Psychosocial & Mental Health Considerations in Juvenile Justice:

A Framework for Judicial Response to Children in Conflict with the Law

A Training Manual for Judicial Personnel

Developed by
Community Child & Adolescent Mental Health Service Project
Dept. of Child & Adolescent Psychiatry,
National Institute of Mental Health & Neurosciences
(NIMHANS)

In Collaboration with
Karnataka Judicial Academy

Supported by
Dept. of Women & Child Development,
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"Justice for all children is the high ideal in a democracy."

--Grace Abbot

"Each of us is more than the worst thing we've ever done."

--Bryan Stevenson

Acknowledgements

At the outset, we would like to acknowledge the commitment of the Juvenile Justice Committee of the Supreme Court, particularly Justice Deepak Gupta, Judge and Chairperson of the Supreme Court Juvenile Justice Committee, and Justice Madan Lokur, Former Judge and Chairperson of the Supreme Court Juvenile Justice Committee, to children's rights and welfare. Their strong recognition of juvenile justiceissues, especially of vulnerable children in institutions, has been heartening to those of us who work in the areas of child mental health and protection.

We are grateful to the National Judicial Academy, the Karnataka Judicial Academy and the Juvenile Justice Committee of the Karnataka High Court for granting us opportunities to conduct training for judges, for, this manual is a result of several training programs implemented for their personnel.

In this regard, we thank all the Juvenile Justice Magistrates and other judicial personnel who participated in our training workshops. Their debates, insights and queries have helped us refine our thinking and pedagogies and methodologies. The Magistrates' empathy for children in difficult circumstances, their caring engagement with children in conflict with the law, and their willingness to use their power and judgements for initiating transformations in existing legal procedures for children, and for the benefit of children themselves, is truly reassuring and encouraging for our country.

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No acknowledgement would be complete without thanks to the children we have had the privilege to serve and assist—their courage in providing us with honest narratives of their difficult lives and decisions, inspire and compel us to examine our pre-conceived notions and prejudices about their situations and responses.

We hope and trust that this manual will serve as a guide for trainers and for legal personnel involved in assisting children in conflict with the law,so that these children will be treated with compassion and provided with opportunities for transformation and rehabilitation, as is their right, and as enshrined in the Juvenile Justice Act.

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Foreword

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FOREWORD

One of the problems in our criminal justice system is the inability to differentiate between the treatment of juvenile and adult offenders. Some positive steps have been taken to appreciate the distinction, such as establishing child-friendly courts, but the more pressing issue of the application of the procedural and substantive law has not yet been addressed in a satisfactory manner. So, an application for bail is treated, by and large, in a manner similar to an application made by an adult. This is contrary to the provisions of the Juvenile Justice (Care and Protection of Children) Act, 2015 but that is how it is. The treatment of child victims of crime is perhaps more unsatisfactory, but that is a subject of reform left for another day. These are issues that have surfaced in the past and continue to haunt us even today - the solution for these issues lies in educating and training key stakeholders in the criminal justice delivery system.

Over the last few years, our judiciary has been at the forefront in confronting some challenges encountered in matters related to juvenile justice. The impact of these steps has yet to be fully comprehended but there has certainly been a realization that something more needs to be done. The National Judicial Academy and several State Judicial Academies have introduced courses for sensitization of judges on the rights of children. The Juvenile Justice Committees in High Courts have been able to persuade the State Commissions for the Protection of Child Rights to pay attention to and address the gaps in the care and welfare of children, including in justice delivery issues. The National Legal Services Authority and the State Legal Services Authorities have also contributed in the effort by encouraging their lawyers to be more sensitive to the interests of the child and explore the possibilities of restoration, rehabilitation and reintegration of offenders in society. In a sense, these are still baby steps since the road ahead is long and winding.

The Manual for Judicial Personnel which provides a framework for judicial response to children in conflict with law is a seminal work which will be of immense value to judges at all levels of the justice delivery system. The reason is simply this: the judiciary has not yet recognized the necessity of going behind the crime and the criminal. Usually, the gravity of the offence influences sentencing or the criminal antecedents play an important role in sentencing. These are only superficial factors. What is perhaps more important is the psychosocial and mental health considerations - the why and how of crime. This is extremely

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relevant when the offender is a child and restoration, rehabilitation and reintegration of the offender in society is the objective. How does a professional counsel a child if he or she is unaware of the psychosocial and mental health build-up? Can a judge arrive at the right conclusion about the innocence or guilt of the accused without being able to delve into the mind of the accused? And it is only after the judge is able to do so, that a correct decision can be taken and if the accused is guilty the appropriate punishment awarded.

In the case of an accused between the ages of 16 and 18 years, the decision-making process becomes more difficult and casts a heavy responsibility on the trial judge. This is because the judge must decide whether the accused child should be subjected to an inquiry under the Juvenile Justice (Care and Protection of Children) Act or subjected to a trial in an 'adult court'. A decision taken on the basis of inputs limited only to the crime and the 'criminal' can make or break the life of a child, depending upon whether the accused is sent to the Juvenile Justice Board for an inquiry or trial in an 'adult court'. This is an example of the significance of psychosocial and mental health considerations at the initial stages of a case, rather than at the punishment stage.

The NIMHANS Community Child & Adolescent Service Project deserves compliments and accolades for preparing the Manual. This will not only assist judges and at all levels but also give food for thought to other decision and policy makers as well as judicial educators. Hopefully, the Manual will become the precursor for further research in an area that is still unexplored, but of great importance. It is time to realize that the best interests of every child, whether in need of care and protection, in conflict with law or simply an accused can be served only if all relevant factors, including those relevant to psychosocial and mental health, are fully understood and appreciated with compassion.

(Madan B. Lokur)

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29th November, 2019

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About the Manual

Why and How it was Developed

The Juvenile Justice (Care and Protection of Children) Act 2015 passed in December 2015 allows for juveniles 16 years or older to be tried as adults for heinous offences[1] such as rape and murder but which also include other offences which, though non-violent in nature, are designated to be heinous (i.e. those crimes that attract a specified duration of punishment) by the law.

This Act resulted from the public outrage, media and political pressures that ensued following the Nirbhaya case in which a juvenile was part of a gang rape of a 23-year-oldwoman in Delhi, some years ago. The reduction of age from 18 to 16 years for a juvenile to be tried as adults has been a controversial issue and has prompted enormous debates.The general public tends to use retributive justice frameworks i.e. 'if you are old enough to rape, you are old enough to stand adult trial'; child rights activists, on the other hand, believe that children in conflict with the law (CICL) should certainly be accountable for their actions but that they should receive responses based on frameworks of vulnerability and restorative justice (as opposed to retributive justice).Socio-economic and family background, education and school, experiences of trauma and abuse, and pre-existing emotional and behavioural issues, including substance abuse and neuro-developmental disabilities, should be assessed to address the pathways to offence, and interventions should be planned and provided to the child to facilitate (behavioural) transformation and prevent recidivism.

These dichotomous approaches to juvenile justice are not new and neither are the issues and concerns of CICL. But the Nirbhaya case and the December 2015 Act propelled the issue into public discourse, and consequently made it imperative for child care services and systems, particularly those addressing juvenile justice, care and protection, legal issues, and mental health issues for children and adolescents, to re-examine their systems and services, the ways in which they assist these children and provide for assessment and intervention processes.

The debates around the culpability of juveniles, including issues of seriousness of circumstances versus crime and proportionality thereof, in the current socio-political milieu have resulted in fresh complexities when it comes to dispensation of justice to CICL. Those working in the Juvenile Justice system are confronted with the challenges of straddling the above described approaches to juvenile justice i.e. considering public opinion/ pressure (and indeed, as part of the public they also have personal and ideological positions on this issue) on the one hand, and their role as Juvenile Justice(JJ) JJ service providers, on the other, wherein they are expected to act in accordance with child rights and principles of restorative justice, in keeping with the spirit of the Juvenile Justice Act.

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1. Heinous offences are those which are punishable with imprisonment of seven years or more.

Aim and Objectives

Aim: To table psychosocial and mental health contexts and issues of children in conflict with the law for discussion with JJ magistrates so that restorative justice is more effectively implemented within the JJ system.

Objectives:

- Obtain an in-depth and nuanced understanding of the psychosocial contexts of children in conflict with the law (CICL).
- Identify and analyze CICL's pathways to offence (if any), including their problem areas.
- Understand the mental health and psychosocial problems of CICL, including the assessments and interventions/ treatments that CICL should be provided with.
- Learn about referral (mental health) criteria and the types of interventions CICL require.

How it is Organized

The training begins by sensitizing judicial personnel to childhood experiences and emotions, by getting in touch with their own childhoods, including their own experiences of trauma and injustice. It moves on to facilitating reflections on current ways in which juvenile justice systems work, including bringing into focus how CICL are adversely impacted by systemic lacunae. Judicial personnel are then guided to develop an understanding of CICL using the vulnerability lens, thereby also orienting them to the psychosocial factors that lead children into conflict with the law. They are oriented to how psychosocial and mental health assessments and preliminaryassessments should be conducted with CICL and on the types of interventions that such children should be assisted to receive; finally, the training covers ways to understand and systematically administer the Preliminary Assessment as required by Section 15 of the Juvenile Justice Act, in ways that enable judicial personnel to comply with the requirements of the law but also to act in the best interests of the child. A range of experiential methods as well as case analysis and film clips are used to deliver these modules.

For Whom

The manual has been developed for training and skill development of judicial personnel of various cadres: primarily the juvenile justice board magistrates who make decisions and judgements with regard to children in conflict with the law; but also for the (other) members of the Juvenile Justice Board, as they assist the magistrates with the understanding of children's situations, including recommendations for psychosocial assistance and rehabilitation.

In fact, as per the structure and workings of the judicial system, any judge appointed as part of the state or country's judicial system might, in the future, occupy the positions of juvenile justice boardmagistrates, thereby necessitating the training of all judges in the matter of children in conflict with the law. So, this training material is for inclusion in training programs for judges in Judicial Academies across the country.

Since this manual was developed by mental health professionals, to provide a psychosocial perspective on children in conflict with law and related legal processes,

it is intended for use by facilitators with psychosocial and/or mental health backgroundsto deliver training workshops to legal personnel assisting such children. However, following the receipt of training and after some amount of field practice and experience, legal personnel may also use this manual to train their teams and colleagues. In fact, the use of the manual by both psychosocial and legal personnel would amalgamate child psychosocial and legal interests, thus greatly enriching capacity building workshops, by melding together multiple perspectives on children, mental health and justice. Since these two groups usually work together on assisting children in conflict with the law, we believe that such exchange of ideas and understanding could foster the growth of multi-disciplinary team approaches and strengthen, structure and standardize response systems to alleged offences by children, all of which are (currently) desperately needed and often lacking in our country.

Finally, it is strongly recommended that this manual be read in conjunction with **a monograph** titled **'Critical Issues in Psychosocial Care & Mental Health of Children in Conflict with the law: A Practitioner's Perspective'**. This document is also developed by the NIMHANS Community Child & Adolescent Mental Health Service Project, through extensive field work with children in conflict with the law. The purpose of the monograph is to appraise field practitioners and law and policy-makers about:

- Psychosocial and mental health contexts and issues of children in conflict with the law, so that they develop an in-depth and nuanced understanding on children's pathways to offence.
- Tools and proformas that help assess the needs and vulnerabilities of CICL, so as to be able to make appropriate decisions for reformation and rehabilitation of these children
- Intervention techniques and methods developed and used to assist these children.
- Other systemic needs and concerns that require to be addressed in order to better assist these children.

It will thus provide both facilitators and participants with more background information and depth explanations on the issues and concepts laid out in this training manual.

1. Setting the Tone: Re~connecting with Childhood

Objectives

- To sensitize participants to children and childhood experiences.
- To enable them to be aware of and alert to children's experiences and emotions, especially in difficult circumstances.

Time

1 hour

Concept…What to Say

Let us, for the first hour, set aside the issue of juvenile justice and children in conflict with the law. Let us just think and talk about children and childhood…and about children and justice, by re-connecting with our own childhoods and remembering what our lives were about then…people, places and events…how we felt—things that made us happy, sad, angry…who were we as children, how we perceived the world as children,whatwe felt and experienced…how we experienced injustice. We are going to do a simple visualization exercise to return to our childhoods.

Activity for Re~Connecting with Childhood

Method: Visualization and sharing

Materials: None

Process:

- Request participants to set aside their notebooks/pens (no note taking to be done now).
- Ask them to close their eyes and remember their childhood days. They may revisit people, places, events that occurred then.
- When they are ready (after about a minute or two), ask them to open their eyes and one by one, to share the images that came to their minds.
- Repeat the process (of visualization) asking participants to revisit childhood memories of:
  - Difficult or traumatic experiences.
  - Experiences of acute injustice i.e. incidents when they felt that some injustice had been done to them.

Note: Be prepared for some participants to become very emotional when sharing difficult and traumatic experiences. Acknowledge the courage of the participant and thank him/her for sharing his/her experience, credit the group for creating a safe space for difficult sharing…offer comfort (within the group) to the participant in a gentle and reassuring manner—before you move on with the session.

Discussion:

- What do you think was the purpose of doing this activity?
- How did you feel when you re-visited happy memories versus difficult and traumatic ones or memories of injustice?
- Who helped/ how did you cope? (What are some specific qualities you remember about this person? Or ways in which he/she did things to help you?)
- The importance of being in touch with your own childhoods so you know what it is like to be a child, what makes children happy, angry or sad…
- How this sensitivity is essential to working effectively with children…what trauma means to children, how acutely children feel injustice…
- The impact of childhood memories—how childhood events and experiences still impact us in adult life and therefore how childhood experiences, especially those of trauma and abuse, can never be undermined.

2. Opening Reflections on Juvenile Justice

Objectives

- Introducing the context of psychosocial assistance for children in conflict with the law.
- Initiating reflections on the ways in which systems respond to CICL—and the far-reaching consequences such responses can have.

Time

40 minutes

Concept…What to Say

Let us examine if or to what extent the Juvenile Justice system is able to address the needs and vulnerabilities of CICL. There are several provisions in the JJ Act itself, to do so, but are the care and protection systems and the associated legal systems making decisions that ensure the effective implementation of the JJ Act?

Consider the 16-year-old apprehended in the Nirbhaya case[2]: He was one of many children in a family that lived in abject poverty; his father was mentally ill. Due to physical abuse by a teacher, he dropped out of school and went to Delhi, and worked to earn and send money to his family. His mother saw him briefly, twice or thrice in the six-seven years after he went to the city, as a boy to find work. His jobs were the jobs of a poor boy with no education – bus cleaner, dishwasher, helper to a milkman, *dhaba* assistant. After the Nirbhaya rape incident occurred, the media reported that he was the 'most brutal' of all those who attacked and abused Nirbhaya; since there were no other witnesses on the scene of crime, this in itself is hard to establish. There were also media reports later, to say that he was being radicalized in prison. But the questions really are: where was the Juvenile Justice system for this boy when he needed care and protection i.e. before he came into conflict with the law? And what did the JJ system do to rehabilitate him after the incident (other than imprisoning him with other criminals allegedly involved in grave offences like terrorism?

Who are CICL?

- Children who have committed offence.
- Children who have not actually committed offence but happened to be in the place of offence.

Both groups i.e. children who have engaged in socially inappropriate behaviours as well as those who may not have engaged in such behaviours but are charged with doing so, have various psychosocial vulnerabilities. The latter group come into conflict with the law due to issues of wrong place and wrong time but also because they are with peer groups that engage in offensive behaviours (therein lies their vulnerability).

Children who come into conflict with the law first come into contact with the Special Juvenile Police Unit (SJPU) at the police station. Here, they may receive counseling and warning and be released, especially if the alleged offence is minor i.e. no FIR will be filed against them. Alternatively, if an FIR is filed against them, they require to be placed in the Observation Home and be produced before the Juvenile Justice Board Magistrate within a period of 24 hours. The case then proceeds with the Juvenile Justice Board, who over time, based on the evidence, makes a decision on bail and release of the child.

[2] Information drawn from media and internet sources.

Activity for Reflections on Juvenile Justice

Objectives:

- To enable participants to begin to critically think about the juvenile justice system and how it functions at each stage, after a child comes into conflict with the law.
- To facilitate reflections on the appropriateness and effectiveness of rehabilitation and repatriation as they tend to happen in the JJ system.

Method: Case Study and Discussion

Materials: Case of a child in conflict with the law as provided below.

(Source:https://www.hindustantimes.com /gurgaon/how-a-high-profile-school-killer-became-a-leading-don-in-haryana-s-underworld/story-usNuuhI7enQ5AkNh18IkWK.html)

(You may use a similar/suitable alternative).

Process:

- Share some excerpts and salient facts from the case, focusing on:
  - Child's background
  - Incidents that occurred (to bring the child in conflict with the law) and immediate impact on child and family
  - Rehabilitation and repatriation
  - Consequences to the child's life (and options available to him thereafter)

Discussion:

- The law says there has to be an individual care plan for each juvenile based on their specific needs. What kind of psychosocial support are the authorities providing?
- Is the environment of observation homes conducive to transformation and rehabilitation of children? (Or are they functioning more as detention centres?)
- To what extent are the following being addressed and by whom:
  - Developmental and life skills training needs
  - Opportunities for education, skilling, vocational training
  - Mental health issues
- Are the JJBs and other systems advocating strongly enough for CICL to be able to return and reintegrate into family and society?
- How do we expect CICL to transform and lead changed lives (if opportunities for behavior change and transformation are not provided)?

Case Study

On 11 November 2007, 14-year-old Akash Yadav, the son of a real-estate dealer in Gurgaon, took his father's imported 0.32 Harrison pistol to his private school and shot a classmate to settle a score. He was sentenced to three years in a juvenile observation home.

What happened soon after the incident:

- Aakash: 'Papa, I am sorry, I have made a mistake'
- People's View: Families moved from traditional Haryanvi villages to the "cyber" city of Gurgaon, the fathers spent their time dealing in land, and the sons felt free to follow their instincts.
- One of the witnesses said he had seen father teach his son how to fire a gun.
- Newspaper articles: Effects of the "new, property-driven wealth" and "modernity" on the "minds of these children".
- On December 11 2007, the court sent Akash back to the juvenile observation home for three years.
- His father was sentenced to a year in jail for keeping an unlicensed gun at home.

Rehabilitation: At the Observation Home

- 10 of them lived in one cell, sleep on dirty mattresses, and line up outside smelly toilets.
- Akash was one of two schoolboys in a cell packed with repeat offenders.
- Neither he nor his family talk about his experiences inside…bullying, sexual abuse, violence said to have occurred.
- Most kids survive by finding someone a few leagues above them in a juvenile jail's been-there-done-that hierarchy--Akash found an 18-year-old hitman from a village gang.
- One day, Aakash arranged a beedi for shooter M and they became best friends. It was a turning point in his life.
- Slowly, Aakash won hearts inside the observation home and began to be seen as a leader.

Reintegration: Returning Home and to Normal Life

- Akash was keen to return to "normal life".
- In 2008, he came out of the observation home on bail. He was 15.
- In 2010, he took his Class 10 board exam from an open school.
- "Then, we admitted him to a regular school…for classes 11 and 12, but a friend…joined the school a few months after, told everyone about Akash's past, and the principal asked us to take our son out," said his mother.
- The family made a few more attempts at returning him to school. "They always found out who I was and struck my name off the rolls," said Akash.
- After finishing class 12, keen on studying law, Akash went as far as Alwar in Rajasthan to enrol in a law college.
- Akash returned from Alwar unable to concentrate on studies.
- Gangs used to contact him and threaten him to join them or else face consequences. Whenever he was home, he did not come out of his room, kept slipping into depression, and used to cry.
- Since he came out of the observation home, Akash "never slept peacefully".

Options& Consequences:

- Mother: “Akash decided that enough is enough,” said Kamlesh.
- At 19 years of age, he believed he had two options: to join a criminal gang or to start his own. So, he decided to form his own gang.
- Akash and his gang members were charged with about a dozen criminal cases, including attempt to murder, robbery, snatching, extortion and assault
- Akash runs a ‘gang with a conscience’…"No robbery, no dacoity, only extortion…never been involved in dirty crimes like rape or molestation…only to “settle personal rivalries”.
- Now at age 24 years, an under-trial prisoner, convicted for shooting/ murder. He has spent three years across two jails in Haryana for his last alleged murder.

What Aakash says now:

- “I am very emotional. I get very angry.”
- Asked why he shot his classmate 11 years ago, Akash looked lost for a few moments before he spoke into his end of the twin-telephone connecting prisoners with their visitors across an iron grille: “He had been annoying me for days.”
- Would he do that again if he could go back to 2007? “No, I regret that mistake. I wanted to apologise to Abhishek’s parents. I tried to visit their house but after reaching their gate, I returned.”
- If Akash comes out of jail, he said the first thing he will do is avenge the recent murder of a cousin by an old enemy. “He killed my brother!” What about his old dreams of a normal life? “I can’t leave this world now. If I don’t kill them, they will kill me.”

3. Identifying Pathways to Offence: Vulnerabilities of Children in Conflict with the Law

Objectives

- To trace children's pathways to offence.
- To develop broad frameworks of understanding children's pathways to offence—namely, psychosocial and environmental factors, and mental health problems.

Time

1hour

Concept…What to Say

Every child's life is a journey, including of those children who arrive at the Observation Home. There have been people, events and experiences along the way...some of which have led them to pathways of coming into conflict with law. We only meet the child when he/she comes to the Observation Home—wherein we primarily know what behaviour or offence they have been admitted for. But who is this child? What was his/her journey...what are all the things that happened before, and along the way, because of which this child finally ended up coming into conflict with the law? That is what we are going to piece together in this session...so we understand the context or circumstances that led a child to the alleged offence. No two children, who may have committed the same alleged offence, have necessarily had the same journeys...and so, if we understand the journey, we can identify specific interventions to address the issues that caused a given child to get to the Observation Home.

