills, inadequate social judgment and high impulsivity i.e. hasty judgements and impulsive actions that may have harmful consequences to the child and others. ADHD thus leads to increased conflicts with peer groups, poor decision-making skills and sensation-seeking activities such as substance abuse, inappropriate sexual behaviour and other high risk behaviours, consequently forming a pathway to offence. Children in conflict with the law must always therefore be assessed for ADHD, which may be a major cause of their offence behaviours. Undiagnosed/untreated ADHD can lead to repeated offence behaviours in children, thus contributing to higher rates of recidivism. ADHD may be at mild, moderate or severe levels. In case to moderate to severe ADHD (more common among CICL), it is necessary to refer them to specialized mental health facility for medication as well as behaviour training therapies (which can then be executed by the institution staff, based on medical advice and recommendations).

Conduct disorder is an overarching term used in psychiatric classification that refers to a persistent pattern of antisocial behaviour in which an individual repeatedly breaks social rules and carries out aggressive acts that upset other people, including stealing and acts of violence and cruelty. A high proportion of children and young people with conduct disorders grow up to be antisocial adults with impoverished and destructive lifestyles. It is therefore important to identify conduct disorder in children and adolescents so as to provide them with interventions that will prevent criminality and antisocial behaviours in the future as well.

If there are any (other) emotional or behavioural issues reported by a child or caregivers/ institution staff do not fit into any of the above four mental health disorder categories, the child may be referred to a specialized mental health facility for further examination and assessment.

[1] When people complain of body aches/ pains/ discomfort in the absence of any diagnosed medical problem and when the basis of their health problems is psychological and stress-related.

5.5. Substance Abuse:

A. DRUG USE HISTORY

For each drug I name, please tell me if you have ever tried it. Then, if you have tried it, tell me how often you typically use it [before you were taken into custody or enter treatment]. Consider only drugs taken without prescription from your doctor; for alcohol, don't count just a few sips from someone else's drink.

Interventions →	No Intervention		Brief Intervention			Intensive Intervention		
Substances ↓	**Never Used**	**Tried But Quit**	**Several Times a Year**	**Several Times a Month**	**Week-Ends Only**	**Several Times a Week**	**Daily**	**Several Times a Day**
Smoking Tobacco (Cigarettes, cigars)	0	1	2	3	4	5	6	7
Alcohol (Beer, Wine, Liquor)	0	1	2	3	4	5	6	7
Marijuana or Hashish (Weed, grass)	0	1	2	3	4	5	6	7
LSD, MDA, Mushrooms Peyote, other hallucinogens (ACID, shrooms)	0	1	2	3	4	5	6	7
Amphetamines (Speed, Ritalin, Ectasy, Crystal)	0	1	2	3	4	5	6	7
Powder Cocaine (Coke, Blow)	0	1	2	3	4	5	6	7
Rock Cocaine (Crack, rock, freebase)	0	1	2	3	4	5	6	7
Barbiturates, (Quaaludes, downers, ludes, blues)	0	1	2	3	4	5	6	7
PCP (angel dust)	0	1	2	3	4	5	6	7
Heroin, other opiates (smack, horse, opium, morphine)	0	1	2	3	4	5	6	7
Inhalants (Glue, gasoline, spray cans, whiteout, rush, etc.)	0	1	2	3	4	5	6	7

DRAFT

Valium, Prozac, other tranquilizers (without Rx)	0	1	2	3	4	5	6	7
OTHER DRUG___________	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

B. Adolescent Alcohol and Drug Involvement Scale (AADIS) [modified version].
These questions refer to your use of alcohol and other drugs (like marijuana/weed or cocaine/rock). Please answer regarding the time you were living in the community before you were taken into custody or entered treatment. Please tell me which of the answers best describe your use of alcohol and/or other drug(s). Even if none of the answers seem exactly right, please pick the ones that come closest to being true. If a question doesn't apply to you, tell me and we will leave it blank.