There may be a number of factors that render a particular child vulnerable—such as poor socio-economic status, experiences of violence/ abuse/ neglect, school dropout etc. However, while these would certainly hold true for a general vulnerability analysis, the fact is that not all factors would have necessarily or directly become the child's pathways to alleged offence i.e. not all children who are abused/ school dropouts etc. necessarily come into conflict with the law. So, what are particular factors in child X's case that led him/her to the offence? For example, two children who came into conflict with the law might have both had substance abuse issues; however, one child may have committed the alleged offence in a state of intoxication (in whose case substance abuse is themajor pathway to offence) while the other child may have committed the abuse in a state of anger, which may have had nothing to do with his/her substance abuse issues at all (in which case substance abuse may not be the pathway to offence).

Activity for Identifying Pathways to Offence

Method: Mapping and story-building

Materials: Large sheets of flip chart-paper, pens/markers

Process:

- Divide participants into small sub-groups of about 5 members each.
- Give each sub-group a sheet of flip-chart paper and pens/ markers.
- At the top of the page, ask them to write the name and age of a child who might have come to the Observation Home.
- At the bottom of the page, ask them to write the offence that he/she may have committed.
- Next, the groups may start to write the answers to questions that help them build the story (journey) of the child. The questions are:
    - Family: Socio-economic status of family? Are both parents present? Father's occupation/ Mother's occupation? Relationship between parents? Relationship between child & mother/ father (good attachment/neglect/abuse)? Alcoholism/ illness or disability in parents or caregivers
    - Institutions: Was child at home or lived in other places/ institutions? What were child's experiences in these institutions?
    - School: Child in school or dropped out? Reasons for dropping out? Academic performance/ Learning issues? Experiences of abuse/ bullying by school?
    - Peers: Did the child have many friends? Older/ younger/ same age? What activities child did with friends? Spent lot of time with friends? Most of the day/ nights out? What decisions of the child did peers influence (school/sexuality/substance use?)
    - Abuse/Trauma: Experiences of physical abuse? Experiences of emotional abuse/ humiliation/ rejection? Experiences of sexual abuse
    - Child Labour: Abuse and other experiences in workplaces (remuneration/ treatment?)
    - Child Labour: Abuse and other experiences in workplaces (remuneration/ treatment?)
    - Substance Abuse: At what age and how (for what reasons) did child start using substances?
    - A description of how the alleged offence happened/ was committed i.e. what actually happened on that day/ at that time.
- When the story is complete, ask the sub-groups to examine all the details of each of their stories/ narratives, and pick the key factors (people/ relationships/ events/ experiences) that were significant in terms of leading to the child committing the alleged offence—what were the pathways of this particular child?
- Ask the participants to discuss within their sub-groups and circle the significant factors identified, in red colour.

Discussion:

- Ask each sub-group to present their child-story in plenary and explain the child's pathway to the offence—ask them to present a clear justification for the pathways to offence they have decided on.
- Invite comments and questions from all participants, enabling them to reflect on:

  i) various pathways to offence;

  ii) how these pathways differ in different children;

  iii) the implications therefore that this differential understanding would have for interventions (for example, if one child's pathway to sexual abuse offence was peer influence while another child's pathway to sexual abuse offence was experience of abuse/ revenge for the same, then the intervention for the former would focus on helping him/her cope with peer pressure while for the latter, it would focus on healing for sexual abuse experienced by him/her).

Summarize: No child is born a 'criminal'; there are various life circumstances and individual factors (that cause different children to respond to their life situations in different ways) that lead children to commit alleged offences.

4. Further Analysis of Vulnerabilities of Children in Conflict with the Law

Objectives

- To further examine and analyze vulnerabilities of children in conflict with the law.
- To obtain a more nuanced understanding of CICL's problem i.e. to understand the 'real' or underlying problems that led to a child committing behaviours that brought him/her into conflict with the law.

Time

2 hours

Concept…What to Say

There are some concepts and frameworks that help us better understand the specific problems and vulnerabilities of children in conflict with the law. Broadly, there are 7 areas of vulnerability that CICL most frequently present with. These vulnerabilities form the basis of their problems and cause them to come into conflict with the law. You may be familiar with many of them but in this session, we will explore the specifics. To say, for example, that family dysfunction is a vulnerability or pathway has no meaning unless we are really able to specify 'how' and 'in what way'. Also, not every child who comes from a dysfunctional family comes into conflict with the law. These specifics are important for making decisions relating to interventions.If a child is a school dropout, how exactly did that lead him/her to allegedly committing an offence? So, we need to be as detailed and nuanced as possible when we identify and understand a given child's vulnerabilities. Refer to the tables below for a description of each of the factors/ vulnerabilities and their specific impact on the child in terms to risk of offending.

Also, as per Section 15 of the JJ Act, the objective of the preliminary assessment of a child, is to 'evaluate the role of the child in the alleged offence, as well as his mental condition and background'. One of the questions to be answered by the preliminary assessment pertains to 'the circumstances in which he/she allegedly committed the offence'. The circumstances of the offence actually refer to the pathways to the offence (as will be discussed in detail in our session on 'Preliminary Assessments'). Therefore, specifically identifying the pathways and vulnerabilities of a given child would be critical to developing the preliminary assessment report for him/her (if applicable).

Areas of Vulnerability in CICL

Basis of CICL's Vulnerability (1): Family Factors	Impact & Consequences/ Pathways to Alleged Offence
Attachment issues, Neglect, Abuse • The families and home environments of these children are frequently fraught with marital problems, domestic violence, and alcohol dependence. • Children who are reared in families where behaviours such as power-based control, aggressiveness, stealing or encroaching on the rights of others are considered the norm. • Single-parenting, lack of time on the part of the parent to care for the child (usually due to financial problems and the need to work long hours outside the home). • Other experiences of harsh/punitive parenting/ rejection, abandonment, or relinquishment to an institution. • Lack of early stimulation and growth opportunities for holistic child development/monitoring & supervision. • Death of/ separation from primary caregivers (leading to trauma, no attachment figure for the child).	✓ Emotional Dysregulation (difficulty managing anger/ anxiety) ○ Not able to exercise control in expressing feelings of anger/ upset. ○ Extreme reaction which could amount to rage or even physical violence. ○ At such times, these children are not amenable to any reason or discussion. ○ It is almost as if an aggression switch has been turned on and cannot be put off. ✓ Neurobiological changes that occur in response to problematic early-life stress/trauma can lead to life-long psychiatric issues. ✓ Behaviour problems (violence, abuse etc)—through learning from families/ role models. ✓ Lack empathy for the suffering of others and so tend to be risk-taking, sensation-seeking, and manipulative.

Basis of CICL's Vulnerability (2): Educational Issues	Impact & Consequences/ Pathways to Alleged Offence
• Learning difficulties and poor academic performance • Financial difficulties that necessitate leaving school (and going into child labour instead). • Experiences of abuse/corporal punishment/ bullying at school.	✓ Lack of motivation or inability to continue education ✓ Truancy/ suspension/ school drop-out issues ✓ Leading to lots of unstructured time spent in neighbourhood/ with other school dropout peers. ✓ Greater risk of substance abuse and antisocial behaviours.

Basis of CICL's Vulnerability (3): Peer Influence	Impact & Consequences/ Pathways to Alleged Offence
• Tendency to like and to be liked by other aggressive/ rule-breaking children • Rejected by more socially appropriate peers • Aggressive/ Rule-breaking behaviour reinforced in the context of peer group • Being part of gangs also reinforces such children's fragmented sense of self/identity/ self-esteem.	✓ Unable to contend with peer pressure/ assert themselves/ say 'no'. ✓ Engage in high risk behaviours in keeping with peer group norms.

Basis of CICL's Vulnerability (4): Child Labour	Impact & Consequences/ Pathways to Alleged Offence
• Children from low socio-economic strata often sent away to work—sometimes to far off places. • Poor remuneration • Exploitative conditions of work. • Cruel treatment by employers.	✓ In the workplace, children live with/are exposed to older adolescents & adults: ○ who might engage in criminal behaviours and act as role models. ○ who force children to engage in such behaviours (for perverse entertainment/ pleasure or to ensure children are caught in the act and they themselves escape punishment). ○ who engage them in practices of substance abuse. ✓ 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.

Basis of CICL's Vulnerability (5): Substance Use	Impact & Consequences/ Pathways to Alleged Offence
• Substance use starts often as experimentation/ in peer group contexts (persuasion by some peers/ poor refusal & assertiveness skills in others...). • As frequency of use increases (for recreation purposes), so does drug tolerance...resulting in consumption of increased quantities of drug, more frequently...leading to dependence & addiction. • Some may use substances for coping with stress/ difficult emotions.	✓ Children may commit offence (stealing/ robbery) in order to get money to buy substances (as they may be dependent/ addicted). ✓ Children commit offence (such as acts of violence etc) in a state of intoxication/ inebriation. ✓

Basis of CICL's Vulnerability (6): Mental Health Disorders	Impact & Consequences/ Pathways to Alleged Offence
A. Externalizing Disorders: **Attention Deficit Hyperactivity Disorder (ADHD)** • A Neuro-Developmental Problem, requiring medication/ behaviour training (often unrecognized & untreated in CICL) • Inattention/ restlessness/ difficulty sticking to & completing tasks/ haste in making decisions • Uncontrolled aggressive behaviours/ poor emotional regulation • Poor social skills, inadequate social judgement and impulsivity	✓ Increased conflict with peer group. ✓ Poor decision-making skills. ✓ Sensation-seeking activities such as substance abuse, inappropriate sexual behaviour and other high risk behaviours.
Conduct Disorder • Rule-breaking behaviours of stealing, violence/ aggression/ cruelty to people & animals • Destruction of property/ use of weapons • Truancy • Threatening, manipulating others towards one's own ends • Engaging in sexual coercion/abuse • Lack of empathy and remorse/ guilt	✓ Most of these behaviours directly lead to conflict with the law. ✓ Some behaviours, especially if they are long-standing (since childhood), may lead to problems with the law later on.

B. Internalizing Disorders:

Anxiety & Depression

- Difficulty concentrating, irritability
- Lot of body aches and pains (no medical cause)
- Low energy/ tiredness/tension of muscles
- Sleep & appetite problems
- Poor self-esteem/ sense of hopelessness
- Difficulty doing daily tasks & activities
- Suicidal thoughts/ attempts

✓ Emotional dysregulation leading to angry or violent behaviours.

✓ Most common risk is substance abuse...can also involve in high risk sexual behaviour—which in turn can lead to conflict with law

Basis of CICL's Vulnerability (7):

Life Skills Deficits

- Due to lack of supervision and guidance by caregivers, typically in the contexts of family factors as detailed above, children do not develop the requisite life skills to be able to negotiate the many situations they find themselves in, on a daily basis (such as peer pressure, substance use etc).Thus, there are deficits in the following life skills (World Health Organisation):

- Decision making
- Problem solving
- Creative thinking
- Critical thinking
- Effective communication
- Interpersonal relationship skills
- Self-awareness
- Empathy
- Coping with emotions
- Coping with stress

*Children with various mental health disorders and/or substance use can also be viewed as lacking critical life skills.

Impact & Consequences/ Pathways to Alleged Offence

✓ Limited ability to process and solve problems

- ○ Seen as a threat to well-being or self-esteem
- ○ Poor ability to thinking through a problem
- ○ Urge either to retaliate or subdue the situation by aggression
- ○ Aggressive (versus non-aggressive) forms of conflict resolution.

✓ Distorted perception regarding events

- ○ Children misinterpret events.
- ○ They over-estimate harmful intent in others, believing that the outcome was not the result of environmental conditions, and the other person was in control of the behaviour that caused the negative outcome: 'You did that on purpose'.
- ○ Where outcomes are interpreted as intended and intentions are perceived as hostile, the chances of an angry/aggressive response become that much higher.

✓ High risk (sexual/ substance abuse & self-harm) behaviours

Substance Use

Additional Information on substance abuse may be presented during the discussion of the above analysis while explaining issues relating to substance use, since it is a common vulnerability in adolescents in conflict with the lawand requires some deeper understanding.

As children grow into adolescents, there are social and peer pressures that cause them to feel the need to use substances such as alcohol, nicotine, tobacco etc. Where there is greater access and availability of substances, and where it is 'normal' or common to use them, adolescents are increasingly likely to use them. For ease of understanding, the stages of substance use can be broadly viewed as follows:

Stage 1: Experimentation

Many adolescents might initially experiment with substance use, usually out of curiosity and/or under peer pressure. For many adolescents, their use of substances might stop right here. But for others, this may be the first step in addiction. In fact, the earlier they begin (such as when they are 12 to 15 years or below), the greater the risk of addiction.

Stage 2: Regular Recreational Use

A certain proportion of those who started to experiment or try a substance, will progress to occasional or even regular use of substances. At this stage some risky behaviour may also begin to occur, such as binge drinking, driving under the influence of substance or becoming pre-occupied with substances. Symptoms such as depression, anxiety and/or opposition/defiance may also begin to emerge.

Stage 3: Problematic Use

Regular use of substance tends to escalate, with increased consumption, greater frequency, and most importantly, worsening consequences: relationships with family, school and friends may be adversely impacted; problems at schools may emerge (with rule breaking, truancy etc); other antisocial activities may also lead to conflict with authorities and law.

Stage 4: Tolerance

In the early stages of substance use, adolescents need to consume relatively smaller amounts of the substance to obtain a 'high' or feel the pleasurable effects. But over time, they feel the need to consume increasing amounts of the substance, in order to enjoy the same pleasurable effects (or the same level of 'high') i.e. they have to use more alcohol then they used to, for instance. This is because with increasing amounts of substance, the pleasure pathways of the brain become less efficient…requiring more substance to stimulate them. But because the person needs to consume more of the drug to get high, does NOT mean that their body can safely handle that amount. In fact, it is this increasing tolerance (and the felt need for more quantity of the substance) that often leads to overdose.

Stage 5: Dependence

As the person's tolerance continues to grow, and they increase the quantity and frequency of substance use, they lose the ability to experience any pleasure unless they are under the influence of intoxicants. Therefore, they also tend to lose interest in other life activities such as play, academics, hobbies etc. because they no longer enjoy them. They become excessively and predominantly preoccupied with substance use over everything else (this is known as salience).

In fact, whenever their drug of choice isn't available, a drug-dependent person may go into withdrawal. Withdrawal is a set of harshly-unpleasant – and sometimes dangerous – mental and physical symptoms (headaches, nausea, sweating, loss of

appetite…) that result when the body goes into "shock" because the accustomed substance is not available. The pain and discomfort of withdrawal is often what pushes a person to continue to use and, if they had been abstaining from use, even into relapse.

Stage 6: Addiction

The final stage is addiction – a medically-diagnosable disorder that has identifiable symptoms, namely:

- *Craving* – A strong desire or sense of compulsion to take the substance
- *Tolerance*– Increasing amounts of substance required to get effects earlier produced by a lower dose
- *Loss of Control* – an inability to limitthe frequency or amount of consumption
- *Salience* – Disproportionate time spent thinking about, acquiring, using, or recovering from use – an obsession that interferes with everyday life with abandonment of other responsibilities and interests
- *Withdrawal* – Characteristic physical signs that emerge when the substance is not taken
- *Continued use despite harm*, i.e. physical or psychological health issues

To the addicted brain, obtaining and taking drugs can literally feel like a matter of life and death—which is also why substance use cause children to come into conflict with the law—it is dependence and addiction on substance, and the desperate need to procure it, that leads people to engage in antisocial activities such as stealing and violence.

The point is that substance abuse and addiction used to be thought of as a sign of 'moral weakness'; but it is (and needs to be) understood as a problem that arises out of the brain changes that occur in response to use of addictive substances. So, it is not a matter of 'will power' alone for an adolescent to stop using substances—he/she requires systematic assistance and treatment, both by way of medications and therapy/counseling (depending on the severity) to overcome substance abuse problems.

The Modified Social Stress Model[3]: This model was developed in the context of substance use—to understand the risk of substance use in children but it can be applied to children in conflict with law in a broader sense...to understand the risk of committing an offence. According to the model:

$$Risk = \frac{\text{(Dis)Stress} + \text{Normalization} + \text{Effect}}{\text{Coping} + \text{Support} + \text{Resources}}$$

Wherein:

- **Risk** refers to how likely a child is to engage in substance use behaviour.
- **(Dis) Stress** is the way a person feels (e.g., anxious, tense, burdened) in response to real or perceived stressors. A stressor may be observable (e.g., violence, poor living conditions, a physical disability), or it may be less visible to others (e.g., emotional abuse, trauma). Thus, a stressor may be a life event (accident/ abuse/ loss experiences), an enduring life strain (psychological

3. World Health Organization: MODULE 3: Understanding Substance Use Among Street Children. A Training Package on Substance Use, Sexual and Reproductive Health including HIV/AIDS and STDs. Mental Health Determinants and Populations Department of Mental Health and Substance Dependence Geneva, Switzerland. WHO/MSD/MDP/00.14 [Available on: https://www.unodc.org/pdf/youthnet/who_street_children_module3.PDF accessed on 17th January 2019].

difficulties/ illness/ lack of educational and recreational opportunities...) or everyday problems (survival issues relating to food/ shelter...). The more stress a child is under, the more likely he or she is to use substances.

- **Normalization of behaviour and situations refers to how normal and acceptable the use of substance is in a child's environment.** According to the Modified Social Stress Model, a person is more likely to become involved with substances if using substances is considered normal in the person's environment i.e. where other children/ peers and adults, in the family or neighbourhood, use or accept the use of some substances, children are more likely to use substances as well. Legality and law enforcement, availability, price, advertising/ media, and community cultures influence normalization of behaviours and situations.
- **Effect of behaviour and situations/ the experience of substance use:** Many children use substances because the substance adds something to their life such as entertainment, or it temporarily solves a problem. Children in difficult socio-economic circumstances use substances because substances lessen hunger, add excitement, decrease physical and emotional pain, induce sleep, may increase energy levels to work, improve alertness, provide a form of recreation, provide a feeling of belonging to the peer group or may even give the courage to engage in risky behaviours. If a substance produces a positive or desired experience for a street child, he or she might use it more frequently.
- **Coping or Skills to Cope** refers to competencies. These include physical and performance capabilities for daily activities, and psycho-social skills (e.g self-awareness, assertiveness, problem solving etc.) needed to deal effectively with the demands of everyday life. These skills are often called life skills. The more coping strategies a child has or the better his/her life skills are, the less likely he/she is to use substances.
- **Support** or attachments refer to personal connections to people, animals, objects and institutions i.e. children's social networks. Having at least one person with whom a personhas a close bond and a feeling of acceptance have been found to be vital to developing a sense of positive self-esteem. Social relationships and networks with people who have a positive influence on the child would make him/her less likely to use substances.
- **Resources** are used to meet physical and emotional needs. Internal resources include intelligence, capacity to work, education, vocational skills, religious faith, optimism, sense of humour, etc.; External resources include information, family, peer networks, educators, positive role models, community organizations, educational and vocational training services, health services, recreational facilities, etc. The greater the access children have to resources, the less likely they are to use substances.

While the model was developed to assess children's risk of substance use, it is applicable in the context of their risk of coming into conflict with law as well.

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In summary, understanding pathways to vulnerabilities and the dynamics of risk, gives a more useful picture of how children come into conflict with the law. Each aspect of vulnerability and risk lends itself amenable to intervention. It should also constitute the basis of conducting the preliminary assessment under Section 15 of the Juvenile Justice Act. Thus, circumstances should encompass the life circumstances of the child, and not merely the circumstances of the alleged offence.

Activity for Further Analysis of Vulnerabilities of Children in Conflict with the Law

Method: Case study analysis and discussion

Material: Case studies (there are several we have provided below but the participants may be encouraged to use any that they have also)—you may select and use as many case studies as you wish, depending upon the time available to you.

Process:

- Explain: *"We have established some broad frameworks to understand how children come into conflict with the law—psychosocial issues, environmental and individual factors, including mental health problems; and we have used those frameworks to build an assessment to understand the pathways to offence of each individual child. But the alleged offence is the final behaviour that led the child to come into conflict with the law... what the 'real', underlying problems that got him there were? Let us now go one level deeper and analyze the information we have from the assessment to identify underlying problems...we need to get to the root of the problem or what is behind the offence/ behaviour so that we can design appropriate interventions. If we don't do a deeper level of analysis, we won't know exactly what issues to target for intervention".*
- Divide participants into sub-groups of 3 to 5 members each and assign 1 (or 2 in case there are fewer participants) case studies to each sub-group.
- Ask participants to read each case study and analyze it using the concepts in the overview that you just provided and:
    - Identify the (possible) trouble spots of the child i.e. what is the 'real' or underlying problem?
    - What might have been the impact of these underlying problems? Or explain how these underlying problems would eventually have led to the child's behaviour/ coming into conflict with the law.
    - So, what issues and problems would your intervention need to address if this child were to transform and not come into conflict with the law again?
- Ask each sub-group to share their analysis in plenary, inviting others to comment and provide additional viewpoints.

Discussion:

- Return to the vulnerability framework discussed and use the case study discussions to connect the case study to the vulnerabilities and impact.
- Encourage participants to clearly state 2 to 3 areas for intervention such as anger control/ specific life skills deficits or de-addiction programs, as the case may be.

Note: *1.1 and 1.2 may appear repetitive in some ways and in fact they are somewhat similar in that they both address pathways to alleged offence. However, activity 1.1 is introductory in nature, only helping to establish some basic understanding, using an inductive approach i.e. getting participants to largely use their own observations and experiences of CICL to develop some explanations for children's behaviours/ offences. However, activity 1.2 aims to deepen analytic thinking using a more deductive approach i.e. getting participants to use certain concepts, theories and conclusions to explain individual behaviours. The two activities complement each other enabling participants to consolidate their learning through an iterative process.*

Case Studies for Discussion:

Case 1:S is a 15-year-old boy from low socio-economic background. Father has severe alcohol abuse due to which there is domestic violence and parental marital conflict at home; the child was also continually physically abused by his father. The child was regular at school until 8th grade. Then he came in contact with a group of boys in the neighbourhood / school. He started missing school to hang out with this peer group. They would steal wires from newly constructed buildings, sell them, and use the money for food; they also engaged in substance abuse, mainly beedi-smoking and solvents. Eventually, the child came into conflict with the law when he, along with his group of friends, were caught stealing a vehicle.

Case 2:V is a 16-year-old boy from a low socio-economic background. His father passed away when he was 12 years old and his mother is a rag-picker, living off the streets. Despite severe deprivation and difficulties at home, the child was given whatever he asked for, especially by his father, because he was a male child. After his father's death, V discontinued school, and started hanging out with a group of older boys in his neighbourhood and was involved in gambling, cannabis smoking and use of solvents. He also had anger/ aggression issues, usually under the influence of substance. On one of these occasions, he assaulted another person with a knife, due to which he came into conflict with law.

Case 3: T came into conflict with the law for stealing (mobile phone theft) —this is his 4th time in the observation home. He is a school drop-out, having attended school until 6th grade, after which he was at home for 2 years, not gainfully occupied. Since then, he has been working occasionally, when he 'needed money' but not on a regular or continuous basis. He has various long-standing behaviour problems-- substance abuse; lack of motivation; inattention, hyperactivity and impulsivity, (thus confirming a diagnosis of ADHD). They caused him to get into trouble at school and at home, wherein his father has often physically abused him. All attempts at 'disciplining' at home did not work. About 1.5 years ago, his mother passed away (child is unaware what type of illness she suffered) and the loss and grief he experienced caused him to re-start alcohol use (which he had temporarily quit).

Case 4:S is a 16-year old boy from very difficult financial circumstances. His father has a heart problem. The child dropped out of school to work as a day labourer in construction and support the family. The child happened to tell one of his friends that his father was very ill, and the mother was exceedingly anxious about gathering resources to arrange for the necessary medical treatments. His friend asked him to meet with him later that day, saying he would be able to help with some money. When the child went to the place of meeting, he was not aware of his friend's plans and was at first shocked when his friend took him to an empty house and broke into it. However, the child then helped his friend search the house for money and valuables which they split between them. The child went home and gave his mother the money for his father's treatment. Later, the police, who had caught the friend, also came and arrested the child for robbery.

Case 5:P is a 14-year-old child from a single parent family. He never went to school and was a child labourer. He usually spent time with his neighbourhood friends who were mostly older than him. One time, they had shown him pornographic videos after which the child was curious about sexual relationships. The next day, the child took one of the young boys in his neighbourhood, an 8 year old, to an abandoned building nearby and touched the young child inappropriately on his genitals, following which he came into conflict with the law when the young child complained to his parents.

Case 6: H is a 15-year-old boy from an upper middle-class family. He went to an expensive private school where he was in a romantic relationship with his classmate. After some months, the girl no longer wanted to be with him, told him so and started going out with another boy. H was very angry. He hacked into the girl's e-mail account wherein he found that she had some nude photographs of herself (that she was sending to her new boyfriend). The child sent those photographs to everyone in his class (including the girl). The girl's parents lodged a complaint to the school and police after which the child was charged under POCSO.

Case 7: M is a 17-year-old boy from middle socio-economic family. He had completed 10th standard and started working in a garage. He was in a mutually consenting, romantic relationship with a 16-year-old girl who lived in his neighbourhood. Their families, however, opposed the relationship. Fearing that they would be separated, the boy and girl ran away to another town and 'got married' in a temple and lived together for 6 months (the boy was working in someone's estate). The parents lodged a police complaint and when the boy and girl were found, the boy was charged with kidnap and rape (POCSO).

Case 8:N is a 16-year-old boy in a mutually consenting romantic relationship with a girl in his class. They had already made long term plans of marriage. The girl told N that she was afraid that her parents may get her married to someone else later. So, she suggested to him to take nude pictures together and send them to their parents—so that 'they will have to get us married'. N was not sure this was the right thing to do. But when he refused, the girl said: 'if you love me, and you really want to marry me, you would do this...else, it means you don't...and I will commit suicide'. So, N finally gave in and took nude pictures and sent them to their parents, following which the girl's parents complained and he was charged under POCSO.

Case 9:Y is a 15-year-old child from a single-parent family; his father (who died) was alcohol-dependent and there was domestic violence at home, also directed at the child. He decided to drop out of school and started to engage heavily in substance abuse—mainly alcohol and solution. He started to steal, along with his peers, in order to procure substance. He had a system with his peers, of sharing the substances they managed to procure. During one of these times, there was a conflict. The child over-heard his two peers plotting to kill him; so, when they fell asleep, he decided to hurt them really badly so that they would fear him. But in doing so, he ended up killing them. He came into conflict with the law for murder.

Case 10: Vis from a middle-class family with no significant family problems (i.e. no domestic violence/parental marital conflict/financial stress). The child has no intellectual or developmental disabilities nor does he have any emotional problems; he has had no difficult experiences of abuse and trauma either. He has a long history of behaviour problems relating to stealing, aggression, truancy and other rule breaking behaviours as well as substance abuse (namely alcohol, tobacco and cannabis). He had been bothered frequently by an older adolescent—who was known for bullying children and youth in the neighbourhood. Thus, V decided to 'finish him' and one day, under influence of alcohol (which he drank in order to have 'more courage'), killed the adolescent, following which he came into conflict with the law.

5. Psychosocial & Mental Health Assessments of Children in Conflict with the Law

Objectives

- To orient judicial personnel on psychosocial and mental health assessment proformas for children in conflict with the law.
- To enable them to understand the basis on which individual care plans, including referral and rehabilitation, are developed.

Time

1 hour

Concept…What to Say

Key Premises for Providing Psychosocial and Rehabilitation Assistance to CICL:

- There is an innate belief that all children including those who have emotional disorders, as well as children who have committed offence and are in conflict with the law, have the potential for (behaviour) transformation. Inherent in this is that any treatment or therapeutic intervention also assumes that children and adolescents have the potential for transformation. If we did not believe this, there would be no need to try to provide treatment at all.
- Whether or not transformation can occur can only be determined after adolescents receive opportunities for process-oriented reflection and life skill acquisition and training, and other requisite treatment and interventions. Not providing for these are akin to child right violations, and contradictory to the care and protection objectives as envisaged by the Juvenile Justice Act.
- The child is and certainly should be held accountable for the offence committed i.e. there are and must be consequences to the offending child. But the method of accountability cannot be those that are used for adults, or in adult criminal justice systems, nor can the consequences be the same. This is because adult and juvenile justice systems differ in their basic objectives: the goal of the adult system is to punish; the goal of the juvenile system, on the other hand, is to rehabilitate and serve the minor's best interest.

Objectives of psychosocial & mental health assessments for CICL

- To examine the (seriousness of) circumstances that the children come from and address the neglect/ abuse and trauma issues and life skills deficits thereof.
- To ensure restorative and transformation processes which address accountability and encourage the under-taking of responsibility by enabling children to understand the impact of their actions on victims/community and repairing harm.
- To identify psychiatric and/or personality issues and life skills deficitsin children and implement interventions accordingly.

Considerations for developing the psychosocial and mental health assessment…

- To ensure quality psychosocial assessment that provides a clear picture of the circumstances of the offence; one that also considers issues of proportionality, through eliciting detailed information on children's experiences at home, in school, in the workplace, of abuse and trauma, and mental health problems. The tool needs to be more than a mere socio-demographic report that provides only 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.
- To accommodate legal concerns of using a 'validated' tool. The tool therefore includes some validated checklists and scales, mainly for diagnosis of mental health disorders. 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 counsellors to assess children for mental health disorders.
- While the tool is detailed and requires some practice (following which its use becomes easier and faster), it is developed on the premise that 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.

  [Note: The Social Investigation Report (SIR) that is used in many parts of the country is inadequate in that the information is too generic and not sufficient to develop rehabilitation and care plans for CICL. We do NOT therefore recommend using these as they are unlikely to enable the JJB in making nuanced decisions to assist CICL].
- 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.

Psychosocial and Mental Health Proforma for CICL

A psychosocial and mental health 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:

  - Internalizing disorders (such as Anxiety/ Depression) and externalizing disorders (such as Attention Deficit Hyperactive Disorder, Conduct Disorders and Substance Abuse) and the processes therein (such as emotional dysregulation, social judgment issues).

- Developmental problems such as Intellectual Disability and Specific Learning Disabilities

iii) Consequences refer to the offence committed, including acts of aggression, stealing, and other behaviours that result in a child coming into conflict with the law.

The assessment proforma elicits information on the following issues:

- **Basic Information (**Name/ Age/Sex/ Location/ Place of Origin; Reasons for current institutionalization--circumstances of coming to the institution, including offence for which child is in the institution –according to the institution staff and police complaint)
- **Social History**
- **Family Issues Identified** (Child's living arrangements/parental relationships/ child's emotional relationship & attachment to parents/ illness & alcoholism in parents/ single-parenting, any experience of loss suffered by the child…)
- **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).
- **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).
- **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).
- **Peer Influence** (Time spent with peers/Which group of friends /Age of friends/ kind of activities or games played/Extent of influence of peers –in the context of school attendance/drug use/sexuality)
- **Trauma & Abuse (Loss & grief experiences; physical, sexual & emotional abuse experiences)**
- **Mental Health Issues**: Standardized/ validated symptom checklists were included for common mental health disorders, namely anxiety, depression, ADHD, conduct disorder (these are drawn from the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID)[4] (a widely used psychiatric semi-structured diagnostic interview for children and adolescents). Intellectual disabilities also need to be identified and children referred to mental health services for IQ testing; likewise, specific learning disabilities, which in turn may be responsible for school dropout problems, require to be assessed through use of appropriate psychological tests.

4. Sheehan DV, Sheehan KH, Shytle RD, Janavs J, Bannon Y, Rogers JE, et al. Reliability and validity of the Mini International Neuropsychiatric Interview for Children and Adolescents (MINI-KID). J Clin Psychiatry. 2010 Mar;71(3):313–26.

❖ **Substance Abuse:** Adolescent Alcohol and Drug Involvement Scale (AADIS)[5]. This tool captures information on reasons for use of substances, frequency and start of use so that the information gathered can directly be used to develop (substance use) therapy goals and interventions for the children.

Interpreting 'Potential for Transformation'

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:

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

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

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

5. 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).

Assessing Potential for Transformation is for Mental Health Understanding, Not Legal Decision-Making!

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

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

❖ **Potential for Transformation**

- **Child's Account of Offence** (Circumstances of coming to the institution, including offence for which he/she is in the institution)
- **Child's insight** (Child's understanding of the problem)
- **Motivation for change (**One reason for staying out of trouble may be because the childdoesn't want to get put into an institution. What are some other reasons, according to the child, to not engage in the actions/ behaviours that brought the child to the institution in the first place?)
- **Skills to avoid (re) offending:** What arethe child's future plans in terms of staying out of trouble? What are some things the child may do to ensure it?

❖ **Life Skills Deficits** (WHO life skills—such as emotional regulation/ empathy/ assertiveness/ problem-solving/ decision-making – that the child demonstrates gaps in)

❖ **Other Observations** (Current Mental Status Examination: Time-place orientation/ cognitive/ thought processes/ cooperativeness, rapport, social responsiveness/ attentiveness & activity level/ speech and language skills).

❖ **Summary and Intervention Plan**

- **Summary** (main problems and concerns of the child, including Vulnerability[6], Pathology[7] and Consequence[8])
- **Care Plan** (first level responses/ recommendations for further evaluation/ interventions incl. pharmacotherapy & rehabilitation/ training).

[Refer to the Annex 1& 2 for a copy of the Mental Health Assessment Proforma and Guidelines on the Assessment Proforma].

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

7. Pathology: Neurodevelopmental disorders – Intellectual Disability, Attention Deficit Hyperactivity Disorder, Specific Learning Disability, etc.; Externalizing Disorders—ADHD/Conduct Disorder/ Conduct Disorder with Limited Prosocial Emotions; Internalizing Disorders—Depressive Disorders/ Anxiety Disorders (including OCD & PTSD) that are trauma-related; Severe mental illnesses—psychosis/ mood disorder; Life Skills Deficits—symptoms that do not meet diagnostic criteria but are life skills related.

8. Consequences—Pathways to institutionalization & 'criminality'

Activity for Psychosocial-Mental Health Assessment (I)

Method: Discussion
Material: Assessment Proforma--1 copy to each participant, See Annex I for proforma. *[Detailed Guidelines on the assessment proforma are also available in Annex II—it is recommended that the facilitator reads them and also provides copies to participants].*
Process and Discussion:

- Help participants familiarize themselves with the assessment proforma:
  - Discuss each question in the assessment proforma i.e. go through it, ensuring that participants understand how to ask questions and record information on various items.
  - Also discuss the nature of information emerging from each question and how it is useful/ how it will feed into intervention and rehabilitation plans.

**This proforma may be used along with the existing SIR forms.*

Activity for Psychosocial-Mental Health Assessment (II)

Method: Film Clip Viewing and Discussion

Material: Training film clips on:

- 'Assessment-How to Get Started'
- 'Assessment-Peer Influence'
- 'Assessment-Trauma and Abuse'
- 'Assessment-Eliciting Child's Account of Offence'
- 'Assessment-Insight, Motivation and Skills'

[These clips demonstrate how to inquire/ elicit information on certain, more complex sections of the assessment proforma].

Process:

- Screen each clip (and follow it with the discussion).
- Ask participants to observe the counselor's use of the assessment proforma and how she conducts the inquiry, using counselling skills (all the ones we have learnt).

Discussion:

- Invite participants to share their observations.
- Explain that this is a demonstration of how psychosocial work/counselling should be conducted with CICL—and that they may also adopt similar ways of communication with CICL.

**Note:* *This film clip viewing and discussion activity may also be done before the previous activity of getting participants to try out the proforma i.e. they may view the clips and then try administering the proforma.*

6. Implementing Section 15: Preliminary Assessment Reports

Objectives

- To understand what the preliminary assessment entails (under Section 15 of the Juvenile Justice Act 2015).
- To learn how to develop a preliminary assessment report, in accordance with principles of child rights and child's best interests.

Time

1 hour 15 minutes

Concept…What to Say

Proportionality, Culpability, Excuse and Mitigation

An understanding of four legal terms, namely those of proportionality, culpability, excuse and mitigation is essential to both understanding and implementing the preliminary assessment (report) provision contained in Section 15 of the Juvenile Justice Act 2015.

The concept of **proportionality**, in legal terms, means that **fair criminal punishment is measured not only by the amount of harm caused or threatened by the alleged offender but also by the his/her culpability or blameworthiness**. So, how culpable juveniles are, requires us to consider the developmental processes and abilities of adolescents as well as the conditions and circumstances in which the offence was committed.[9]

It is important to differentiate between the constructs of excuse and mitigation: in law, **excuse refers to complete pardon of a criminal defendant i.e. he/she does not bear any responsibility for the crime and consequently, receives no punishment.** For example, crimes committed under circumstances of coercion may be excused, such as an individual who acts at gun point.[10,11]In such a situation, a binary judgement of guilty or not guilty, is made. However, in crimes that are committed under less stressful circumstances, the construct of mitigation, as opposed to the one of excuse, would apply. In this, the culpability of the offender would lie somewhere on the continuum of criminal culpability, and consequently, the punishment would also lie on a continuum. Thus, **mitigation is considered when an individual has committed a criminal act for which he/she is culpable enough to be held responsible but the individual's capacities are sufficiently compromised or the circumstances of the crime are sufficiently coercive, to justify less punishment**.[12] For instance, if the individual has mental illness that

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9. Scott, E.S, Steinberg, L. (2003). Blaming Youth. *Texas Law Review*, *81*, 799.
10. Robinson, P. (1997)*. Criminal law. New York: Aspen*. New York: Aspen.
11. Wasik, M. (1977). Duress and criminal responsibility. Criminal Law Review, 453–74.
12. Steinberg, L., & Scott, E. S. (2003). Less guilty by reason of adolescence: Developmental immaturity, diminished responsibility,and the juvenile death penalty. Am Psychol. *American Psychologist*, *58*(12), 1009–1018. Retrieved from: http://citeseerx.ist.psu.edu/viewdoc/citations;jsessionid= D48D35D7946E1A1A0 BBE62DBC603E8D7?doi=10.1.1.334.9858

adversely impacts his/her decision-making, but is not severe enough to be considered as insanity that would warrant exculpation, the severity of punishment maybe reduced.[13]

Public opinion on juvenile offenders tend to be heated and somewhat vengeful on the one hand, and ill-informed on the other. In India, as in other countries, lay persons do not understand the concept of proportionality i.e. there is a tendency to focus only on the nature and severity of the offence, whilst completely ignoring factors such as developmental stage and limitations of adolescents, and the circumstances of the offence. Furthermore, there is an inability to distinguish between excuse and mitigation—with lay persons tending to view mitigation as a process by which adolescents are not held accountable at all for their actions, that they are not being punished or that a lenient view is being taken towards adolescents due their age.

This poorly informed, one-sided view has in turn led the public to push strongly for the government to 'take appropriate action' against adolescents in the interests of 'public safety'—such actions, invariably refer to punishments, including public demand that adolescents who commit 'adult' offences should receive the same punishments as adults do. Such public pressure actually resulted in the enactment of the new Juvenile Justice Act 2015, along with the incorporation of Section 15 which is about the transfer of older adolescents (between 16 and 18 years) for trial in the adult criminal justice system.

Interpreting Section 15

Section15 of the Juvenile Justice Act 2015 states that *"In case of a heinous offence alleged to have been committed by a child, who has completed or is above the age of sixteen years, the Board shall conduct a preliminary assessment with regard to his mental and physical capacity to commit such offence, ability to understand the consequences of the offence and the circumstances in which he allegedly committed the offence, and may pass an order in accordance with the provisions of subsection (3) of article 18"*.

Article 18 discusses the options available to the JJB in terms of their direction to the child: these range from "*allow[ing] the child to go home after advice or admonition by following appropriate inquiry and counselling to such child and to his parents or the guardian, direct[ing] the child to participate in group counselling and similar activities, order[ing] the child to perform community service under the supervision of an organisation or institution, or a specified person, persons or group of persons identified by the Board to order[ing] the child or parents or the guardian of the child to pay fine."* The article states that depending on the best interests of the child, the JJB may also pass orders for the child to be in a place of safety and/or additional orders for the child to attend school/ vocational training centres/ therapeutic centres or undergo de-addiction programs.

Furthermore, while the JJ Act also says, in article 18 *that "Where the Board after preliminary assessment under section 15 pass an order that there is a need for trial of the said child as an adult, then the Board may order transfer of the trial of the case to the Children's Court having jurisdiction to try such offences*", interestingly, the explanation for article 15 clarifies *"…that preliminary assessment is not a trial, but is to assess the capacity of such child to commit and understand the consequences of the alleged offence".*

13. Bonnie, R., Coughlin, A., & Jeffries, J. (1997). *Criminal law*. New York: Foundation Press.

The general interpretation of Section 15 of the JJ Act is that preliminary assessments are conducted in order to make decisions for transfer of trial of 16-18 years old children to the Children's Court and to conduct trial of the child as an adult. However, when article 15 and 18 are read together, it also appears that the JJ Act states that preliminary assessment is to be used not to make decisions regarding the trial, but to make decisions that assist children with rehabilitation and reformation (as evident in article 18).

One of the premises on which CICL work is based is the existing law and the relevant professionals need to be able to use the legislation, namely the Juvenile Justice Act, 2015, to address CICL concerns. Indeed, the JJ law has sufficient provisions to be able to provide assistance to CICL in a proactive manner, so that their problems are alleviated within the JJ system (so that these children are not transferred to the adult criminal justice system).

Why Both Child Rights Activists and Child Mental Health Professionals are not in Concurrence Section 15 of Juvenile Justice Act 2015

The issue of preliminary assessments for CICL has been much debated and it is ridden with controversy.Many child mental health professionals have disagreed with Section 15 as it appears in JJ Act 2015--the reasons pertain to neurobiological, psychological and sociological issues, all of which together have a bearing upon the rights and welfare of CICL.

Neurobiological reasons pertain to brain development in children and adolescents. The prefrontal cortex, also called the brain's rational part is responsible for many brain functions that pertain to impulse control and control and organization of emotional reactions, focus and organization of attention, complex planning and adjustment of complex behaviour. This is the part of the brain that responds to situations with appropriate judgment and an awareness of long-term consequences. Most neurologists agree that the prefrontal cortex continues to develop well into the third decade of life, which is why adolescents do not have the full use of this part of the brain; and consequently, their difficulty in making decisions and judgements in ways that adults see as socially inappropriate.

The amygdala, also called the brain's emotional part, is associated with emotions, impulses, aggression and instinctive behaviour. Changes in this part of the brain also continue into early adulthood, especially in terms of the prefrontal cortical control on the amygdala. Because the prefrontal cortex is still developing, adolescents tend to respond according to their amygdalar, or emotional, reactions in making decisions and solving problems i.e. they rely more on their amygdala compared to adults who rely more on the prefrontal cortex. That adolescents use the emotional part of their brain more than the rational one (which is still not fully developed), explains a great deal of their functioning and behaviours in terms of aggressiveness and impulsivity.

Crudely explained, the mechanisms responsible for impulsivity controland social judgement, are not fully developedin the adolescent brain; these mechanisms of the brain continue to grow and develop until an individual enters his/her mid-twenties. Therefore, expecting adolescents to be perfectly functional on issues that pertain to impulsivity controland social judgement is akin to expecting an individual without a leg to run fast (or a 7-month-old infant to walk)!

Psychological and sociological reasons pertain to a plethora of individual and social vulnerabilities that CICL are subject to. Social vulnerabilities are the life circumstances referred to in the previous chapter, by way of socio-economic status, family dysfunction, problems with educational abilities and opportunities, and child labour. Individual and psychological vulnerabilities pertain to experiences of trauma

and abuse, mental health morbidities and life skills deficits. Of course, psychological and sociological vulnerabilities are inter-connected, with one leading to the other.