1. How often do [did] you use alcohol or other drugs (such as weed or rock) [before you were taken into Custody/entered treatment]?

a.	never	0
b.	once or twice a year	2
c.	once or twice a month	3
d.	every weekend	4
e.	several times a week	5
f.	every day	6
g.	several times a day	7

2. When did you last use alcohol or drugs? [Before you entered treatment or were taken into custody]

a.	never used alcohol or drugs	0
b.	not for over a year	2
c.	between 6 months and 1 year [before]	3
d.	several weeks ago [before] custody]	4
e.	last week [the week before]	5
f.	yesterday [the day before]	6
g.	Today [the same day I was taken into.	7

3. I usually start to drink or use drugs because: (TELL ME ALL THAT ARE TRUE OF YOU)

a.	I like the feeling	1
b.	to be like my friends	2
c.	I am bored; or just to have fun	3
d.	I feel stressed, nervous, tense, full of worries or problems	4
e.	I feel sad, lonely, sorry for myself	5

4. What do you drink, when you drink alcohol? (CIRCLE ALL MENTIONS)

a.	wine	1
b.	beer	2
c.	mixed drinks	3
d.	hard liquor (vodka, whisky, etc.)	4
e.	A substitute for alcohol	5

DRAFT

5. How do you get your alcohol or drugs? (CIRCLE ALL THAT YOU DO)

a.	Supervised by parents or relatives	1
b.	from brothers or sisters	2
c.	from home without parents' knowledge	3
d.	get from friends	4
e.	buy my own (on the street or with false ID)	5

6. When did you first use drugs or take your first drink? (CIRCLE ONE)

a.	never	0
b.	after age 15	2
c.	at ages 14 or 15	3
d.	at ages 12 or 13	4
e.	at ages 10 or 11	5
f.	before age 10	6

7. What time of day do you use alcohol or drugs? (CIRCLE ALL THAT APPLY TO YOU)

a.	at night	1
b.	afternoons/after school	2
c.	before or during school or work	3
d.	in the morning or when I first awaken	4
e.	I often get up during my sleep to use alcohol or drugs	5

8. Why did you take your first drink or first use drugs? (CIRCLE ALL THAT APPLY)

a.	curiosity	1
b.	parents or relatives offered	2
c.	friends encouraged me; to have fun	3
d.	to get away from my problems	4
e.	to get high or drunk	5

9. When you drink alcohol, how much do you usually drink?

a.	1 drink	1
b.	2 drinks	2
c.	3-4 drinks	3
d.	5 -9 drinks	4
e.	10 or more drinks	5

10. Whom do you drink or use drugs with? (CIRCLE ALL THAT ARE TRUE OF YOU)

a.	parents or adult relatives	1
b.	with brothers or sisters	2
c.	with friends or relatives own age	3
d.	with older friends	4
e.	alone	5

11. What effects have you had from drinking or drugs? (CIRCLE ALL THAT APPLY TO YOU)

a.	loose, easy feeling	1
b.	got moderately high	2

DRAFT

c.	got drunk or wasted	3
d.	became ill	4
e.	passed out or overdosed	5
f.	used a lot and next day didn’t remember what happened	6

12. What effects has using alcohol or drugs had on your life? (CIRCLE ALL THAT APPLY)

a.	none	0
b.	has interfered with talking to someone	2
c.	has prevented me from having a good time	3
d.	has interfered with my school work for using alcohol or drugs	4
e.	have lost friends because of use	5
f.	has gotten me into trouble at home	6
g.	was in a fight or destroyed property	7
h.	has resulted in an accident, an injury, arrest, or being punished at school	8

13. How do you feel about your use of alcohol or drugs? (CIRCLE ALL THAT APPLY)

a.	no problem at all	0
b.	I can control it and set limits on myself	2
c.	I can control myself, but my friends easily influence me	3
d.	I often feel bad about my use	4
e.	I need help to control myself	5
f.	I have had professional help to control my drinking or drug use.	6

14. How do others see you in relation to your alcohol or drug use? (CIRCLE ALL THAT APPLY)

a.	can’t say or normal for my age	0
b.	when I use I tend to neglect my family or friends	2
c.	my family or friends advise me to control or cut down on my use	3
d.	my family or friends tell me to get help for my alcohol or drug use	4
e.	my family or friends have already gone for help about my use	5

DRAFT

AADIS SCORING RESULTS

AADIS SCORE: ______ (Score of 37 or above requires a full assessment)

DO YOU RECOMMEND FULL ASSESSMENT (Regardless of the AADIS score)?
0. NO
1. YES

COMMENTS:

Scoring and Diagnosis of Substance Dependence: (Notes for facilitator)

- Under section A, for any given substance, if a child falls in the categories:
    - ‘Never Used’ and/or ‘Tried but Quit’, he/she requires **NO INTERVENTION**.