We use the term 'most vulnerable' in the context of CICL also because when they enter systems for children who are vulnerable and need protection (there are many such children —all those in need of care and protection because they are orphaned, abandoned, neglected, abused, chronically ill, disabled…), CICL are rendered more vulnerable because of how they are viewed by society and child care service providers alike: unlike other children in the care and protection section who are empathized with and seen to be deserving of various forms of support and assistance. CICL are viewed as 'criminals' and therefore undeserving of empathy, support or help. Thus, society and service providers both find it difficult to recognize the inherent vulnerabilities that CICL have, and that in fact they have the same type of vulnerabilities that children in need of care and protection do. Hence, our view that every child in conflict with the law was once a child in need of care and protection, and still continues to be. Consequently, child rights activists and child mental health professionals have been deeply concerned that the provisions of the JJ Act 2015 would only serve to further 'criminalize' these vulnerable children and exacerbate the existing negative views about them amongst the general public and child care service providers—versus providing them with the same level of care, protection, and opportunities for transformation that the care and protection category of children receive.

So, why child rights activists and child mental health professionals were (and continue to be) concerned about Section 15 was because they felt that in the framing of this section, the above-described developmental issues and vulnerabilities were not taken into consideration. As a result, the provisions of Section 15 are not seen as being in keeping with the objectives and spirit of the juvenile justice system and of the Act, nor with the rights of one of the most vulnerable child populations.

Why the Preliminary Assessment Proforma was Developed

Whether or not child rights activists and mental health professionalsare in concurrence with Section 15, the law has been passed, and for now, it is here to stay. Judicial personnel, too, have their individual opinions about Section 15, i.e. there are those Juvenile Justice Board (JJB) magistrates who state that they do not agree with it and will not ever resort to transfer; and then there are those who wish to adhere strictly to the rule book and ask for preliminary assessments, with a view to make decisions about transfer. The point is that our personal or professional opinions and ideological disagreements about Section 15, as valid as they may be, cannot control what happens across the country in various JJBs.

Those JJB magistrates who (either because they are in ideological agreement with Section 15 or feel that they are duty-bound to make strict interpretation and implementations of the law) comply with Section 15 have, over the past two years, been asking for preliminary assessments to be done. They tend to request psychiatrists and mental health professionals (in the districts they are based in) to provide these assessments.One of the difficulties the magistrates express is that these mental health personnel send preliminary assessment reports that are uninformative and arbitrary; in fact, many of them report that currently they often just receive one-line reports to say that 'the child is mentally and physically fit'—which is both meaningless and useless.The kind of preliminary assessment report a given mental health professional may provide to the JJ Board would depend on a number of variables such as:

- His/her views on the Section 15 and its implications (there are those who are ideologically against the new Act and therefore are reluctant to comply/ implement preliminary assessments);

- The depth and nuance of his/her understanding of these children and their needs and vulnerabilities (seeing CICL as 'problem' children having conduct and behaviour issues that merely require behavioural modification versus being able to understand the circumstances of the offence in terms of the individual and social vulnerabilities of these children).
- Extent of knowledge and skills in child mental health (which also depends on the amount of work/ practice of the professional in child mental health).

If preliminary assessments are implemented by untrained, inexperienced mental health professionals, who do not understand the contexts and vulnerabilities of CICL, this will not be beneficial to children at all. On the contrary, it is harmful to children when reports say that they have the mental and physical capacity to commit offences. The NIMHANS Department of Child & Adolescent Psychiatry, including its community-based/outreach initiative has been gradually working to train childcare protection and mental health workers in different parts of the country, so as to skill them to assist CICL and the JJBs. This effort is on-going and is likely to have to continue in the coming years, to reach childcare and protection systems across the country.

Addressing Concerns about CICL's Risk of Self-Incrimination

One of the concerns of professionals who are against preliminary assessments is that the preliminary assessment report could be used for further (and longer-term) detention of the child—that evidence on substance abuse or life skills deficits, for instance, could be 'self-incriminating' or work against the child if a JJB magistrate decided to transfer the child to be tried as an adult. In fact, this formed one of the reasons for the development of a systematic, standardized proforma i.e. to reduce the risk of CICL continuing to be 'criminalized' in case they 'confessed' to their actions. If JJB magistrates were trained to interpret the preliminary assessment as intended, and in keeping with the JJ Act, such self-incrimination is unlikely to happen. This means that even where the child admits to having engaged in an offence, the JJB magistrate also focuses on examining his/her vulnerabilities i.e. psychosocial factors that led him/her to the offence—in order to understand how best to assist or rehabilitate the child.

Our experiences have shown that when Observation Home Superintendents and JJB magistrates and board members are proactive in asking for psychosocial and mental health assessments and preliminary assessments for CICL, it can actually reduce the amount of time children spend in the institution; prompt and speedy assessments and care plans can ensure that JJB cases are efficiently dispensed with (thereby reducing pendency), and more importantly, that children can move on to receiving the assistance they require to get their lives back on track.

Thus, another reason for developing the preliminary assessment proforma was to avoid random, uninformed opinions professed by various mental health professionals. In addition to developing the proforma for standardized assessments to benefit child rights and child mental health (not favouring transfer), the NIMHANS team is also working to systematize the use of the proforma by mental health professionals who are trained in the use of the assessment proformas.

Finally, the main purpose for which we developed the preliminary assessment was to ensure the initiation of opportunities for children's transformation—for this to happen, JJB magistrates, and the judicial system as a whole, have to make a paradigm shift

from retributive to reformative approaches of justice because child welfare and protection systems are required to adopt the latter measures of justice—and the preliminary assessment report developed by NIMHANS is designed to help the system make this shift. Any disagreement on the need for reformative approaches in child welfare systems goes against the very essence and spirit of the JJ Act, and nullifies its objectives. Why would India create a juvenile justice system i.e. a system distinct from that for adults, including a juvenile justice board to deal with CICL, a system detached from the adult criminal justice system, if its intention was not to create a different ideology and unique way of functioning, when dealing with children?

Furthermore, it is assumed that the JJ Act includes CICL and makes special provisions for them (versus placing this category of individuals under the adult justice systems) because of (i) an acknowledgement of the risks and vulnerabilities faced by CICL; (ii) a belief that children (perhaps more so than adults), given their age and life stage, have the potential to grow, develop and transform, if presented with appropriate opportunities and support to do so.

The preliminary assessment was therefore developed with an understanding of the psychosocial and mental health vulnerabilities and needs of CICL, with a view to steer the juvenile justice board and system in the direction of restoration, rehabilitation and re-integration of these children.

How the Preliminary Assessment was Developed

Despite a lack of agreement, on the part of child mental health professionals, with Section 15, considering the importance of the preliminary assessment and the bearing it will have on an individual child's case, the assessmentwas developed after much thought and debate, with advice and guidance from legal experts, to ensure that the questions in the JJ Act were answered but in a manner that a) recognized a given child's unique context and vulnerabilities; b) ensured thebest interests of the child i.e. giving him/her a chance for transformation and rehabilitation[14].In other words, the erstwhile described concepts of proportionality and mitigation were used as a basis to develop the preliminary assessment report.

Furthermore, child and adolescent mental health approaches were used to develop a methodology to resolve the proportionality-culpability debate in India, to enable the juvenile justice system, including legal personnel, to implement the law regarding transfer of adolescents to the adult criminal system for trial in such a way as to ensure:

- Decisions that consider the best interests of the child, including the child's safety and retention within the juvenile justice system.
- The enforcement of child rights, so as to allow juvenile offenders to receive opportunities for development and rehabilitation, in ways similar to other vulnerable children who fall within the state juvenile justice system.
- The recognition and understanding of child psychosocial care issues (especially of children in difficult circumstances) and how difficult individual, familial and social variables adversely influence children's behaviours and actions.

14. It is to be noted that the Department of Child & Adolescent Psychiatry, NIMHANS, is strongly in favour of child rights and given its understanding of child mental health issues, especially of children in difficult circumstances, the team was against the provision in the December 2015 JJ Act i.e. regarding the transfer system for 16+ year olds.

- Access to assistance to juveniles, by way of treatment, rehabilitation, transformation and (social) reintegration.

The preliminary report proforma was developed through revision and iterative processes, through use of interviews and mental health intervention-related work with CICL in the Observation Homes. The preliminary assessment uses information from the detailed psychosocial and mental health assessment (that is done first) i.e. the preliminary assessment report proforma is not administered to the child, rather it draws upon interpretations made during the detailed psychosocial and mental health assessments.

The preliminary assessment report and the psychosocial and mental health assessment are closely related: the development of the preliminary report requires the detailed psychosocial and mental health assessment proforma to be completed; the information from the detailed assessment is then used to complete the preliminary assessment report.

Differences between Mental Health-Psychosocial Assessment & Preliminary Assessment

Mental Health-Psychosocial Assessment	**Preliminary Assessment**
Administered to all children who come into conflict with the law and used to plan treatment and rehabilitation interventions for them.	Applicable only for those who are between ages 16 and 18 years, for heinous crimes (as defined by law), upon request by the Juvenile Justice Magistrate.
Conducted first (before preliminary assessment) and directly with the child.	Developed (filled out) based on the detailed psychosocial-mental health assessment; and does not require any further inquiry with the child.
Among other things, it contains an account, i.e. the child's version, of the alleged offence committed.	Does not include any details of the offence incident; it focuses only on the broader psychosocial contexts and circumstances or vulnerabilities of the child (that may have led to vulnerability, and tocommitting theoffence).
Primarily for use to design care plans/ interventions to assist the child—so, from a psychosocial perspective, the child's confidentiality needs to be maintained.	Any details that the child has disclosed in confidence in the mental health psychosocial assessment (especially regarding the offence) are not shared in the preliminary assessment report.
Even in cases where preliminary assessments are not done, the information from this proforma is summarized into a letter and shared with the JJB.	Submitted to the Juvenile Justice Board, when requested.

Both the detailed psychosocial assessment and preliminary assessment report seek to be fair in that they believe that children must be accountable and responsible for their actions—indeed the premise of psychosocial and behaviour change interventions are to acknowledge that a child's action has been problematic. Thus, the assessments/ reports do not aim to absolve children from culpability. However, in keeping with the spirit of the JJ Act and the fact that child offenders must be treated

differently from adult offenders, they seek to provide an account of the circumstances in which the offence occurred so that an individual child's circumstances may be understood, in all their uniqueness and distinctiveness, and the necessary assistance provided to the child, to also prevent recidivism.

Components of the Preliminary Assessment Proforma

A. Mental & Physical Capacity to Commit Offence

The child's ability to make social decisions and judgments are compromised due to:

i) **Life skills deficits** (whether the child have any deficits in emotional regulation/ difficulty coping with peer pressure/ deficits in assertiveness & negotiation skills/ problem-solving/ conflict-resolution/ decision-making).

ii) **Neglect / poor supervision by family/poor family role models**

iii) **Experiences of abuse and trauma** (whether the child has experienced either physical/emotional/ sexual abuse).

iv) **Substance abuse problems**

v) **Intellectual disability** (does the child have any mental retardation?)

vi) **Mental health disorder/ developmental disability** (whether the child has mental health issues or any developmental disability).

vii) **Treatment/ interventions provided so far**: whether the child has received any treatment interventions provided so far to address the above issues.

B. Circumstances of Offence

i) **Family history and relationships** (child's living arrangements, parental relationships, child's emotional relationship & attachment to parents, illness & alcoholism in the family, domestic violence and marital discord, if any).

ii) **School and education** (child's school attendance, Last grade attended, reasons for child not attending school- whether it is due to financial issues or lack of motivation, school refusal, corporal punishment, if any).

iii) **Work experience/ Child labour** (why the child had to work/ how child found the place of work, where he was working / hours of work and amount of remuneration received, was there any physical/emotional abuse by the employer and also regarding negative influences the child may have encountered in the workplace regarding substance abuse etc).

iv) **Peer relationships**- (adverse peer influences in the context of substance use/ rule-breaking/inappropriate sexual behaviour/school attendance)

v) **Experiences of trauma and abuse (**physical, sexual & emotional Abuse experiences)

vi) **Mental health disorders and developmental disabilities**: (Mental health disorders and developmental disabilities that the child may have).

C. Child's Knowledge of Consequences of Committing the Offence:

A brief about the child's Understanding of Social/ Interpersonal and Legal Consequences of Committing Offence along with the child's insights regarding committing such an offence is provided.

D. <u>Other Observations & Issues</u>

Any other observation made during the assessment regarding the child's social temperament/ child's behaviour in the observation home/ level of motivation for change/ if any positive behaviour noted, is also provided.

Finally, the report makes recommendations for treatment and rehabilitation interventions for the child.

Who Administers the Preliminary Assessment

Who the preliminary assessment report is administered by, seems to differ from one Indian state to another, and perhaps also from one JJB to another. In Bangalore Urban, for instance, perhaps due to the accessibility of the Department of Child & Adolescent Psychiatry, NIMHANS, the JJB refers all children requiring preliminary assessment to the department's child psychiatry out-patient services; in Uttar Pradesh, in some places, the JJB magistrate administers it while in others, there is no systematic administration of preliminary assessment on which to make decisions regarding transfer—JJBs simply transfer all children between ages 16 and 18 years, who have allegedly committed a 'heinous' crime.

While the Act states that preliminary assessments should be conducted by the JJB, it may be preferable for children to be sent to mental health services for complete psychosocial and mental health assessments, on which preliminary assessments are based. That said, most mental health services in the country are not aware of the nuances of the JJ Act, nor how to work with CICL, including administration of mental health and preliminary assessments for them. NIMHANS has completed training of the ICPS staff in some states and will shortly be initiating country-wide training for childcare service providers and mental health care professionals, in order to equip them with the skills to assist CICL and serve as points of referral for the JJBs.

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As Harsh Mander, a human rights activist, writer and teacher, points out, *'it has been a long civilizational journey through which we as a people moved gradually from condemning teenage crime to a humane approach of offering the child the opportunity to reform, in the way we would to our own children who lose their way… the law gradually evolved over 150 years to make unlawful housing young offenders with adult criminals, recognizing that adult prisons are sites in which a teenager is far more likely to be both brutalized and initiated into a life of adult crime, rather than deterred from further crime and receiving steady compassionate guidance to reform'.* It is with this last concern that we must endeavor for the preliminary assessment to be compassionate and reformative in nature rather than judgmental and condemnatory.

To summarize in the words of Minna Kabir, a child activist, about children who enter crime *'because of poverty, because of a drug habit, because of a faulty peer group, because of dysfunctional families, because of an empty stomach, and because of adults who use them…'* She emphasizes that '*every society is responsible for the wellbeing and care of its children up to the age of eighteen years, especially if they are marginalized, helpless and powerless to do anything for themselves'*, *adding that 'society has to protect its children up to that age, rather than protect itself from its children'*. Thus, it is essential that we use the preliminary assessment provision empathically, and wisely, to protect children from coming into conflict with the law in the future.

No Matter What, No Transfer!

The preliminary assessment does not contain any facts of the case because:

i) For legal decisions, the JJB would use lawyers and other means of inquiry to ascertain the facts of the case;
ii) The mental health professional providing the preliminary assessment, based on the psychosocial and mental health assessment, is not in a position to provide hard evidence on whether or not the offence was committed by a child (nor is this the goal of mental health services);
iii) the mental health professional should not be providing evidence about the offence that might further incriminate the child.

What we have developed is not only based on psychosocial and mental health principles, thereby introducing vulnerability factors that can be taken into consideration by the JJB, but we are also directing their attention to it before they arrive at any decisions about transfer.

The preliminary assessment, from a mental health perspective, has the twin goals of:

a) protecting the child from transfer to the adult justice system and b) facilitating opportunities for behaviour change and rehabilitation. Therefore, in some instances where the child, even after extensive treatment by mental health care facilities, is unable to transform, the mental health system may write to the JJB recommending that the child be sent to a 'place of safety'.
b) A 'place of safety' is a space or institutional facility (often run by non-governmental organizations), essentially a closed setting, wherein the child can remain until the age of 21 years, under close supervision, with access to vocational training and continued mental healthcare inputs. The purpose of placing the child in such a protected environment for an extended period of time is to reduce exposure to risk factors (whether by way of peer influences or substance use), thereby preventing him/her from committing offences and coming into conflict with the law.
c) Related to this is the issue of children from socio-economically 'well-off' families, wherein the vulnerability factors(erstwhile discussed) that have led these children to coming in conflict with the law may not be so apparent; or in some situations, they may be no overt vulnerability factors. Even in such cases, we do not advocate for transfer; because the position we take on a child's mental capacity to commit offence is that whether or not there are other family/ circumstantial vulnerabilities, a given child may have life skills deficits pertaining to emotional regulation, decision-making, problem-solving etc.
d) First, life skills deficits may occur in children due to lack of supervision and poor parenting styles—which children from higher socio-economic strata are also vulnerable to, just like their counter-parts from poorer families—so these factors need to be closely examined in the process of the mental health and psychosocial assessment, and the writing of the preliminary assessment report. Second, life skills may also be a result of pre-existing temperamental vulnerabilities, that are constitutional in nature note: temperament refers to a child's unique 'style' pertaining to activity level, sensitivity, regularity and rhythm, approach and withdrawal, adaptability etc. These temperamental characteristics influence the way in which he/she approaches and reacts to the world, and consequently impacts his/her behavior. Difficult temperament placesa child at risk of problem behaviours. Thus, even where there appears to be no environmental vulnerability, mental health assessments must seek to identify temperamental vulnerabilities in CICL, so that they may be assisted with appropriate mental health interventions.
e) Finally, there is the neuro-biological argument (erstwhile discussed) about the developing adolescent brain and its limited abilities, no matter what the circumstances or environment, to make socially appropriate decisions. This vulnerability remains across the board for all CICL (all adolescents, in fact) and therefore necessitates mental health and psychosocial assistance to children, not transfer to the adult criminal justice system.

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Activity for Preliminary Assessment Reports (I)

Method: Discussion

Material: Preliminary Assessment Proforma--1 copy to each participant, See Annex III for proforma. *[Detailed Guidelines on the assessment proforma are also available in Annex IV—it is recommended that the facilitator reads them and also provides copies to participants];* sample of completed preliminary assessment reports—see Annex V.

Process and Discussion:

- Help participants familiarize themselves with the assessment proforma:
  - Discuss the proforma i.e. go through it, ensuring that participants understand how to ask questions and record information on various items.
  - Link the items on the preliminary assessment proforma to the psychosocial and mental health assessment—showing them how to draw information from the latter to fill out the preliminary assessment report.
  - Also discuss the nature of information emerging from each question and how it is useful/ how it will feed into intervention and rehabilitation plans.
- Share some examples of completed preliminary assessment proformas and have the participants engage in discussions on how they might use these in their judgements.

Activity for Preliminary Assessment Reports (II)

Method: Analysis and Discussion

Material: Bombay High Court Judgment: Mumtaz Ahmed Nasir Khan vs The State Of Maharashtra on 15 July, 2019 (Available in Annex VI)

Process and Discussion:

- Provide copies of the above-named judgement to the participants, ideally before the training workshop; request them to read the judgement in preparation for the workshop.
- In the workshop, discuss the following:
  - What were some of the complex elements of the case?
  - From what perspectives did Justice Naidu approach the case?
  - What are your viewpoints on the judgement?
  - Did you think that Justice Naidu's judgement was in keeping with the Juvenile Justice Act (and with Section 15)?

7. A Brief Overview of Essential Psychosocial & Mental Health Interventions for Children in Conflict with the Law

Objectives

- To provide participants with a brief overview of the types of intervention that can be offered by child and adolescent mental health professionals to CICL.
- To enable participants to understand when to refer children to specialized/ tertiary mental health care facilities.

Time

20 minutes

Concept…What to Say

Objectives of Psychosocial Assistance to CICL:

- Individual counseling and therapy (including pharmacological treatment and psychotherapy) for children, with a view to effecting transformation and preventing recidivism.
- Group therapy and life skills training to enable children to acquire the requisite life skills with special focus on decision-making, social judgment and empathy (necessary for transformation).
- Providing preliminary assessment reports to the JJB magistrate to address Section 15 of JJ Act 2015.
- Collaborative work with the staff/ superintendent to develop daily schedules and activities for children to meet children's rehabilitation needs (so that the Observation Home is not viewed as a mere place of detention or punishment).
- Coordinating with other agencies to facilitate vocational training needs of children in the observation home.
- Training of childcare service providers/ counselors in the use of tools and methods for providing psychosocial assistance to CICL.

Individual Interventions

a) First Level Responses

First level responses are provided to all children assessed (which ideally should be every child who comes to the Observation Home). Reflection &perspective-taking methods are used in gentle, encouraging, non-judgmental conversations 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.Following the administration of the detailed psychosocial assessment, the therapist/ counselor provides what are known as first level responses to the child.

First level responses could take about an hour's time and help initiate the process of behaviour change in the child. It entails:

- ✓ Insight facilitation
- ✓ The basis and motivation for change (other than being out of the Observation Home)
- ✓ 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

b) Depth Therapeutic Interventions

Based on the psychosocial assessments, some children are identified for depth intervention based on the assessment. (See adjoining box for referral criteria). These children require depth (individual) counseling and therapy on a medium to long term basis for behaviour transformation; depending upon the nature of mental health issues, they may also require pharmacotherapy. They require referral to a tertiary care facility (i.e. a department of psychiatry)—where specialized treatments may be provided. In NIMHANS, for instance, such children are assisted by the Department of Child & Adolescent Psychiatry; however, further referrals are also made to the Centre for Addicition Medicine and to the Psychosocial Rehabilitation Services, for treatment of substance use and assistance with vocational training, etc., respectively. If necessary, referrals of the child's family and caregivers are made to the Department

Referral Criteria for children in need of 'Depth Therapeutic Interventions'

- Self-harm and suicide
- Substance use (high frequency/ intensity use of substances)
- Repeated run away behaviour (child may need to be treated for ADHD and/or substance use)
- Excessive violence (destruction of property/ causing severe injury to others through physical or sexual abuse)
- Intellectual Disability
- POCSO cases (both perpetrator and victim require depth interventions)
- 'Odd behaviours' such as talking to self/ no time or place orientation/ disinhibited behaviours/become very suspicious or paranoid/hear or see things that are not there/act very differently than they did before (these behaviours indicate the presence of severe mental illness).

of Psychiatry and/or the Family Psychiatry Unit—in order to provide more systemic assistance to the child, in addition to individual treatment. Thus, a multi-disciplinary approach is used to assist children coming to NIMHANS.

4.2. Group Interventions

a) Rehabilitation and Recreation Interventions

In addition to individual assessments and therapy, aimed at behavioural transformation, it is also exceedingly important to create a communal environment, in which children feel at home as well as ensure a culture of rehabilitation versus one of censure and punishment. Day-to-day activities and structuring children's time in the institution should therefore include the following

- **Film Screening (and discussion):** Selection of (commercial and popular) films that contain themes ofinterpersonal relationships, empathy, prosocial behaviours, conflict-resolution...followed byreflection and discussions on various themes emerging from the films.
- **Art:** Drawing, painting, clay, music and dance to allow children to express their creativity as well as their emotions.
- **Indoor Games:** Engaging children in indoor games, namely board games/ card games/ jigsaw puzzles/ dumb charades/ quiz games/ reading story books, in order to enable them to engage in rule-based games so as to enhance their social skills/ team-playing abilities, and also to enhance their attention-concentration skills and sitting tolerance.

b) Life Skills Training

Most children coming to the Observation Home have life skills deficits—attributable to dysfunctional family circumstances and poor supervision at home. Thus, in addition to individual counselling, ideally, life skills sessions should be conducted for (all) children. The objectives of life skills[15] sessions for CICL is to enable them to acquire skills pertaining to interpersonal relationships, emotional regulation, negotiation, assertiveness, refusal, conflict resolution, problem-solving and decision-making in keeping with their problem contexts i.e. emotional dysregulation, sex and sexuality, substance use, violence and other difficult behaviours. Life skills approaches entail non-didactic methods wherein all participants are learners and theyall participate in and contribute equally to the production of knowledge, which is a continuous dialogue; various creative methods such as art, story-telling and narratives, theatre and role plays, films and video clips, board games and quizzes are used, followed by reflection, perspective-taking and discussion.

15. Life skills methods entail non-didactic methods wherein all participants are learners and they all participate in and contribute equally to the production of knowledge, which is a continuous dialogue.

Annex I

Psychosocial & Mental Health Assessment Proforma for Children in Conflict with the Law

Psychosocial & Mental Health Assessment Proforma

for Children in Conflict with Law

Community Child & Adolescent Mental Health Service Project

Dept. of Child & Adolescent Psychiatry, NIMHANS

In Collaboration with Dept. of Women & Child Development, Govt. Of Karnataka

- *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.*

Section 1: Basic Information (including alleged offence)

Assessment done by (Name of Individual & Agency):

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

Age: **Sex:**

Location/ Place of Origin:

Reasons for current institutionalization (circumstances of coming to the institution, incl. offence for which child is in institution- According to institution staff and police complaint)

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

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

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).

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.)

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 of influence of peers**
I will read you some statements about your relationship with friends and family 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).

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?

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

Section 4: Mental Health Concerns *(Ask Child)

4.1. 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

4.2. Depression Issues

C1. (Screening Question) Have you felt sad or depressed, or felt down or empty, or felt grouchy or	No	Yes

annoyed, most of the time, for the past year?		

I

f '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

4.3. Attention Deficit Hyperactive Disorder (ADHD)

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

Attention Deficit Hyperactivity Disorder (ADHD): Yes/ No

4.4. 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

4.4. Substance Abuse

Note: The 3-month period in the questions refers to the last 3 months wherein the child was outside the Observation Home i.e. he/she had access to substances, if desired, when he/she was still not in the protected environment of the Home. This time period could therefore be in the immediate 3 months before assessment i.e. if child joined the OH recently; or it may be in the more distant past if the child is being assessed several months after joining the OH.

Question 1: (Screening Question)

In your life, which of the following substances have you ever used? (Non-medical use only)	No	Yes
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
Alcoholic beverages (beer, wine, spirits, etc.)	0	3
Cannabis (marijuana, pot, grass, hash, etc.)	0	3
Cocaine (coke, crack, etc.)	0	3
Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
Other - specify:	0	3

Probe if all answers are negative: Probe if all answers are negative: "Not even when you were in school?" "Not even when you were in school?" If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2:

In the past three months how often have you used the substances you mentioned (FIRST DRUG, (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Weekly	Monthly	Daily or Almost Daily
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
Cocaine (coke, crack, etc.)	0	2	3	4	6
Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6

Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with if any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance Questions 3, 4 & 5 for each substance each substance used.

Question 3:

During the past three months, how often have you had a strong desire or urge to use (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Weekly	Monthly	Daily or Almost Daily
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
Cocaine (coke, crack, etc.)	0	2	3	4	6
Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
Other - specify:	0	2	3	4	6

Question 4:

During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?	Never	Once or Twice	Weekly	Monthly	Daily or Almost Daily
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
Cocaine (coke, crack, etc.)	0	2	3	4	6
Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
Other - specify:	0	2	3	4	6

Question 5:

During the past three months, how often have you failed to do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or Twice	Weekly	Monthly	Daily or Almost Daily
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
Cocaine (coke, crack, etc.)	0	2	3	4	6
Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6

Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
Other - specify:	0	2	3	4	6

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)
Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)
those endorsed in Question 1).

Question 6:

Has a friend or relative or anyone else ever expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?	Never	Once or Twice	Weekly	Monthly	Daily or Almost Daily
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
Cocaine (coke, crack, etc.)	0	2	3	4	6
Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
Other - specify:	0	2	3	4	6

Question 7:

Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)?	Never	Once or Twice	Weekly	Monthly	Daily or Almost Daily
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6

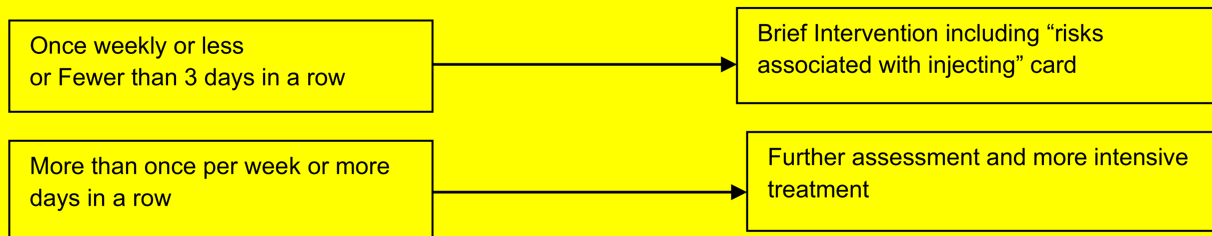
Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
Cocaine (coke, crack, etc.)	0	2	3	4	6
Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
Other - specify:	0	2	3	4	6

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? Used any drug by injection? (NON-MEDICAL USE ONLY)	0	2	1

IMPORTANT NOTE: Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

PATTERN OF INJECTING GUIDELINES

INTERVENTION



HOW TO CALCULATE A SPECIFIC SUBSTANCE IN OW TO CALCULATE A SPECIFIC SUBSTANCE IN PECIFIC SUBSTANCE INVOLVEMENT SCORE VOLVEMENT SCORE. For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive. Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as: Q2c + Q3c + Q4c + Q5c + Q6c + Q7c Q2c + Q3c + Q4c + Q5c + Q6c + Q7c Q2c + Q3c + Q4c + Q5c + Q6c + Q7c Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a Q2a + Q3a + Q4a + Q6a + Q7a Q2a + Q3a + Q4a + Q6a + Q7a

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a Q2a + Q3a + Q4a + Q6a + Q7a Q2a + Q3a + Q4a + Q6a + Q7a

The type of intervention is determined by the type of intervention is determined by ion is determined by the patient the patient's specific substance involvement score.

	Record Specific Substance Score	No Intervention	Receive Brief Intervention	More Intensive Treatment
Tobacco		0-3	4-26	27+
Alcohol		0-10	11-26	27+
Cannabis		0-3	4-26	27+
Cocaine		0-3	4-26	27+
Amphetamine		0-3	4-26	27+
Inhalants		0-3	4-26	27+
Sedatives/ Sleeping Pills		0-3	4-26	27+
Hallucinogens		0-3	4-26	27+
Opioids		0-3	4-26	27+
Other		0-3	4-26	27+

Section 5: Potential for transformation*(Ask Child)

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

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

5.3. 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?

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/enhancing 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)	

6.2.Other Observations

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

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[16], Pathology[17] and Consequence[18].** 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).

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

17. 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.

18. Consequences—Pathways to institutionalization & 'criminality'

Annex II
Guidance Note son
Psychosocial & Mental Health Assessment Proforma for Children in Conflict with the Law

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 is 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 developmental issues and their psychosocial contexts, so as to 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.

2. 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.

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.

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

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

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

V. School/ Classmates

VI. Family members- cousins etc.

VII. Friends in your neighborhood

VIII. Others

j) 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.	

k) Age of friends?

"Most of them are…."

iv. Older than you

v. Younger than you

vi. Same age as you

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

m) 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.			

n) 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).

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:

c) 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
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).

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.

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 complaints[19]. ADHD and CD may both be considered as externalizing behaviours i.e. disruptive, negative behaviours that are directed at the environment.

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19. 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.

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, 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 of 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.

It is also important to screen the child for other developmental disabilities such as Intellectual Disability and Specific Learning Disabilities. Intellectual disability is a disability characterized by significant limitations in both **intellectual functioning** and in **adaptive behavior**, which covers many everyday social and practical skills. *Intellectual functioning* (also called intelligence)—refers to general mental capacity, such as learning, reasoning, problem solving etc. One way to measure intellectual functioning is an IQ test—which the child may be referred for to mental health services. *Adaptivebehavior* is the collection of conceptual skills (language and literacy; money, time, and number concepts; and self-direction), social skills (interpersonal skills, social responsibility, self-esteem, gullibility, naïveté, social problem solving, and the ability to follow rules/obey laws and to avoid being victimized, and practical skills (activities of daily living (personal care), occupational skills, healthcare, travel/transportation, schedules/routines, safety, use of money, use of the telephone) that are learned and performed by people in their everyday lives. CICL are most likely to present with mild to moderate intellectual disabilities—wherein their lowered levels of cognition make them highly suggestible and place them at risk of being ‘used’ by adults or peers, to assist with offence-related activities. (CICL are unlikely to present withsevere or profound levels of intellectual disability, wherein the cognitive and, at times, even physical and locomotor abilities are too severely impaired to allow these children to interact with others).

It is also useful to refer children, particularly those who have dropped out of school for assessment of Specific Learning Disabilities—this is a neuro-developmental disorder wherein children have normal (sometimes even high) IQ levels i.e. they do not have

intellectual disability, but have specific difficulties with reading, writing and mathematics. Children with SLD tend to be de-motivated and so drop out of school; they also have other related emotional disorders such as anxiety and problems with self-esteem, that in turn place them at risk of adverse peer influences (and coming into conflict with the law).

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.

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
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

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
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

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)[20] 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

20. 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).

substances and so the questions would no longer apply. Therefore, we request children to 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 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 strategies 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)	

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[21].

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 generalchild's behavior and relationships, problems faced, difficult times, other life experiences, in different contexts (not only those pertaining to the alleged offence);

ii) child's account of his/her circumstances;

iii) the offence he/she has been apprehended for;

iv) 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.

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21. 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.

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. These observations may also be reflective of the current mental status of the child. They often complement questions about psychiatric disorders, enquired with the help of the (MINI-KID) screening checklists.

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[22], Pathology[23] and Consequence[24].** 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:

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

23. 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.

24. Consequences—Pathways to institutionalization & 'criminality'

(a) First level responses[25] 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

(b) Referral to tertiary care mental health facilities for further evaluation including psychological testing (in case more information is requiredfor diagnostic and intervention purposes; pharmacotherapy may also be necessary for children depending on the type and severity of the mental health problems).

(c) 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).

(d) 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).

(e) Rehabilitation and training plans may be made based on the child's existing skills and interests and his/her future aspirations.

25. 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.

Annex III

Example of Completed Psychosocial & Mental Health Assessment Proforma

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, Govt. Of Karnataka

- *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.*

Section 1: Basic Information (including alleged offence)

Assessment done by (Name of Individual & Agency):

Child's Name: XXXXXXXXXXXXX Date of Assessment: XXXXXXXXXXXX

Age: 17 **Sex: M**

Location/ Place of Origin: XXXXXXXXXX

Reasons for current institutionalization (circumstances of coming to the institution, incl. offence for which child is in institution- According to institution staff and police complaint)

- Alleged theft for a.

- History of substance abuse- (nicotine and cannabis) for past 2 years.

- Involved in gang activities and was reported to have anger and aggressive behaviour during intoxication.

Number times the child has been in conflict with the law (previously has the child come in conflict with law/ come to the observation home/police station – if so what were the circumstances, incl. offence for which child was in conflict with the law)

Total of 3 times over the past 2 years—for theft.

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

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

The child was the 1st born child of a non-consanguineous marriage. The child's father had a history of Alcohol addiction, expired 4 years ago due to liver failure. The mother is 37 years old, a manual labourer with no formal education. The child has 2 younger sisters, one of whom lives with the mother and the other lives with a maternal aunt. Poor social support and financial stressors are observed. The child has a history of defiant behaviour and demanding behaviour in the home context. There has also been a great deal of permissive parenting by the mother, and poor supervision (as mother is a daily labourer).It was also observed that there was permissive parenting.The child's mother is living on the streets and did not have a permanent residence. The child's

sisters are staying with the extended family and working in a convention hall as cleaners. The family has lot of financial difficulties.

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).

None

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).

The child discontinued going to a formal school at a very young age, instead was attending a non-formal school run by an NGO. The child is very good at drawing and is minimally capable of reading Kannada. Since then the child discontinued going to school and started to spend time with his peers and subsequently became involved in gang activities and substance abuse.

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.)

The child has been working in various places such mechanics shops, playing the drums in funeral/ religious processions; he also worked for a local gangster who had considerable political influence. The child's substance use problems were exacerbated in these occupations.

2.4. Peer Influence

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

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

i) School/ Classmates

ii) Friends in your neighborhood – incl. cousins, extended family etc.

iii) Work place

iv) Others

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

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

r) Age of friends?

"Most of them are…."

vii. Older than you

viii. Younger than you

ix. Same age as you

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

The child goes on long (two-wheeler) drives with friends, also doing risky activities such as 'wheeling'; he spends much of his time with friends, engaging in substance use.

t) Extent of influence of peers

I will read you some statements about your relationship with friends and family 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.	Yes		
ii	My friends influence my actions to do with stealing and breaking rules.	Yes		
iii	My friends influence my actions about smoking.	Yes		
iv	My friends influence my actions about alcohol use.	Yes		
v	My friends influence my actions about drugs.	Yes		
vi	My friends influence my actions about sexuality.		Yes	

u) 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).

The child has been caught by the police several times, for not having (two-wheeler) licence, as well as for engaging in physical assault and stealing behaviours.

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…)…

The child was found to be much affected by the death of his father—that is the time he quit school and then spent increasing amounts of time with older peers in the neighbourhood, and also began engaging in substance use.

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:

d) Physically hurt you and caused you injury?

The child reports physical abuse and violence at the police station; he was also often beaten by his mother (when she would become angry with him for engaging in anti-social activities).

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

Persons in the neighbourhood would often complain about the child and also say hurtful things about him even when he did not engage in anti-social behaviours i.e. even at times when he made attempts at socially appropriate behaviours. This made the child feel angry and humiliated.

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

The child does not report any sexual abuse experience.

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...**		
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...**		
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	No	Yes

	finished the question?		
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

O4. Did you have problems paying attention, being hyper, or impulsive before you were 7 years old?	No	Yes
O5. 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).

Attention Deficit Hyperactivity Disorder (ADHD): Yes / No

5.4. Conduct Disorder

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

j.	Have you run away from home two times or more?	No	Yes
k.	Have you skipped school often? Did this start before you were 13 years old?	No	Yes (circled)

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 (Yes circled)

5.5. Substance Abuse: Adolescent Alcohol and Drug Involvement Scale: AADIS

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 (circled)
Alcohol (Beer, Wine, Liquor)	0	1	2	3	4	5 (circled)	6	7
Marijuana or Hashish (Weed, grass)	0	1	2	3	4	5	6 (circled)	7
LSD, MDA, Mushrooms Peyote, other hallucinogens (ACID, mushrooms)	0 (circled)	1	2	3	4	5	6	7
Amphetamines (Speed, Ritalin,	0 (circled)	1	2	3	4	5	6	7

Ectasy, Crystal)								
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
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. AADIS

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 (circled)

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 (circled)

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 (circled)
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 (circled)
d.	hard liquor (vodka, whisky, etc.)	4
e.	A substitute for alcohol	5

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
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 (circled)

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 (circled)
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 (circled)

AADIS SCORING RESULTS

AADIS SCORE: 93 **(Score of 37 or above requires a full assessment)**

DO YOU RECOMMEND FULL ASSESSMENT (Regardless of the AADIS score)?

0. NO

1. YES (circled)

COMMENTS:

He has also had a history of substance abuse- (nicotine and cannabis) from past 2 years.

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.

Section 4: Potential for transformation*(Ask Child)

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

Since the child had been engaging in stealing and physical assault behaviours for a long period of time, the neighbourhood and the local police station often accused him of antisocial activities, even at times when he was not involved. At one such time, when he was under the influence of substance (alcohol and cannabis), one of the locals in his community got into a fight with him; the child was provoked, became angry and picked up a knife injured that person. His most recent admission to the observation home was this incident.

Previously, the child has been admitted to the observation home several times—once because he had forcibly broken into a house (for theft purposes); another time for pick-pocketing, and other times for physical assault and theft.

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

The child said he knew he had done things that were 'wrong' and had hurt people; but he says, when he is under the influence of cannabis/ alcohol, he is unable to control himself—nor does he recall later, what happened or what he did in a given situation.

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?)

The child states that his motivation for change is to not return to the observation home; he also said he wished to take care of his family.

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).

1. My mother should be healthy.
2. I want to get a good job and earn money.

3. I want to help my sisters to get married.

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?

None that the child was able to report.

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)	Yes
b)	Development of empathy/enhancing interpersonal relationships	No
c)	Coping with Stress (Coping with financial difficulties at home/ finding alternatives to running away from home or school…)	No
d)	Assertiveness (Ability to say 'no' to peers when necessary.)	No
e)	Problem Solving and Conflict Resolution (When confronted with difficult situations, to be able to generate alternatives/ evaluate them and select the appropriate option).	Yes
f)	Decision-making in various life contexts (Evaluate available options and select appropriate ones in a given situation).	Yes
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)	No

6.2. Other Observations

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

The child has average level of intelligence. The child had increased level of activity and decreased attention span (since young age also, as reported by his mother).

The child has partial insight into his problems—however, much work will have to be done with him in order for him to develop insight and motivation for behaviour change.

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[26], Pathology[27] and Consequence[28].** Highlight areas for immediate assistance/ response.

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

27. 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.

28. Consequences—Pathways to institutionalization & 'criminality'

Vulnerability:

The pathways to coming into conflict with the law were death of his father, school dropout, peer influence wherein he was exposed to various risk behaviours such as substance use and other rule-breaking behaviours by (older) peers. These core factors played out in the backdrop of extensive permissive parenting, and a family context where there was inadequate monitoring and supervision of the child.

The child also has a minor physical disability: Five years ago, the child had a fall from a tree during which incident the child sustained injury to the left optic nerve and has partially lost vision in the left eye.

Pathology:

- Attention Deficit Hyperactivity Disorder (ADHD)

- Conduct Disorder (CD)

- Substance Use: Initially, at the age of 8 years, the child had started experimenting with nicotine-cigarette and by the age of 12 years, the habit had evolved into a dependence pattern with up to 10- 14 cigarette/day. At age 12, the child experimented on cannabis (Ganja) and started smoking upto 3-5 joints/day. The child and the mother reported that during the use of Ganja (Cannabis) there was loss of control, bouts of anger and that he was usually not aware about his actions.

Consequence:

Repeatedly coming into conflict with the law

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).

- Referral to NIMHANS with possible in-patient admission.

- Individual therapy to focus on:

- Life Skills Training (including coping with peer pressure, assertiveness & negotiation skills, future orientation, motivation for change, emotional regulation, stress/anger management and decision-making skills).

- Substance Abuse (including refusal skills, motivation to stop substance abuse, relapse prevention)

- Taking perspective on conduct issues, namely stealing and rule-breaking.

- Discussions on child's sense of on entitlement and his contribution/responsibilities towards the family.

- Vocational training and placement for child

- Assistance to the mother on parenting issues.

Annex IV
Preliminary Assessment Report Proforma

Psychosocial & Mental Health of Children in Conflict with the Law (Age 16 to 18 Years)

Preliminary Individual Assessment Report for Juvenile Justice Board

Community Child & Adolescent Mental Health Service Project

Dept. of Child & Adolescent Psychiatry, NIMHANS-DWCD

As per the JJ Act 2015, the objective of the preliminary assessment of a child, is to 'evaluate the role of the child in the alleged offence, as well as his mental condition and background'. In keeping with this, the psychosocial and mental health assessment report provides information on the child's mental condition and background, namely the developmental level of the child, family history and relationships, school and education, involvement in child labour, peer relationships and experiences of trauma and abuse; it also provides information on any mental health disorders and developmental disabilities that the child may have. Finally, the report makes recommendations for treatment and rehabilitation interventions for the child. The report presents the above-said information using the framework proposed by JJ Act 2015 i.e. whether the child has the mental and physical capacity to commit the offence, the circumstances of the offence committed, whether the child knew the consequences of the offence.