- ‘Several Times a Year’, ‘Several Times a Month’ and/or ‘Week- Ends Only’, he/she will require **BRIEF INTERVENTION**.
- **‘**Several Times a Week’, ‘Daily’ and/or ‘Several Times a Day’ he/she will require **INTENSIVE INTERVENTION**.

- Under Section B, for each item 1-14, add the weights associated with the highest category circled [weights are the numbers in square brackets].The higher the total score, the more serious the level of alcohol/drug involvement.
    - If a child **drinks alcohol**, score him/her on a **scale of 37**. A Score of **37** or above requires further depth assessment, including referral to tertiary healthcare (specialized) facilities.
    - If a child does **NOT drink alcohol**, score him/her on a **scale of 35**. A Score of **35** or above requires further depth assessment, including referral to tertiary healthcare (specialized) facilities.

Guidance Notes

The Adolescent Alcohol and Drug Involvement Scale (AADIS)[2] tool has been incorporated into the CICL psychosocial assessment proforma to elicit information on the types of substance a child uses, reasons for use of substances, how substance use started, and frequency of use of substances. This tool was selected for use because of its relative simplicity of questions (compared to other substance use assessment tools) and because the information gathered can directly be used to develop (substance use) therapy goals and interventions for a given child.

We made a few minor additions and modifications to the AAIDS tool in order to adapt it to the needs of the CICL in the context of observation homes:

(a) Section A: To keep the focus on intervention, a row was added to the table on ‘Drug Use History’:

- Scores: 0-1 (‘Never Used’ and ‘Tried but Quit’ respectively) were marked ‘No intervention’ since the child does not require intervention in these cases. In fact, the rest of the substance use questions need not be asked at all thereafter.

- Scores 2 – 4 (‘Several Times a Year’, ‘Several Times a Month’ and ‘Week Ends Only’) were marked ‘Brief intervention’; the occasional (but not regular and continuous) use of substance require brief interventions, mainly comprising of life skills education and perspective-taking on use of substance and the risks associated with it, especially if it grew to be a habit.

- Scores 5-7 (‘Several Times a Week’, ‘Daily’ and ‘Several Times a Day’) were marked ‘Intensive Intervention’; as the frequency and pattern of substance use here is more akin to dependency and addiction and would thus require more intensive treatments for de-addiction and withdrawal symptoms (were the child to stop), in addition to life skill education and perspective-taking on risks of substance use.

(b) In section B, all questions in the original AAIDS referred to children’s use of alcohol and other drugs in their current surroundings i.e. home or community. However, CICL’s current location (where they are being assessed) is the observation home, which is a protective environment i.e. wherein children do not have access to substances and so the questions would no longer apply. Therefore, we request children to

[2] Developed by D. Paul Moberg, Center for Health Policy and Program Evaluation, University of Wisconsin Medical School.Adapted with permission from Mayer and Filstead‘s ―Adolescent Alcohol Involvement Scale‖ (Journal of Studies on Alcohol 40: 291-300, 1979) and Moberg and Hahn‘s ―Adolescent Drug Involvement Scale‖ (Journal of Adolescent Chemical Dependency, 2: 75-88, 1991).

answer the substance use questions with reference to the time they were living in the community i.e. before they were taken into custody or entered treatment in the observation home. This information then helps us understand substance abuse problems in the child as well as how substance abuse may also have served as a pathway to offence. Many offences are also committed under the influence of substance, in which the primary problem is the child's engagement substance abuse; many violence and theft related offences are also committed in order to get money to support a substance use habit or addiction, therefore making substance abuse a primary problem again.

(c) Under Section B, item number 4, it corresponds only to alcohol use ('What do you drink, when you drink alcohol?') The total score of AAIDS, including this item is 37, based on which a diagnosis is made. However, for a child who does not drink alcohol, we consider the total score by removing this question i.e. the total score is reduced from 37 to 35 for a child who does not use alcohol. The higher the score the more intensive the problem. Scores above 35 (for children who do not use alcohol) and scores above 37 (for children who use alcohol) mean that children need to be referred for further assessment and treatment—in all probably they require intensive interventions.