This assessment report is dated:

Name of Child:

Age: **Sex:** **Male** **Place of Origin:**

A. Mental & Physical Capacity to Commit Alleged Offence

The child's ability to make social decisions and judgments are compromised due to:

Physical disability (observed in child)	
Life skills deficits (emotional dysregulation/ difficulty coping with peer pressure/ assertiveness & negotiation skills /problem-solving/ conflict-resolution/ decision-making)	
Neglect / poor supervision by family/poor family role models	
Experiences of abuse and trauma	
Substance abuse problems	
Intellectual disability	

Mental health disorder/ developmental disability	
Any other (specify):	
No treatment/ interventions provided so far to address the above issues	

*NA- Not applicable

B. Circumstances of Alleged Offence

Family History:

School History:

Child Labour:

Peer Relationships:

Abuse and Trauma:

Mental Health Disorder/ Developmental Disability:

C. Child's Knowledge of Consequences of Committing the Alleged Offence

Child's Understanding of Social/ Interpersonal and Legal Consequences of Committing Offence:

D. Other Observations & Issues

E. Recommendations

[Name/Signature/ Designation/ Institution of Assessor]

Annex V
Guidance Notes on
Preliminary Assessment Report Proforma

The preliminary assessment uses information from the detailed psychosocial and mental health assessment (that is done first) and presents that information as outlined below.

A. Mental & Physical Capacity to Commit Offence

The child's ability to make social decisions and judgments are compromised due to:

(i) Life skills deficits (emotional dysregulation/ difficulty coping with peer pressure/ assertiveness & negotiation skills /problem-solving/ conflict-resolution/ decision-making).

(ii) Neglect / poor supervision by family/poor family role models

(iii) Experiences of abuse and trauma

(iv) Substance abuse problems

(v) Intellectual disability

(vi) Mental health disorder/ developmental disability

(vii) Treatment/ interventions provided so far

Guidance Notes

For this section, the professional filling out the preliminary assessment form is simply required to mark off against each item (a tick mark to indicate 'yes' and an X mark to indicate 'no') whether or not the child is compromised in this particular area. The information is drawn from relevant sections of the detailed psychosocial and mental health proforma, which contain information on: how a child's abilities to make appropriate social decisions and judgements (which translate into actions and behaviours) have been affected by the child's life circumstances and mental health or developmental problems.

For item (i) on life skills deficits, refer to Section 6, 'Life Skills Deficits and Other Observations of the Child' and sub-section 6.1. on 'Life Skills Deficits'.

For item (ii), refer to Section 2, sub-section 2.1. on 'Family Issues Identified'.

For item (iii) on experiences of abuse and trauma, refer to Section 3, 'Trauma Experiences: Physical, Sexual and Emotional Abuse Experiences'.

For items (iv) and (vi) on substance abuse problems and mental health disorders/ developmental disability, refer to Section 5, 'Mental Health Concerns'.

For item (v) on intellectual disability, you may rely on your judgement based on your interaction with the child during the entire process of administering the psychosocial and mental health proforma—if the child was unable to respond to most questions or responded in an age-appropriate manner (like a younger child would, demonstrating little understanding of many things asked or discussed), then you may suspect that he/she has intellectual disability. (Following this, it would be useful and necessary to

confirm this through relevant IQ testing conducted by psychologists located in mental health facilities).

For item (vii), you may have enquired from the child, during the assessment, about whether he/she has received any professional assistance or treatment for any mental health issues/ family problems or life skills deficits that he/she has. (Generally, children in the Observation Home have never received any treatment or interventions for their problems).

In actual fact, everyone, except someone with serious physical disability (the type that severely impacts locomotor skills) or with intellectual disability, has the mental and physical capacity to commit offence. So, to ask whether a given child has the mental and physical capacity to commit offence, in simplistic terms, is likely to elicit the answer 'yes' in most cases. And just because someone has the physical and mental capacity to commit an offence, does not mean that they will or that they have. Therefore, a dichotomous response as elicited by this question posed by the JJ Act is of little use in making decisions regarding child who has come into conflict with the law.

Thus, in response to the problems resulting from a simplistic dichotomous response to the physical-mental capacity question, we have adopted a more detailed, descriptive and nuanced interpretation. As per the preliminary assessment report we have developed, mental and physical capacity to commit offence is the ability of a child to make social decisions and judgments, based on certain limitations that the child may have. In other words, a child's abilities to make social decisions and judgments are compromised due to life skills deficits, neglect / poor supervision by family/poor family role models, experiences of abuse and trauma, substance abuse problems, intellectual disability, and/or mental health disorder/ developmental disability. Such issues (if untreated) adversely impact children's world view, and their interactions with their physical and social environment, thereby placing them at risk of engaging in antisocial activities.

B. Circumstances of Offence

(i) Family history and relationships (child's living arrangements, parental relationships, child's emotional relationship & attachment to parents, illness & alcoholism in the family, domestic violence and marital discord if any).

(ii) School and education (child's school attendance, Last grade attended, reasons for child not attending school- whether it is due to financial issues or lack of motivation, school refusal, corporal punishment).

(iii) Work experience/ Child labour (why the child had to work/ how child found the place of work, where he was working / hours of work and amount of remuneration received, was there any physical/emotional abuse by the employer and also regarding negative influence the child may have encountered in the workplace regarding substance abuse etc).

(iv) Peer relationships (adverse peer influence in the context of substance use/ rule-breaking/inappropriate sexual behaviour/school attendance)

(v) Experiences of trauma and abuse (physical, sexual& emotional Abuse experiences)

(vi) Mental health disorders and developmental disabilities: (Mental health disorders and developmental disabilities that the child may have).

Guidance Notes

All of the above information for this section is to be documented as it is in the detailed psychosocial and mental health assessment, drawing on relevant sections from the detailed assessment, so as to present the factors and circumstances that made the child vulnerable to committing offence.

Information for the first four heads needs to be drawn from Section 2, Social History, of the psychosocial and mental health proforma—which contains details on family, school, institution and peer issues; Information for the fifth item on trauma, needs to be drawn from Section 3, Trauma Experiences: Physical, Sexual, and Emotional Abuse Experiences' of the psychosocial assessment form;

For the sixth item on Mental Health Disorders, Section 5, 'Mental Health Concerns' (including substance abuse) from the psychosocial assessment form, would need to be used.

It is important to recognize that 'Circumstances of the Offence' does NOT refer to proximal factors i.e. what happened right before the offence incident took place. This is because proximal factors have a history which is important to recognize—there is a whole set of factors and life events that led up to the decisions and actions to just before the offence as well as the offence itself. Therefore, 'circumstances' are interpreted as life circumstances and a longitudinal approach is taken to understanding vulnerabilities and pathways to offences. This entails events and circumstances starting from the child's birth (or starting with the mother's pregnancy experiences) to the current date. This is the universal approach to history-taking in child and adolescent mental health, to be able to understand children's emotions and behaviours based on their contexts and experiences, as they have played out over several years(and so it is not actually specific to children in conflict with the law).

C. Child's Knowledge of Consequences of Committing the Offence

(A brief about the child's understanding of social/ interpersonal and legal consequences of committing offence along with the child's insights regarding committing such an offence).

Guidance Notes

This is based on the 'Potential for Transformation' section in the detailed psychosocial and mental health assessment, as well as the first level interventions provided immediately after. How the child responded during the assessment i.e. extent of his/her insight and motivation, must be documented here.

Social and interpersonal consequences refer to the child's sense of empathy and understanding of how his/her actions would (negatively) impact his/her relationship with family, friends and others; legal consequences refer to the child's understanding of his/her actions as being a boundary violation/ breaking of rules with serious negative consequences for himself/herself, including punishment and coming into conflict with the law.

D. Other Observations & Issues

Guidance Notes

Any other observation made during the assessment regarding the child's social temperament/ child's behaviour in the observation home/ level of motivation for change/ if any positive behaviour noted is also provided. This may be drawn from Section 6 of the psychosocial and mental health proforma, on 'Life Skills Deficits and Other Observations of the Child', sub-section 6.2 'Other Observations of the Child'.

These refer not just to negative observations but also to positive ones you might have made during the assessment. Observations may thus include the child's demeanour, or any views or ideologies that the child may have expressed regarding problem behaviours such as violence or abuse—which may better help understand who he/she is (and help the magistrate view the offence behaviour from varied perspectives). They may also include any odd behaviours that you observe which might help substantiate the evidence on mental health disorders and developmental disabilities—for instance, if the child's responses appear socially and cognitively inappropriate to his age, you may note possible intellectual disability; or if a child appears disoriented in terms of place and time or has marks of self-harm on his body, then you might note mental health issues.

E. Recommendations

Guidance Notes

Finally, the report makes recommendations for treatment and rehabilitation interventions for the child, based on the interests and desires of the child. These could pertain to placement, living arrangements, education and schooling, counseling for parents, referral to a tertiary facility for further mental health and psychosocial care and treatment. This sub-section is critical as it provides the JJB magistrate with clear direction on what assistance the child requires, thus creating an imperative for the board to consider options and respond in ways that are supportive and proactive (versus making decisions of transfer to the adult justice system).

JJB magistrates may be requested to refer the child to a psychiatric facility for treatment, so that other issues pertaining to family and school can also be taken care of by the mental health system, which is then obligated to report to the JJB on the child's progress. In many instances, JJB magistrates have issued a conditional bail to ensure that the child and family follow through with mental health services as required i.e. bail is given to the child on condition that he/she presents at the mental health facility and complies with treatment (if the child refuses to do so, the magistrate can revoke the bail). Thus, there are adequate provisions under the JJ Act, which if effectively invoked, can be used to protect CICL from transfer to adult systems, and to facilitate their rehabilitation instead.

Annex VI

Examples of Completed Preliminary Assessment Reports

Example 1:

Psychosocial & Mental Health of Children in Conflict with the Law (Age 16 to 18 Years)

Preliminary Individual Assessment Report for Juvenile Justice Board

Community Child & Adolescent Mental Health Service Project

Dept. of Child & Adolescent Psychiatry, NIMHANS-DWCD

As per the JJ Act 2015, the objective of the preliminary assessment of a child, is to 'evaluate the role of the child in the alleged offence, as well as his mental condition and background'. In keeping with this, the psychosocial and mental health assessment report provides information on the child's mental condition and background, namely the developmental level of the child, family history and relationships, school and education, involvement in child labour, peer relationships and experiences of trauma and abuse; it also provides information on any mental health disorders and developmental disabilities that the child may have. Finally, the report makes recommendations for treatment and rehabilitation interventions for the child. The report presents the above-said information using the framework proposed by JJ Act 2015 i.e. whether the child has the mental and physical capacity to commit the offence, the circumstances of the offence committed, whether the child knew the consequences of the offence.

This assessment report is dated: *2nd May, 2017*

Name of Child: XXXXXXX

Age: *17 years* **Sex:** *Male* **Place of Origin:** *XXXXXX*

A. Mental & Physical Capacity to Commit Offence

The child's ability to make social decisions and judgments are compromised due to:

Life skills deficits **(emotional dysregulation/ difficulty coping with peer pressure/ assertiveness & negotiation skills /problem-solving/ conflict-resolution/ decision-making)**	*Yes* *(gap in decision making and problem solving)*
Neglect / poor supervision by family/poor family role models	*Yes*

Experiences of abuse and trauma	Yes
Substance abuse problems	NA
Intellectual disability	NA
Mental health disorder/ developmental disability	Yes
Any other (specify):	NA
No treatment/ interventions provided so far to address the above issues	Yes

* NA- Not applicable

B. Circumstances of Offence

Family History:

The child is from low socio-economic strata; No history of parental marital conflict/ domestic violence/illness. The child's father passed away few years back due to lungs cancer (based on the child's report). Currently child lives with his mother. The child does not enjoy good relationship with his elder brother and he lives in their native.

School History:

Child has dropped out of school after 7th standard, due to severe stigma and discrimination done by his peers and schoolmates as the child has stuttering disorder (Speech disorder). Child also reports he has been bullied by his school mates on several occasions.

Child Labour:

Child after dropping out of school has been working in a petrol bunk. There were no significant problems in his work place.

Peer Relationships:

The child has very few friends, he reports – as most of them discriminates him for his stuttering problem he do not wish to spend time with friends. However, child had a friend who had been involved in various illegal activities (such as stealing/ robbery) with whom the child was friends with, but has never been involved/ present with him during his illegal activities.

Abuse and Trauma:

The child has lost his father and his grandfather due which he has mild level of depression. As the child has lost primary caregiver (father) the child is vulnerable to lack of supervision at home.

Emotional abuse- experience of stigma and discrimination due to his stuttering (Speech disorder).

Mental Health Disorder/ Developmental Disability:

His developmental milestones followed normal trajectories, other than his Speech disorder- stuttering.
Anxiety symptoms were noted in the context of stigma and discrimination which the child has experienced due to his stuttering (Speech disorder).
Depression symptoms were noted in the context of his father's death and his experience of loss and grief.

C. Child's Knowledge of Consequences of Committing the Offence

Child's Understanding of Social/ Interpersonal and Legal Consequences of Committing Offence:

He has some understanding of the social/ legal and interpersonal consequences of committing such an offence. The child also reported that he would never consider taking away anybodies things without their permission. He also said that he is aware how difficult it is to earn money, and how will other people feel when their belongings are taken away.

D. Other Observations & Issues

He has been of easy and friendly/ social temperament since early childhood. Based on the history taken from the child and the Observation home staff, child has no anger/ aggression issues, or any behavioural issues.

E. Recommendations

A brief intervention has been carried out for the child's anxiety and depressive symptoms.
Some discussions and interventions were conducted for his stigma and discrimination experiences.
Given that the child has Speech disorder- Stuttering along with Anxiety and depression, we recommend that the child be referred to Dept. of Child & Adolescent Psychiatry NIMHANS, after he is released on bail in order to address his issues. These interventions would be greatly beneficial to the child and protect him in the future.
Again, thank you for your referral; we are, as always, happy to assist vulnerable children, in particular children in conflict with the law, and the systems working with them.

Thanking you,
Yours sincerely,

xxxxxxxxxxxxxxxx
[Name & Designation of Mental Health Professional]

Example 2:

Psychosocial & Mental Health of Children in Conflict with the Law (Age 16 to 18 Years)

Preliminary Individual Assessment Report for Juvenile Justice Board

Community Child & Adolescent Mental Health Service Project

Dept. of Child & Adolescent Psychiatry, NIMHANS-DWCD

As per the JJ Act 2015, the objective of the preliminary assessment of a child, is to 'evaluate the role of the child in the alleged offence, as well as his mental condition and background'. In keeping with this, the psychosocial and mental health assessment report provides information on the child's mental condition and background, namely the developmental level of the child, family history and relationships, school and education, involvement in child labour, peer relationships and experiences of trauma and abuse; it also provides information on any mental health disorders and developmental disabilities that the child may have. Finally, the report makes recommendations for treatment and rehabilitation interventions for the child. The report presents the above-said information using the framework proposed by JJ Act 2015 i.e. whether the child has the mental and physical capacity to commit the offence, the circumstances of the offence committed, whether the child knew the consequences of the offence.

This assessment report is dated: *6th December 7, 2016*

Name of Child: *XXXXX*

Age: *17 years* **Sex:** *Male* **Place of Origin:** *XXXXXXX*

A. Mental & Physical Capacity to Commit Offence

The child's ability to make social decisions and judgments are compromised due to:

Life skills deficits **(emotional dysregulation/ difficulty coping with peer pressure/ assertiveness & negotiation skills /problem-solving/ conflict-resolution/ decision-making)**	*Yes* *(Gap in decision-making)*
Neglect / poor supervision by family/poor family role models	*Yes*
Experiences of abuse and trauma	*NA*
Substance abuse problems	*Yes*
Intellectual disability	*NA*
Mental health disorder/ developmental disability	*NA*
Any other (specify):	*NA*
No treatment/ interventions provided so far to address the above issues	*Yes*

B. Circumstances of Offence

Family History:

The child is from low socio-economic strata; child hails from a family in Tamil Nadu and lived with his grandparents. Child's parents had separated since past 13 years. This has caused mild level of anxiety and depression in the child since childhood.

School History:

Child has completed 6th standard and is a dropout of school due to financial issues as well as lack of motivation.

Child Labour:

The child has been working as a construction worker in various places, where he interacts mostly with adults. It was also noted that there was a negative impact by his peers in the work place, with regard to substance abuse.

Peer Relationships:

He is involved with them in recreational activities and substance abuse. Child had adverse peer influence with regards to substance abuse and truancy/ run away behaviours.

Abuse and Trauma:

The child has experienced the loss of primary caregivers due to marital discord and child never lived with them. This has made the child vulnerable due to lack of care and supervision at home.

Mental Health Disorder/ Developmental Disability:

The child's developmental milestones followed normal trajectories.

However, our psychosocial assessment reveals serious mental health issues namely:

i) Conduct Disorder: this refers to behaviour problems in children and adolescents manifesting in symptoms such as substance use, truancy and runaway behaviours (the child had run away from home twice)

ii) Substance abuse—previously (before coming to the OH), the child had alcohol, tobacco and nicotine use for which a brief intervention is done.

iii) Mild level of Adjustment disorder: this refers to a mixed anxiety and depressive disorder; in the context of marital discord and his parent's separation.

C. Child's Knowledge of Consequences of Committing the Offence

Child's Understanding of Social/ Interpersonal and Legal Consequences of Committing Offence:

He has some understanding of the social and interpersonal consequences of committing such an offence. His knowledge of the legal consequences was inadequate i.e. he was aware that commission of offence would lead to conviction by the police. He is against such acts of offence; he reports that he would never engage in such an offence.

D. Other Observations & Issues

He has been of easy and friendly/ social temperament since early childhood.

Based on the history taken from the child and the Observation home staff, child has no anger/ aggression issues, or any behavioural issues.

E. Recommendations

A brief intervention has been carried out for the child's negative peer influence, insights were provided to the child regarding the negative impacts and consequences of the same.

Referral: Given the nature of the alleged offence, we recommend that the child be referred to Dept. of Child & Adolescent Psychiatry NIMHANS, after he is released on bail in order to address his mental health issues namely- Conduct disorder, substance abuse and adjustment disorder. These learnings and skills would be greatly beneficial to the child and protect him in the future.

Again, we are, as always, happy to assist vulnerable children, in particular children in conflict with the law, and the systems working with them.

Thanking you,

Yours sincerely,

xxxxxxxxxxxxxxxx

[Name & Designation of Mental Health Professional]

Example 3:

Psychosocial & Mental Health of Children in Conflict with the Law (Age 16 to 18 Years)

Preliminary Individual Assessment Report for Juvenile Justice Board

Community Child & Adolescent Mental Health Service Project

Dept. of Child & Adolescent Psychiatry, NIMHANS-DWCD

As per the JJ Act 2015, the objective of the preliminary assessment of a child, is to 'evaluate the role of the child in the alleged offence, as well as his mental condition and background'. In keeping with this, the psychosocial and mental health assessment report provides information on the child's mental condition and background, namely the developmental level of the child, family history and relationships, school and education, involvement in child labour, peer relationships and experiences of trauma and abuse; it also provides information on any mental health disorders and developmental disabilities that the child may have. Finally, the report makes recommendations for treatment and rehabilitation interventions for the child. The report presents the above-said information using the framework proposed by JJ Act 2015 i.e. whether the child has the mental and physical capacity to commit the offence, the circumstances of the offence committed, whether the child knew the consequences of the offence.

This assessment report is dated: *6th December 7, 2016*

Name of Child: *XXXXXXXX*

Age: *16 years* **Sex:** *Male* **Place of Origin:** *XXXXXXX*

A. Mental & Physical Capacity to Commit Offence

The child's ability to make social decisions and judgments are compromised due to:

Life skills deficits **(emotional dysregulation/ difficulty coping with peer pressure/ assertiveness & negotiation skills /problem-solving/ conflict-resolution/ decision-making)**	*Yes* *(Gap in decision-making)*
Neglect / poor supervision by family/poor family role models	*Yes*
Experiences of abuse and trauma	*NA*
Substance abuse problems	*Yes*
Intellectual disability	*NA*
Mental health disorder/ developmental disability	*NA*
Any other (specify):	*NA*
No treatment/ interventions provided so far to address the above issues	*Yes*

B. Circumstances of Offence

Family History:

The child is from a low socio-economic stratum; father is an auto driver and the mother works as a domestic helper.

The child's father is alcohol dependent and spends most of his income on alcohol. The child also reports that the father had asked the child to procure/buy cigarettes for him over the last several years (as a result of which the child has been exposed to substance use since childhood).

No history of parental marital conflict or domestic violence.

The child is attached to his parents and enjoys good family relationships.

School History:

He has finished 7th std and later discontinued due to lack of motivation/ interest in studies.

Child Labour:

Due to financial difficulties the child has been working in 2 auto garages over the past 3 years. He is currently therefore one of the main bread-winners of the family (given his father's alcohol dependency and the mother's meager income).

Peer Relationships:

The child has few friends and does not spend much time with his peers.

Abuse and Trauma:

None reported by the child.

Mental Health Disorder/ Developmental Disability:

- His developmental milestones followed normal trajectories.

- Substance abuse—prior to being admitted to the observation home, child was using nicotine (Cigarettes- 2 to 3/day).

C. Child's Knowledge of Consequences of Committing the Offence

Child's Understanding of Social/ Interpersonal and Legal Consequences of Committing Offence:

He has some understanding of the social and interpersonal consequences of committing such an offence. His knowledge of the legal consequences was inadequate i.e. he was aware that commission of offence would lead to conviction by the police and was not aware of the POCSO act and other relevant laws.

D. Other Observations & Issues

He has been of easy and friendly/ social temperament since early childhood.

Based on the history taken from the child's mother and the Observation home staff, child has no anger/ aggression issues, or any behavioural issues; in fact, he is observed to be very gentle and soft-spoken, of a serious nature and largely concerned about his mother's/ family's socio-economic situation and is the main financial support for the family.

E. Recommendations

A brief intervention has been carried out for the child's substance use practices. Child is motivated to quit and responded well to the inputs given.

Some discussions were had with the child (and his mother) regarding his future and what he intends to pursue as a career. Child wishes to stay at home and continue his work in the garage.

Given the nature of the alleged offence, we recommend that the child be referred to Dept. of Child & Adolescent Psychiatry NIMHANS, after he is released on bail in order to address his life skills deficits namely, decision making skills in the context of relationship and sexuality issues. These learnings and skills would be greatly beneficial to the child and protect him in the future.

Again, thank you for your referral; we are, as always, happy to assist vulnerable children, in particular children in conflict with the law, and the systems working with them.