Section 4: Potential for transformation*(Ask Child)

a) Child's Account of Offence (Circumstances of coming to the institution, incl. offence for which he/she is in institution)

b) Child's insight: (What is the problem according to you/What is your understanding of why you are here?

c) Motivation for change

i) One reason for staying out of trouble may be because you don't want to get put into an institution. What are some other reasons to not engage in the actions/ behaviours that brought you to the institution in the first place?)

ii) If a genie were to appear and grant you 3 wishes…saying you could have anything you wanted…what would you wish for? Your dreams and long term goals…(Before and after this incident/offence in case they are different).

d) Skills to avoid (re) offending: What are your future plans in terms of staying out of trouble? What are some things you may do to ensure it?

Guidance Notes

Any treatment or therapeutic intervention assumes that every child/ adolescent has the potential for transformation. If we did not believe this, there would be no need to try to provide treatment at all. Thus, 'Potential for Transformation' in the context of child and adolescent mental health (and consequently in case of children in conflict with the law) does not seek to make any predictions about whether the child can actually change or not—we do not know that until we have provided opportunities and interventions that facilitate change. So, what this phrase refers to is:

a) Child's Account of Offence refers to the child's version of the story i.e. how the events leading to his/her admission to the observation home played out. This account may or may not be the same as the

DRAFT

alleged offence as recorded in the FIR because children are often not asked for details or believed if they were to provide an account to the police. It is important to get the child's version of the story for the following reasons: i) it is often more detailed and accurate than the FIR, providing an understanding of how things played out/ how the child was rendered vulnerable by people and events at a given point in time (the time at which the offence or offence-related events occurred); ii) the child's account provides a basis for the counselor to initiate psychosocial and therapeutic inputs—as it is followed by discussions on insight and motivation (explained below).

b) Children's insight into the problem –-this refers to what understanding children have of the offence they have committed: Do they see it as a problem for themselves and others? Children who have an understanding of their offence and acknowledge the difficulties the offence has created for self and others, are said to have insight. As discussed earlier, insight into/ acknowledgement of the problem are the first steps for transformation to occur and consequently, presence of insight can be seen as having potential for change.
How to analyse or enter data on a child's response to insight:
- Low extent: if the child is not able to give any reasons on why he/she feels his actions are a problem.
- To some extent: if the child is able to state at least one reason on why he/she feels his actions are a problem.
- To high extent- If the child is able to provide more than 1 reason on why he/she feels his actions are a problem.
Example: I think I got into this problem because I listened to my friends and did what they told me to…and that is how I got drunk…and did what I did.

c) Children's Motivation for Change--other than needing to stay out of trouble because they don't want to get put into an institution, are children able to reflect on reasons to not engage in the actions/ behaviours that brought them into conflict with the law in the first place? This factor actually refers to higher levels of moral development: avoidance of punishment and benefits to self are more basic levels of moral development and reasoning that motivate people to not perform certain actions; but social desirability, the importance of empathy and inter-personal relationships, and maintenance of law and order, social contracts and universal ethics are higher levels of moral development and reasoning. The potential for change seeks to examine where the child stands in his/her moral development—the higher the levels of moral development and reasoning, the greater the potential for change.
How to analyse or enter data on a child's response to motivation for change:
- Low extent: if the child is not able to give any reasons why he/she feels the need to change his/her behaviours.
- To some extent: if the child is able to state at least one reason why he/she feels the need to change his/her behaviours.
- To high extent- If the child is able to provide more than onereason why he/she feels the need to change his/her behaviours.
Example: "I feel I must do something about my anger problem because if the problem continues, I will have no friends, my family will have difficulty…if I get a job tomorrow, it may be difficult for me."

d) Skills to Avoid Offence—this refers to life skills such as emotional regulation, empathetic response, problem solving and conflict resolution. Children who have some of these skills are likely to have higher potential for behaviour change.
How to analyse or enter data on a child's response to skills to avoid re-offence:
- Low extent - if the child is not able to give any ways to stay out of trouble.
- To some extent- if the child is able to state at least one step he/she would take to ensure that he/she would stay out of trouble.

- To high extent- if the child is able to provide more than 2 steps or strategies to stay out of trouble. Example: "May be I could spend time with a different set of friends so that I do not get into trouble."

Finally, while every child is assessed for potential for change, the objective of understanding potential for change, for mental health purposes, is only to establish the baseline, with a view to designing interventions, depending on what levels of reflectivity the child is at and what skills (deficits) he/she has. Therefore, a child who may, according to the assessment, have low potential for change, cannot be judged as having little or no hope for transformation; all that this means is that his/her insight, motivation for change and skills to avoid offence are low or weak, implying that the counsellor needs to work on these areas as part of therapy. In other words, the potential for change is only a baseline or indicator for the counsellor on where the work with the child needs to be pitched i.e. if the child already has high insight and motivation, for instance, it is only a matter of providing inputs on the skills to protect him/her against re-offence versus a child who has no insight wherein the initial discussions in therapy need to focus on facilitating the child's deeper understanding of the problem before moving to starategies to address the problem.
The information and analysis of a child's potential for transformation, at assessment stage, is therefore to be used for psychosocial and therapeutic purposes only; and at least before interventions and opportunities are provided for transformation, should NOT be:
- aimed at contributing to legal judgements about the child.
- used to make decisions about bail or release.
- used for transfer to adult systems of criminal justice.

Section 6: Life Skills Deficits & Other Observations of the Child

6.1. Life Skills Needs & Deficits

a)	Emotional Regulation (Management and control of anger & anxiety)	
b)	Development of empathy/ interpersonal relationships	
c)	Coping with Stress (Coping with financial difficulties at home/ finding alternatives to running away from home or school…)	
d)	Assertiveness (Ability to say 'no' to peers when necessary.)	
e)	Problem Solving and Conflict Resolution (When confronted with difficult situations, to be able to generate alternatives/ evaluate them and select the appropriate option).	
f)	Decision-making in various life contexts (Evaluate available options and select appropriate ones in a given situation).	
g)	Decision-making in contexts of romance/ relationships/ sexuality (making decisions about sexual/ relational issues with due consideration to health, safety, consent, emotional contexts of relationships)	

DRAFT

Guidance Notes
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.'* Core life skills for the promotion of child and adolescent mental health include: decisions-making, problem-solving, creative thinking, critical thinking, effective communication, inter-personal relationship skills, self-awareness, empathy, coping with stress and emotions[3].

[3] WHO, *Life Skills Education for Children and Adolescents in Schools: Introduction and Guidelines to Facilitate the Development and Implementation of Life Skills Programs*. 1997, World Health Organization: Geneva.

One of the main reasons why children come into conflict with the law is because of life skills deficits. These life skills deficits occur because of dysfunctional families and the poor adult support and supervision as well as due to exposure to trauma and difficult circumstances. Seriousness of circumstances need to be analyzed in terms of their consequences—which manifest as life skills deficits.

Thus, this sub-section is to filled in based on the counselor's understanding and analysis of the i) child's account of his/her circumstances ii) the offence he/she has been apprehended for; iii) insight into the problem, motivation for change and skills to avoid re-offence. Here are some examples on how to analyse what types of life skills deficits children have:
- Emotional Regulation: Children who have difficulty controlling anger and anxiety, children who get into violent fights.
- Development of empathy/ interpersonal relationships: children who have difficulty recognizing other people's feelings and have little or no insight into how their actions (usually of cruelty or violence and abuse) may have caused hurt or harm to others; children who frequently get into conflicts with family and peer groups, unable to negotiate relationships in ways that are emotionally beneficial to them and others.
Coping with Stress (Coping with financial difficulties at home/ finding alternatives to running away from home or school…)
- Assertiveness (Ability to say 'no' to peers when necessary.): children who use substance because of peer pressure, have been involved in gangs, have participated in theft, violence and other antisocial activities due to persuasion by peers.
Problem Solving and Conflict Resolution (When confronted with difficult situations, to be able to generate alternatives/ evaluate them and select the appropriate option): children who have resorted to theft or violence when they have been unable to find other means to get their needs met or resolve difficulties they are facing.
Decision-making in various life contexts (Evaluate available options and select appropriate ones in a given situation): children who have little insight and have been unable to make informed decisions by evaluating the various options available to them and thinking through the consequences of each option—children who pick the option of theft when in financial difficulties or children who have committed murder as they has not thought of social and legal consequences of such acts.
Decision-making in contexts of romance/ relationships/ sexuality (making decisions about sexual/ relational issues with due consideration to health, safety, consent, emotional contexts of relationships) children who have sexually abused other/younger, failing to make a decision on the basis on empathy and/or of social and legal consequences that would follow; older children who have run away with their peers or with older adolescents/ adults to get married or have physical intimacy and have not thought through the implications of a marriage or (unprotected) sexual engagement.