Thanking you,

Yours sincerely,

xxxxxxxxxxxxxxxx

[Name & Designation of Mental Health Professional]

Annex VII
Bombay High Court Judgment:
Mumtaz Ahmed Nasir Khan vs The State Of Maharashtra on 15 July, 2019

Bombay High Court
Mumtaz Ahmed Nasir Khan vs The State Of Maharashtra on 15 July, 2019
Bench: D. S. Naidu

IN THE HIGH COURT OF JUDICATURE AT BOMBAY
CRIMINAL APPELLATE JURISDICTION

CRIMINAL APPEAL NO. 1153 of 2018

Mumtaz Ahmed Nasir Khan
R/o.117/125, Room No.10,
Sharbatwala Building,
Maulana Azad Road, Dunkan Road,
Mumbai - 8. ... Appellant/
Original Complainant.

v/s.

The State of Maharashtra
(Through J.J. Marg Police Station)

2. Shoeb Mohamed Akram Shaikh
Through his father
Mohd. Akram Shaikh
R/o: Room No.1603, Zain Tower,
Temkar Street, Mumbai

... Respondents/
Original CCL-2

WITH
CRIMINAL WRIT PETITION NO.1346 OF 2018
WITH
CRIMINAL APPLICATION NO.262 OF 2018
IN
WRIT PETITION NO.1346 OF 2018

Mohamed Huzaifa JavedAhemd Ansari
Through his Guardian
Javed Ahmed Ismail Ansari
R/at: 125/14, Kalvert Building,
M.A.Road (Duncan Road),
Mumbai - 400 008

::: Uploaded on - 17/07/2019 ::: Downloaded on - 17/07/2019 21:59:37 :::

At present lodged at Children Home,
Dongri Mumbai. ... Petitioner
(Ori. Accused/CCL-1)

v/s.

The State of Maharashtra
(at the instance of
Senior Inspector of Police,
J.J.Marg Police Station
vide C.R. No.228 of 2016) ...Respondents

Ms. Gayatri Gokhale a/w.Ms. Samruddhi Salvi i/b. Rizwan Merchant & associates for the appellant.

Mr. MubinSollkar a/w. Mrs. Tahera Qureshi i/b Yakub Shaikh for respondent no.2.
Mr. Nitin Sejpal a/w. Akshata Desai for petitioner in wp 1346/18.
Mr. A.S. Patil, APP for the State.

CORAM : DAMA SESHADRI NAIDU, J.

JUDGMENT RESERVED ON : 20th June 2019

JUDGMENT PRONOUNCED ON : 15th July 2019

JUDGMENT

Introduction:

1. A boy, on the verge of attaining adulthood--to be precise, seventeen and half years old--faces an allegation he has inhumanly killed a three-and-half-year-old child. Motive uncertain, the offence remains heinous.

2. Another boy, only a little younger--sixteen and half years--

 faces the allegation of, first, conspiring with the older boy in the offence and, second, helping him, later, to "make the evidence disappear," besides screening that older boy from police detection, too. Procedural History:

3. The Juvenile Justice Board ("the Board") assesses the older juvenile's physical health, mental maturity, and other collateral factors, and decides to try him, under Section 15 of the Juvenile Justice Act, 2015, as if he were an adult. After applying the same standards, it, however, decides to try the younger one as a juvenile. The Board's decision engendered before the Sessions Court two appeals: One by the Government against the Board's

decision to try the younger boy as a juvenile; the other by the older boy against its decision to try him as an adult.

4. The Sessions Court, on the merits, through its Orders, dated 21st February 2018, dismissed both the appeals. Now against the two appellate orders, the victim's father, instead of the Government, filed Appeal No.1153 of 2018. The older juvenile, too, has filed Writ Petition No.1346 of 2018, in which the victim's father joined as an intervener.

Facts:

5. On 5th December 2016, the complainant received a phone call from his wife that their daughter, three-and-half-year old, went missing. He rushed home, searched for his daughter, and then lodged a 4/44 juvenile justice board.doc complaint with the jurisdictional police. The next day, the police registered a crime under Section 363 of IPC. Until 18th December the case saw no progress. The next day, an anonymous person called the complainant over the phone and demanded a ransom of one crore rupees. The calls continued the next three days. When the police tracked the calls, they led to the older juvenile; they took him into custody. On the information provided by him, the police recovered the baby's dead body.

6. The older juvenile, on interrogation, has allegedly revealed that, first, he applied chloroform to the baby and, later, strangulated her by the cord of a mobile charger. He is said to have disposed of the dead body helped by the younger juvenile. In the investigation, the police have also learned how the older juvenile used to boast of his criminal ability or acumen, and how he enticed into his house the baby playing in their residential complex. They have also gathered evidence about the role the younger juvenile played not only in disposing of the body but also in trying to conceal the older juvenile's identity from the police: the use of different phones, sim cards, and, as a whole, the technological adventures. So the police added to the crime Sections 302, 385, 201, and 34 of IPC.

7. As both the accused are juveniles, the Board took up their case for determining whether they should be tried as juveniles or adults, under Section 15 of the Act. It has held that the older one should be 5/44 juvenile justice board.doc tried as an adult and the younger one as a juvenile. The appeals rejected, the complainant and the older juvenile have filed Appeal No.5160 of 2018 and WP No.1346 of 2018 respectively. The nomenclature of the proceedings does not seem to jibe with the statutory mandate, for what lies is only a revision under Section 102 of the Juvenile Justice Act. Yet one is an appeal and the other a criminal writ petition.

Submissions:

Victim's Father (Appellant in Appeal No.1153 of 2018 and Intervener in WP No.1346 of 2018):

8. Ms. Gayatri Gokhale, instructed by Rizwan Merchants & Associates, the appellant's counsel, has strenuously contended that the murder is gruesome, and both the juveniles played equal role in that one. According to her, it is a misnomer to call these two accused juveniles, because of both the depravity of the crime and their near adulthood--just a few months short of 18 years.

9. Ms. Gokhale has taken pains to take me through the record, especially a few portions of the chargesheet as well as the orders of both the Juvenile Justice Board and the Sessions Court. First, she contends there is voluminous evidence on record that the younger juvenile has harboured common interest

since inception and conspired with the older one. To drive home her point, she has read out the statements of a couple of witnesses. Second, according to her, after the murder, the 6/44 juvenile justice board.doc younger juvenile has continued to act in concert with the older one and did all he could to give different colour to the crime, to make the evidence disappear, and to screen the older juvenile from the needle of suspicion.

10. To conclude, Ms. Gokhale has submitted that to attract Section 34 IPC, it is unnecessary that the co-accused should have committed any overt act. Thus, the younger juvenile's participation in the crime, she stresses, amounts to his committing the heinous crime by himself, as defined under section 2(33) of the Juvenile Justice Act. And in that background, he must be tried as an adult, Ms. Gokhale concludes.

11. Besides highlighting Section 15 of the Act, Ms. Gokhale draws my attention to Section 19 of the Act and stresses that the Magistrate trying the offence has ample powers to declare a juvenile an adult, even disregarding the Board's opinion.

12. About the older juvenile, Ms. Gokhale, for the intervening second respondent, has highlighted, what she calls, the callous attitude the older juvenile has displayed throughout. She has referred to the social status and seemingly normal childhood of the older juvenile. According to her, with no poverty and no familial deprivation, the older juvenile had no justification for committing such monstrous crime.

13. Ms. Gokhale stresses that the Court ought to be guided by 7/44 juvenile justice board.doc the prima facie allegations, at this stage. And that is what, she points out, the Board and the Session Court have done; they have been, in fact, solely guided by what has been brought on record until now.

14. Eventually, Ms. Gokhale has taken me to a few parts of the chargesheet to highlight how both the juveniles used the technology and how their street-smart attitude helped them not only to commit the crime but also to hide it, for a while though. According to her, their conduct even post-murder deserves no sympathy. Thus, she urges this Court not to interfere with concurrent findings of the Board and the Sessions Court.

Younger Juvenile (Respondent in Appeal No.1153 of 2018):

15. On the contrary, Shri MobinSolkar, the younger juvenile's counsel, has submitted that even prima facie the younger juvenile's role commenced only after the older one committed the alleged murder. In this context, he contends that none of the Sections 302, 385, 201, 363, r/w 34 of the IPC applies to the alleged role the younger juvenile has played. So, the contention that the younger juvenile has harboured a common intention and conspired to kill the child attracting Section 34 of Indian Penal Code (IPC), Shri Solkar stresses, falls to the ground.

16. Only as a matter of hypothesis does Shri Solkar want the Court to treat Section 201 of IPC as applying to the allegations the younger juvenile has faced. Then, he has drawn my attention to section 2(33) to underline the fact that any offence to be labeled heinous must 8/44 juvenile justice board.doc be punishable with a minimum punishment of seven years and above. The punishment under section 201 of IPC, according to him, even for a capital offence, is a minimum of three years, extendable up to seven years. With that statutory prop, he asserts that any offence under Section 201 cannot be termed 'heinous'.

17. On his part too, Shri Solkar has taken me through the statements of various witnesses to stress that until the murder was committed, the younger juvenile was nowhere in the picture. In the same vein, he submits that post-murder, there are, indeed, certain allegations against the younger juvenile. But none amounts to a heinous crime. Thus, he urges this Court to dismiss the appeal. Older Juvenile (Appellant in WP No.1346 of 2018):

18. Shri Nitin Sejpal, the older juvenile's counsel, has taken me to the definitional dynamics of Section 2 of the Act, with a particular reference to sub-sections (12), (13), (33), (35), (40) and (54). According to him, there is nothing much to distinguish between the younger and the older juveniles (technically called CCL-1 and CCL-2 respectively). Yet the JJ Board has given the benefit of the Act only to the younger juvenile.

19. To elaborate, Shri Sejpal submits that both the juveniles are almost of the same age, but for a few months between them. Their social background, family circumstances, and physical as well as mental capacity shows the same pattern as revealed by the social investigation.

9/44 juvenile justice board.doc Then, Shri Sejpal has stressed that drastic may be the allegations but even the older juvenile has always enjoyed the presumption of the innocence, as statutorily secured under Section 3 of the Act.

20. Shri Sejpal has taken me through every observation in investigation report to hammer home his contentions that the older juvenile is a normal child, brought up in a family with values. In that context, he has submitted that the father is well educated, the family is respected, and none in that family has been accused of any crime hitherto.

21. Elaborating on the older juvenile's credentials, Shri Sejpal submits that when the alleged incident took place, the older juvenile was pursuing his eleventh class. Even in judicial custody, he continued his education and cleared the Board examination, that is Class 12th, as well. The Social opprobrium the family has already suffered apart, the Court's decision to try the older juvenile as an adult will jeopardize his future, including educational and career prospects.

22. True, Shri Sejpal has also referred to the alleged police brutality and how they have extracted confessions from him. I am afraid they fall beyond the scope of this adjudication. Nor has the appeal refers to the alleged police brutality. Eventually, Shri Sejpal has referred to a judgment of this Court in Saurabh JalinderNangre and others v. State of Maharashtra[1] . Based on that decision, he submits 1[] 2019 (1) Crimes 253 (Bom.) 10/44 juvenile justice board.doc that the prosecution and the Juvenile Justice Court have failed to establish anything heinous against the older juvenile.

23. Finally, Shri Sejpal submits that mere incorporation of, for instance, Section 302 would not foreclose a juvenile's option--even right--to be tried only as a juvenile. Thus, summing up his submission, Shri Sejpal urges this Court to reverse the concurrent findings of the Juvenile Justice Court and the Sessions Court. Consequently, he wants the older juvenile, too, tried as a juvenile.

Discussion:

24. To preface, let me invoke William Shakespeare. In Winter's Tale, (Act 3, Scene 3), through a shepherd, he bemoans the terrible teens: I would that there were no age between sixteen and three-and- twenty, or that youth

would sleep out the rest, for there is nothing in the between but getting wenches with child, wronging the ancientry, stealing, fighting . . .[2]

25. Two juveniles--one aged seventeen and half years and the other sixteen and a half years--face the allegation of killing a child of three and a half years. To face the trial, they must first be assessed whether they are mentally and physically still juveniles or have the maturity of an adult. For this, we must, to begin with, survey the statutory scheme.

2[] Paraphrased: I wish that the ages between sixteen and twenty- three didn't exist, or that young men would spend them asleep. Otherwise there is nothing between those ages but getting . . . acting dishonestly toward their elders, stealing, fighting . . .

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Statutory Stipulations:

26. Juvenile Justice (Care and Protection of Children) Act, 2015, governs the issue. It is a law that concerns the "children alleged and found to be in conflict with the law and children in need of care and protection." The enactment has its constitutional foundations in clause (3) of Article 15, clauses (e) and (f) of Articles 39, Article 45, and Article 47 of the Constitution of India. Traveling beyond the Municipal Law, we find that "the Government of India has acceded on the 11th December 1992 to the Convention on the Rights of the Child, adopted by the General Assembly of United Nations." This Convention prescribes a set of standards to be adhered to by all State parties in securing the best interest of the child. The 2015 Act models itself after the standards prescribed in the Convention's Beijing Rules, 1985, the UN Rules for the Protection of Juveniles Deprived of their Liberty, 1990, and the Hague Convention on Protection of Children and Co-operation in Respect of Inter-country Adoption, 1993.

27. This Act applies to all matters affecting the children needing care and protection and children in conflict with the law. Under Section 2 (12), a "child" means a person who has not completed eighteen years of age. A "child in conflict with law", under Section 2 (13), means a child who is alleged or found to have committed an offence and who has not completed eighteen years of age on the date of commission of the offence. And "heinous offences", as defined under 12/44 juvenile justice board.doc Section 2(33), include "the offences for which the minimum punishment under the IPC or any other law for the time being in force is imprisonment for seven years or more."

28. Under Section 2 (35) a "juvenile" means a child below the age of eighteen years. Thus a "child" and a "juvenile" seem synonymous

--both having the threshold of 18 years. Sub-section (4) defines an "observation home." And sub-section (54) defines "serious offences". As the definition is inclusive, any offences for which the punishment, under the IPC or any other law in force, is imprisonment between three to seven years.

29. Section 3 enumerates the "general principles to be followed in the administration of the Act." Among those principles, the principal are these: (a) The presumption of innocence: every child shall be presumed to be innocent of any mala fide or criminal intent up to the age of eighteen years. (b) Dignity and worth: all humans shall be treated with equal dignity and rights. (c) Participation: Every child shall have a right to be heard and to participate in all

processes and decisions affecting his or her interest. (d) Best Interest: all decisions about the child shall be in the best interest of the child and to help the child develop full potential. (e) Non-stigmatic semantics (words): adversarial or accusatory words are not to be used against a child. (f) No waiver of rights: no waiver of the child's any right. (g) Diversion: all measures must be taken to avoid judicial proceedings while dealing 13/44 juvenile justice board.doc with the children in conflict with the law. The judicial recourse, however, must be in the child's best interest or the society's.

30. Under Section 4 of the Act, the Juvenile Justice Board comprises a Metropolitan Magistrate or a Judicial Magistrate of First Class with prescribed qualifications such as experience, and two social workers, of whom at least one must be a woman. This Board will have the powers of a Metropolitan Magistrate or a Judicial Magistrate of First Class. If a person committed an offence when he was a juvenile but was apprehended after his crossing 18 years, he must be treated, under Section 6, as a child during the process of inquiry. Among the powers, functions, and responsibilities of the Board is its power to adjudicate and dispose of cases of children in conflict with the law in accordance with the process of inquiry specified in Section 14.

31. Under Section 14 of the Act, the Board inquires and passes orders under Sections 17 and 18. The inquiry encompasses all aspects of a child in conflict with the law. Indeed, under subsection (3), the Board preliminarily assesses heinous offences under section 15, in three months after the child is produced before it. Of course, the time may be extended for the reasons recorded. The Board would inquire into or try a heinous offence adopting the procedure of summons cases if the child was below sixteen years when he had committed the offence. For a child above sixteen years, inquiry must be as per Section 15.

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32. Now comes the prominent provision for our purpose: Section 15 of the Act. If a child above 16 years is accused of committing a heinous offence, the Board must conduct a preliminary assessment about the child's mental and physical capacity to commit the alleged offence, his ability to understand the consequences of the offence and the circumstances in which he allegedly committed the offence. Then, the Board will pass an order under Section 18 (3) of the Act. It pays to quote Section 15:

Section 15 - Preliminary assessment into heinous offences by Board:

(1) In case of a heinous offence alleged to have been committed by a child, who has completed or is above the age of sixteen years, the Board shall conduct a preliminary assessment with regard to his mental and physical capacity to commit such offence, ability to understand the consequences of the offence and the circumstances in which he allegedly committed the offence, and may pass an order in accordance with the provisions of subsection (3) of section 18:

Provided that for such an assessment, the Board may take the assistance of experienced psychologists or psycho-social workers or other experts.

Explanation.-- For the purposes of this section, it is clarified that preliminary assessment is not a trial , but is to assess the capacity of such child to commit and understand the consequences of the alleged offence.

(2) Where the Board is satisfied on preliminary assessment that the matter should be disposed of by the Board, then the Board shall follow the procedure, as far as may be, for trial in summons case under the Code of Criminal Procedure, 1973 (2 of 1974): Provided that the order of the Board to dispose of the matter shall be appealable under sub-section (2) of section 101:

15/44 juvenile justice board.doc Provided further that the assessment under this section shall be completed within the period specified in section 14.

(italics supplied)

33. As Section 15 permits the Board may, during the preliminary assessment, take the assistance of experienced psychologists or psycho- social workers or other experts. First, the preliminary assessment is "not a trial." Second, it is, instead, an inquiry to assess the child's capacity to commit the alleged offence and to understand its consequences. On inquiry, the Board must satisfy itself in its preliminary assessment about the juvenile's mental and physical capacity, his ability to understand the consequences of the offence, and so on. Then, if the Board is "satisfied on preliminary assessment that the matter should be disposed of", it will follow "the procedure, as far as may be, for trial in summons case under Cr PC." The Board's order is appealable under sub-section (2) of Section 101.

34. Now comes the role of the Children's Court. Once it receives the preliminary assessment from the Board under section 15, it may decide to try the child as an adult under Cr. P.C. If it decides to the contrary, it tries him as a juvenile. The Children's Court, too, "may conduct an inquiry as a Board and pass appropriate orders" under Section 18.

The Adjudicatory Bounds:

35. Against the Board's order under Section 15 of the Act, Section 101 (2) provides for an appeal. The appeal must be before the 16/44 juvenile justice board.doc Court of Sessions. The appellate court, too, takes the assistance of experienced psychologists and medical specialists, other than those who assisted the Board in its passing the order under appeal. As subsection (4) mandates, there is no further appeal against the Court of Session's order.

36. Indeed, the High Court, under Section 102, has revisional powers. It is, as I see, a generic revisional power. It may, at any time, "call for the record of any proceeding in which any Committee or Board or Children's Court, or Court has passed an order". Once the record is placed before it, the High Court may satisfy itself about "the legality or propriety" of any order and "pass such order in relation thereto as it thinks fit."

37. Earlier the Supreme Court has considered the High Court's revisional powers under the now-repealed 2002 Act. In Jabar Singh v. Dinesh[3], it has held that the revisional court's powers differ from the appellate court's. They are more restricted. Especially on the findings of a fact, the revisional court does not interfere unless there is illegality or perversity.

What makes a juvenile an adult, besides the numerical called age?

38. A universally accepted ideal is that children are dependent and deficient in the mental and physical capacities, and are in need of 3[ ] 2010 3 SCR 353 17/44 juvenile justice board.doc guidance. Perhaps, initially, a multi-visual medium like TV; later, a globe devouring internet (appropriately, ominously worded as "world wide web"), and finally--and fatally--the post-truth

social media have let the children, especially the adolescents, leapfrog into the adult world. Mostly it is a crash-landing, with disastrous consequences. So the childhood innocence is the casualty. These devices may have made a child bypass his or her childhood, sadly. Then, naturally, the theory of reduced culpability for juveniles relative to adults has taken a statutory dent. The good-old-days icon of a truant child seems to get replaced by the modern-day mascot of a violent predator.

39. If we take the USA as a case in point because there the data are more easily accessible, we can see a dramatic upswing in youth crimes beginning in the 1970s. It caused a new shift in the treatment of juvenile offenders. The public became increasingly alarmed by the reported surge in murders, rapes, and other violent assaults committed by teenagers. So people began demanding their legislatures to act. Some experts have blamed the increase in juvenile crime on the rise in drug abuse, especially the influx of crack cocaine, while others blame a lack of parental guidance due to the decline of the traditional two- parent home. While overall crime increased during the 1980s and 1990s, juvenile crime grew at a disproportionately faster rate. According to one study cited by Richard E. Redding in Juvenile and Family Court Journal, from 1987 to 1995 the number of juveniles 18/44 juvenile justice board.doc arrested for violent crimes such as aggravated assault, murder, manslaughter, and rape rose 60%, while adult violent crime rose only 24% over the same period. But Redding also notes that between 1994 and 1996, there were significant decreases in juvenile crime, including a 31% decrease in juvenile homicide[4].

40. The perception of a juvenile crime wave persists, however, largely because of national media coverage of extreme cases. So concludes Richard E. Redding.[5]

41. As a result, since the mid-1970s, nearly every U.S. state has revised its laws to facilitate the transfer of adolescents from juvenile to criminal court (these laws are thus called the "transfer laws"). Some states have lowered the age at which an adolescent is eligible to be transferred by a judge to criminal court; some states have allowed prosecutors to directly file adolescents' cases in criminal court, before any hearing in the juvenile court; and some states created laws that automatically exclude certain adolescents (based on their age and charged offense) from juvenile court. The specifics of states' transfer laws vary considerably, but the result is that more youth below eighteen are now prosecuted in criminal court rather than juvenile court.[6] 4[] As quoted in Trial of Juveniles as Adults, Kevil Hile, Chelsea House Publishers, Philadelphia, Ed.2003, pp.21 and 22. 5[].Id.