6.2. Other Observations

(Time-place orientation/ cognitive/ thought processes/ cooperativeness, rapport, social responsiveness/ attentiveness & activity level/ speech and language skills).

Guidance Notes

This refers to any general observations about the child that the counsellor makes during the initial assessment of the child. Deficits in time-place orientation, cognition and thought processes, speech and language, and social responsiveness could mean that either the child has intellectual disability or mental health problems; attentiveness and activity levels (that are high) may add to observational evidence on attention deficit hyperactivity disorder.

Section 7: Summary and Intervention Plan

7.1. Summary

Based on the above assessment, summarize the main problems and concerns of the child, including **Vulnerability[4], Pathology[5] and Consequence[6].** Highlight areas for immediate assistance/ response.

7.2. Care Plan

List actions taken or planned by the assessment agency/ case worker to assist the child, such as psychosocial interventions, emergency actions/ measures to address immediate concerns, referrals made to other agencies.(Attach extra sheets to continue documentation).

Guidance Notes

Summary refers to a statement of the main problems and concerns of the child, using the vulnerability-pathology-consequences framework (described at the beginning of this document):

- Vulnerability needs to include significant information social history i.e. family, school, institutional, peer and child labour issues as well as abuse and trauma experiences that the child may have undergone. (Vulnerability refers to the circumstances of the offence from a longitudinal or life cycle perspective).
- Pathology should include any mental health disorder and/or substance use issues that the child may have.
- Consequences should include child's behaviours/actions, including the offence committed by the child.

Thus, the summary is a brief descriptive analysis of the child's problem.

Care Plan refers to the counselor's response to the child's problem, both in terms of initial inputs provided to the child at the end of the assessment, with regard to his/her problem as well as those planned for implementation in the immediate/near future. It includes:

(a) First level responses[7] which help initiate the process of behaviour change in the child. It entails dialogue and discussion with the child for:

- Insight facilitation
- The basis and motivation for change (other than being out of the OH)
- Future orientation (the impact of current behaviours on their future plans/ ambitions)
- Examining consequences and decision-making processes in behaviours such as stealing, violence and substance abuse and high risk sexual behaviours (pros and cons of actions)—impact on health, relationship with family and friends, on income/ economics
- Anger management and control strategies
- Conflict resolution (in brief/ with a few examples)
- Considering other people's feelings/ empathy
- Frameworks for sexual decision-making
- Anxiety management and control strategies (for children with internalizing disorders)
- Acknowledging and validating loss; using memory work for initial processing of loss experiences.
- Acknowledging and validating abuse experiences; using self-esteem and identity work methods to initially counter abuse internalizations

---

[4] Vulnerability: abuse/ neglect/ family pathology/ school drop-out issues that make children vulnerable to emotional & behaviour problems

[5] Pathology: Externalizing Disorders—ADHD/Conduct Disorder/ Conduct Disorder with Limited Prosocial Emotions; Internalizing Disorders—Depressive Disorders/ Anxiety Disorders (incl. OCD & PTSD) that are trauma-related; Severe mental illness—psychosis/ mood disorder; Life Skills Deficits—symptoms that do not meet diagnostic criteria but are life skills related.

[6] Consequences—Pathways to institutionalization & 'criminality'

[7] Reflection & perspective-taking methods are used in gentle, encouraging, non-judgmental conversation with the child; the aim is also to build a rapport with the child to enable further discussions and depth therapy work (if necessary), in order to facilitate behavioural transformation.

(b) Referral to tertiary care mental health facilities for further evaluation including psychological testing (in case more information is required for diagnostic and intervention purposes; pharmacotherapy may also be necessary for children depending on the type and severity of the mental health problems).
(d) Recommendations and/or referral for depth therapeutic work with the child (which can be undertaken either in the Home or at a tertiary care facility, depending on the skills and resources of the counsellor).
(e) Referral to other medical and health facilities in case the child is suspected of having other medical issues (based on the child's report as well as an understanding of his living arrangements and conditions in the recent past—for instance, a street child with poor access to food, shelter and healthcare over a long period of time, and having a life style with high risk behaviours may be at risk of ceratin communicable diseases for which he/she may need to be examined).
(f) Rehabilitation and training plans may be made based on the child's existing skills and interests and his/her future aspirations.

DRAFT