6[] Judging Juveniles, Prosecuting Adolescents in Adult and Juvenile Court, by Aaron Kupchik, New York University Press, Ed. 2006. P.4 19/44 juvenile justice board.doc

42. On transfer to the regular criminal court, the trial may be according to the mainstream criminal procedure, but the punishment, however, must be reformative and rehabilitative--rather than retributive. Then what is the difference between the two trials--the trial before the regular court and that before the children's court?

43. Essentially, the trial in the regular court is offense oriented; in the juvenile court, it is offender oriented. In other words, in the children's court, societal safety and the child's future are balanced. For an adult offender, prison is the default option; for a juvenile it is the last resort. Aaron Kupchik calls the method adopted by the regular criminal courts vis-a-vis juveniles the

"sequential model of justice." That is, it adheres to a criminal justice model during the trial phase of case processing, but moves toward a juvenile justice model during sentencing, though the quantum varies in both methods. In contrast, the juvenile court follows a justice model throughout.

44. Under the Chapter "Understanding the Scope of the Problem", Aaron Kupchik notes that jurisdictional transfer is hardly an innovation. Since the creation of the juvenile court, judges have been able to designate as adults and transfer to criminal court certain serious offenders who require punishments beyond what the juvenile court can give. The methods, according to him, vary, though. He identifies three methods.

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45. The first method is judge-centric. The judge can select for transfer the most serious juvenile court cases, involving either the most severe offenses or chronic offenders. This method is termed "judicial transfer" or "judicial waiver". It was once prevalent. The second method is legislative transfer, or statutory exclusion. This is what Section 15 of the Act advocates. The third is "direct file", or "prosecutorial transfer". This method gives prosecutors "substantial authority without any oversight or judicial supervision."

46. The learned author then quotes from the book, The Child Savers, in which its author Anthony Platt responds to how he would ideally like to handle cases of adolescents. He replies:

If I was going to do social engineering, I suppose what I would do is create a system where the courts would deal with these issues, the [Juvenile] Court and the [Criminal] Court, would be permitted access to impaneled and certified experts in child psychology, child behavior, mental health, where assessments could be done that would be state-of-the-art to evaluate the child's cognitive skills and educational level, where we would have the benefit of a full analysis of the capacity of the individual in front of us and access to expertise at will. And then we can do what is appropriate based on a better understanding [of] who is in front of us.[7]

47. I reckon Section 15 of the Act precisely does this. It takes into the evaluative process the child's behaviour, mental health, cognitive skills, and educational level. The criteria met, then it is "adult time for 7[] Anthony Platt's The Child Savers, as quoted in Judging Juveniles, P.97 21/44 juvenile justice board.doc adult crime." That said, it is no easy task to apply this adage of adult crime and adult time.

48. In Rethinking Juvenile Justice[8], Elizabeth S. Scott & Laurence Steinberg, under the caption "The Psychology of Adolescence and the Regulation of Crime," observe that adolescents differ from adults--and juvenile offenders differ from adult criminals--in ways important to the regulation of youth crime. A vast body of recent research that was not available a generation ago, according to the authors, offers insights into both adolescence and youth crime. The research demonstrates convincingly this developmental stage is distinctive in ways that are relevant both to the involvement of adolescents in crime and to the effective legal responses.

49. According to Elizabeth S. Scott et al, first, available scientific knowledge confirms what parents of adolescents surely know--that although teenagers are not childlike, they are less competent decision makers than are adults. Indeed, adolescents' capacities for reasoning and understanding (what might be called "pure" cognitive abilities) approach adult levels by about age sixteen. But the evidence suggests they may be less capable than are adults

of using these capacities in making real-world choices. More important perhaps is that the juvenile's emotional and psychosocial development lags behind their cognitive maturation.

8[] Harvard University Press, Ed. 2008, Pp.4-6 22/44 juvenile justice board.doc

50. For example, teenagers are, according to Elizabeth S. Scott et al, considerably more susceptible to peer influence than are adults; they are more likely to focus on immediate rather than long-term consequences; they are more impulsive and subject to mood fluctuations. They are, in fact, more likely to take risks and probably less skilled in balancing risks and rewards. Finally, personal identity, the authors opine, is fluid and unformed in adolescence. This is a period when individuals separate from their parents, experiment (often in risky endeavors), and struggle to figure out who they are.

51. Then, Elizabeth S. Scott et al note that these developmental factors, in combination, undermine adolescent decision making and contribute to immature judgment--as this term is used in common parlance. Moreover, recent research has elucidated the biological underpinnings of many of these psychological attributes. Studies of brain development show that during adolescence, significant maturation occurs in brain systems and regions involved in long-term planning, impulse control, regulation of emotion, and evaluation of risk and reward. Thus, the immature judgment of teenagers to some extent may be a function of hard wiring.[9]

52. Of course, there are people who scoff at this pro-juvenile slant. For them juvenile offenders are "criminals who happen to be young, not children who happen to be criminal."[10] Finally, Elizabeth 9[] Id., p.--------10[] Id., p.82

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S. Scott et al caution that "the categorical waiver of youths on the basis of age and the seriousness of the presenting criminal charges alone is undesirable" on social welfare grounds because almost surely it will lead to adult prosecution and punishment not only of life-course persistent offenders but "also of many normative adolescents who would likely mature out of their inclinations to get involved in criminal conduct." Then, "to avoid sweeping many youths who are not incipient criminals into the adult system," they conclude, "transfer should be precluded for any juvenile with no previous record of serious violent offending"[11]. In the UK:

53. Under the English Legal System, young offenders are usually tried in youth courts (formerly called juvenile courts), which are a branch of the magistrates' court. Other than those involved in the proceedings, the parents and the press, nobody may be present unless authorised by the court. Parents or guardians of children under 16 must attend court at all stages of the proceedings, and the court has the power to order parents of older children to attend.

54. Young persons can, in limited circumstances, be tried in a Crown Court: for example, if the offence charged is murder, manslaughter, or causing death by dangerous driving. They may sometimes be tried in an adult magistrates' court or the Crown Court if a co-defendant in the case is an adult. Following a Practice Direction, 11[] Id., p.243 24/44 juvenile justice board.doc discussed below, a separate trial should be ordered unless it is in the interests of justice

to do otherwise. If a joint trial is ordered, the ordinary procedures apply 'subject to such modifications (if any) as the court might see fit to order'.

55. The trial procedures for young offenders have been reformed in the light of a ruling of the European Court of Human Rights in T v UK and V v UK (2000). The EC Court has found that Jon Venables and Robert Thompson, who were convicted by a Crown Court of murdering the two-year-old James Bulger in 1993, did not have a fair trial under Art. 6 of the European Convention on Human Rights.

56. Following that decision in Thompson and Venables, a Practice Direction was issued by the Lord Chief Justice laying down guidance on how young offenders should be tried when their case is to be heard in the Crown Court. The language used by the Practice Direction follows closely that employed in the European decision. It does not lay down fixed rules but states that the individual trial judge must decide what special measures are required by the particular case, considering 'the age, maturity, and development (intellectual and emotional) of the young defendant on trial'.

57. The trial process should not expose that defendant to avoidable intimidation, humiliation or distress. All possible steps should be taken to assist the defendant to understand and participate in the proceedings. It recommends that young defendants be brought into 25/44 juvenile justice board.doc the court out of hours, so they become accustomed to its layout. Jon Venables and Robert Thompson had both benefited from these familiarisation visits. The police should try to avoid exposing the defendant to intimidation, vilification or abuse. As regards the trial, it is recommended that wigs and gowns should not be worn and public access should be limited. The courtroom should be adapted so that, ordinarily, everyone sits on the same level[12]. Europe:

58. In Western continental Europe, the upper limit of penal liability within the juvenile justice system is 18 years. In some countries this upper-age limit is absolute: strict model. It means minors can never be brought before an adult court. In others, this limit is flexible, so minors can get adult sentences and (in some countries) even be sentenced by an adult criminal court. It is a flexible model.

59. Germany is a striking example of the strict model. In that country, juveniles only come under the youth justice system from the age of 14. The German Jugendgerichtsgesetz (JGG) distinguishes educational measures, disciplinary measures, and punishments. Austria, too, operates, under the strict model. So is Switzerland.

60. The second model in operation in Europe is one in which a flexible upper limit is coupled with relatively low maximum penalties in the juvenile justice system.

12[] English Legal System, Catherine Elliott and Frances Quinn, 17th Ed., Pp.514-15 26/44 juvenile justice board.doc

61. Under the flexible model, most juveniles who appear in court are guaranteed a relatively low maximum penalty, with exceptions for very serious cases. This model operates in the Netherlands. Article 77b of the Penal Code allows courts to try suspects who were 16 or 17 years old at the time of the offence under ordinary adult criminal law if they find grounds to do so in 'the seriousness of the crime, the personality of the offender, or the circumstances in which the crime was committed'. Belgium and France, too, operate this model, with variations as to the juvenile's age.[13] In the USA:

62. In Kent v. United States[14] , Kent, 16-year-old, was arrested for various charges. For 24 hours he was in police custody; questioned, he admitted to some offenses. Then Kent was subject to the "exclusive jurisdiction" of the District Juvenile Court, which could "only waive jurisdiction after a "full investigation" of the question of waiver." In Kent's case, the Juvenile Court waived its jurisdiction without a hearing or allowing Kent's counsel to access important Court Social Service files. The U.S. District Court dismissed Kent's claim and tried him as an adult. Later, he was convicted as an adult.

63. When Kent's challenge eventually reached the US Supreme Court, it has considered the factors to be considered before transferring 13[] Reforming Juvenile Justice, Josine Junger-Tas Frieder Dünkel Editors, Springer, Ed. 2009 14[] 383 U.S. 541 (1966) 27/44 juvenile justice board.doc juveniles to criminal court. According to it, the judges must assess these factors thoroughly before waiving a juvenile to criminal court:

    1. The seriousness of the alleged offense to the community and whether protecting the community requires waiver;

    2. Whether the alleged offense was committed in an aggressive, violent, premeditated, or willed manner;

    3. Whether the alleged offense was against persons or against property, greater weight being given to offenses against persons, especially if personal injury resulted;

    4. The prosecutive merit, i.e., whether there is evidence upon which a [court] may be expected to return an indictment;

    5. The desirability of trial and disposition of the entire offense in one court when the juvenile's associates in the alleged offense are adults;

    6. The sophistication and maturity of the juvenile by consideration of his home, environmental situation, emotional attitude, and pattern of living;

    7. The record and previous history of the juvenile, including previous contacts with . . . law enforcement agencies, juvenile courts and other jurisdictions, prior periods of probation . . . or prior commitments to juvenile institutions;

    8. The prospects for adequate protection of the public and the likelihood of reasonable rehabilitation of the juvenile (if he is found to have committed the alleged offense) by the use of procedures, services, and facilities currently available 28/44 juvenile justice board.doc to the juvenile court.[15] (italics supplied) The Older Juvenile's Characteristics:

    (a) The Social Investigation Report, dt.18.08.2018:

64. In the absence of any other criteria, let us examine the case in the light shown by Kent. First, we will examine the Social Investigation Report. Prefatorily, the Report classifies, rightly, the offence as heinous. About the older juvenile, it notes he is a normal child; his father is an architect having his own office; the mother a homemaker; and two siblings, younger sisters, both studying.

65. As to the relationship among the members of the family: father & mother--cordial; father & child--cordial; mother & child-- cordial; father & siblings--cordial; mother & siblings--cordial; child & siblings--cordial; child & relative--not known. The older juvenile's attitude towards religion, to sum up, is God-fearing; he does his prayers regularly. Of moral code at home, the Report records it to be good, as the father is well-educated and is well aware and

concerned about the children's education. "All children are pursuing education. Parents often inquire about daily schedule of children."

66. About the present living conditions, the Report reveals that before the incident, the family was living in its own house. Post-

15[] Source: Dean J. Champion and G. Larry Mays, Transferring Juveniles to Criminal Courts: Trends and Implications for Criminal Justice, Praeger, 1991, as quoted in Trial of Juveniles as Adults, p.19 29/44 juvenile justice board.doc incident, it shifted to paternal uncle's house. Under the caption "other factors of importance if any", the Report notes that after the incident the complainant and the neighbours turned hostile, so the family had to leave the place.

67. About the older juvenile's habits, the Report notes that he does not smoke, drink, gamble, or beg. He uses no drugs. He watches TV and movies, loves playing both indoors and outdoor games, reads books, but does not have specific religious activities. He is fond of sports cars.

68. The juvenile's personality trait is reported to be "cool tempered and noticed to be sensible." The older juvenile's attitude towards school, teachers, classmates and "vice-versa" reveals that he was not so regular to college and average in studies. "He said he is absent from long as he was not keeping well due to harpies that he was infected." Majority of his friends are educated, either of the same age or older, but belong to the same gender. His attitude towards friends reveals that he spends good time with his friends. He is stated to have a good bonding with friends and "so does his friends."

69. Of importance is the neighbours' observations or, more precisely, their absence. The Report reveals that "neighbours are not contacted as the society is a flat system, other flats on the floor were locked & no one was available to interact." This version, first, is difficult to believe and, second, the Report misses a vital opportunity to 30/44 juvenile justice board.doc assess the juvenile in the eye of the neighbours--the miniature society. Then, on the parental attitude towards discipline in the home and child's reaction, the Report observes that it is "noticed to be good", as the parents stated they often enquire about the daily schedule of children, keep supervision on academics. And the juvenile too affirms it.

70. Another vital factor in the Report concerns whether the "child has been subjected to any form of abuse." The older juvenile informs the authorities that at the time of his admission into OHU, he "was beaten in the police station by police officials" and that the statement was submitted to the Juvenile Justice Board for information. About the "alleged role of the child in the offence", the older juvenile admits that he committed the crime. Despite that, the Report concludes that the child is "manipulative based on verbal statements given by him."

71. The older juvenile's health is normal. As to the emotional factors, he is "observed to be emotionally stable. There is no evidence of any kind of psychological disorder. " The [older juvenile] expressed his feelings of guilt and regret for his unhealthy action in the offence." In other words, he is penitent.

72. Now comes the summation part of the Report. Under "Analysis of the case", the Report records that "the [older juvenile] accepted his active involvement in the offence & stated that the girl was accidentally death by him.

31/44 juvenile justice board.doc [The older juvenile] mentioned that he and his friend Shoeb is partially involved in the offence whereas he refers to this incident with the coincidence."

73. From the above extract, I gather that the older juvenile has admitted that he killed the girl, but that was accidental. He states that his friend, the younger juvenile, has a partial role in the crime. He again reiterates the crime was accidental.

74. Then comes the subjective observation in the Report. It states that the older juvenile "fumbled while providing the details of the incident; his own information is contradicting with the other factors provided by him. And he was not so co-operative during interview sessions and seems to be highly manipulate[ive]."

75. With due deference to the Probation Officer's opinion, I may note that the conclusion does not jibe well with the rest of the Report. If the older juvenile is manipulative, he ought to be crafty and cunning. He must be glib, not fumbling and clumsy. Then, he must not have admitted his guilt. On the contrary, he has, prima facie, made a clean breast of the event.

76. Finally comes the "recommendation regarding rehabilitation by Probation Officer." The Report records that the older juvenile is undergoing Class XII exam in OHU, "preparing well for the exam." Now it comes to light, he did clear that examination. The parents were "at present unwilling . . . for the custody" of their child. They felt it better if the child is kept in the 32/44 juvenile justice board.doc Observation Home for some more time, "as outside environment is unfavourable and it might be harmful to the [older juvenile.]

77. The Report also records that the older juvenile was "counselled against the involvement in the criminal act & he was also motivated for a need to focus on his academic career that will help him" make a better future. But the Report concludes thus: "Considering the gravity of the offence and in the best interest of the [older juvenile], further necessary orders can be passed." This report emanates from the Probation Officer.

(b) Mental Health Report:

78. The Mental Health Report comes from three Mental Health Experts of J. J. Group of Hospitals. It was given on 10th April 2017.

79. The MH Report begins with an observation that the older juvenile "has no psychiatric complaints at present." Then it records, what the juvenile has narrated. The juvenile knew the victim as she used to stay in the same building and often visited his house asking for chocolate, which he regularly kept in the house. Once he ignored the child's request (on the fateful day), she started to snatch at his phone; then he pushed her. When she fell down, a wooden plank fell on her. In that process, she got "accidentally strangulated due to computer wire." He is said to have panicked and hidden her body in a bag (in his house) and threw it from the window to the terrace of a neighbouring structure to evade suspicion.

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80. The MH Report records how the older juvenile has further dealt with the incident. He says that he announced the news of the missing girl in the local Masjid. He claims to have tried to keep track of the search operations for the missing child. Some people started voicing concerns that as no ransom calls were made, the child must be in the locality. So he made ransom calls along

with his friend, the second juvenile. He further claims to have never gone to the place where he asked the child's father to drop the ransom money.

81. Then, MH Report records the juvenile's mental health assessment. In January 2008, he was taken to Psychiatry OPD in Nair hospital for behavioural problems. "Provisional diagnosis conduct was made and he was kept under observation on OPD basis. His IQ test showed average intelligence and CAT test in 2009 showed conflicts with "authority figures". As per the available documents, he was given medications on 14.11.2009 for his behavioural problems after which they never followed up. Further documents of treatment and further progression of illness is not available. No history of any substance use. No family history of psychiatric illness. No history of any medical or surgical illness.

82. On Mental Status Examination, the MH Report concludes that the older juvenile is "conscious, cooperative, communicative; Attention is aroused and sustained; eye to eye contact initiated and maintained; rapport established; oriented of time, place and person;

34/44 juvenile justice board.doc speech and thought conscious, coherent, relevant, no delusions. In one word, the MH Report concludes that the older juvenile is normal and suffers from no mental incapacity to commit the offence.

(b) Juvenile Justice Board:

83. The Board comprised the Principal Magistrate and two members, one of whom was absent. In its Report or Order, dt.22.08.2017, the Board has decided to try the older juvenile as an adult and the younger one as a juvenile.

84. After referring to the Social Investigation Report and the MH Report, the Board concludes, "[i]n the circumstances stated above, I do not find any mitigating circumstances in the case of [older juvenile] to extend him the benefit of Juvenile Justice Act." Of course, it takes a lenient view vis-à-vis the younger juvenile, given his limited role in the crime.

(d) The Appellate Court:

85. On appeal, the Special Judge, Children's Court, has observed that the JJ Board has rightly appreciated the Social Investigation Report and Physical & Mental Health Report. The appellate order holds that the older juvenile was of sound mind and had the age of understanding the consequences when he allegedly committed the offence. It, then, concluded, "I am of the considered view that [the older juvenile] cannot be inquired with by the JJ Board in view of the heinous act committed by him, he has to be treated as an adult."

35/44 juvenile justice board.doc Does the Board's Decision, as Affirmed by the Appellate Court, Brook Interference?

86. It is inadvisable to tinker with an expert's opinion. Yet it remains, after all is said and done, an opinion, at that. The JJ Board has undertaken no independent assessment; it has, in fact, heavily relied on the Social Investigation Report and MH Report. So its opinion, in the strict sense, cannot be branded an "expert opinion." The same reasoning applies to the appellate order, too. That said, the two reports the Board has relied on are, indeed, expert opinions: one rendered by a Probation Officer and the other by a panel of doctors. But neither report brings out into open any exceptional circumstances that compel the older juvenile to face the trial as an adult.

87. So we need to revisit Section 15 of the Act to determine what circumstances compel a juvenile to face the trial as if he were an adult. (1) It must be a heinous offence; here it is. (2) The child must have completed sixteen years; here he has. (3) The Board must have conducted a preliminary assessment; here it has. (4) That preliminary assessment concerns four aspects: (a) the child's mental and (b) physical capacity to commit such offence; (c) his ability to understand the consequences of the offence; (d) and the circumstances in which he allegedly committed the offence. The preliminary assessment, indeed, has been on all these aspects. Agreed. But has the Board found the child fitting into the scheme on all four counts?

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88. I reckon of the four aspects--physical capacity, mental ability, understanding, and the circumstances--none is dispensable. They all must be present, for they are not in the alternative. Let us remind ourselves, just because the statute permits a child of 16 years and beyond can stand trial in a heinous offence as an adult, it does not mean that the statute intends that all those children should be subject to adult punishment. It is not a default choice; a conscious, calibrated one. And for that, all the statutory criteria must be fulfilled.

89. Here, the Social Investigation Report records many factors uniformly in the older juvenile's favour. It misses out on one very vital aspect: the neighbourhood perception of the juvenile. It records an improbable circumstance: that in a residential apartment, none was present to provide information on that count. On every other parameter, the Report favours the juvenile. In fact, the juvenile makes a clean breast of the incident or crime and expresses remorse for the accident, as he calls it. It is, true, an extra-judicial confession. So is what the police have extracted from him about the child's death. The older juvenile did report to the Probation Officer about the police brutality and the Report responds to it. It has informed the Board about the juvenile's allegation.

90. Despite the older juvenile's "confession" to crime, the Report records that he has been manipulative and evasive--even contradictory. But the very Report belies it. Perhaps, the gravity of the offence and the 37/44 juvenile justice board.doc public outcry must have heavily weighed on the Report. Let us take, for want of better evaluative norms, Kent's criteria and assess the Board's justification to try the older juvenile as an adult:

(1) The seriousness of the alleged offense to the community and whether protecting the community requires a waiver:

The offence serious--even grave--and the community needs protection. But the Social Investigation Report misses out on gathering the community's opinion whether it needs protection from this juvenile. Is he a predator on the prowl and out to repeat the offence with or without provocation? The older juvenile, in fact, is an ordinary, unremarkable neighbourhood boy.

(2) Was the alleged offence committed in an aggressive, violent, premeditated, or willed manner?

No. Even the extra-judicial confession does not spell out that it was.

(3) Was the alleged offense committed against persons or against property, with a greater weight attached to offenses against persons, especially if personal injury resulted.

The alleged offence answers this claim here.

(4) The prosecutive merit of the complaint; that is, is there evidence upon which the court may be expected to return a guilty verdict?

Very likely (only for the evaluative purpose, though) (5) The desirability of trial and disposition of the entire offense in one court when the juvenile's associates in the alleged offense are 38/44 juvenile justice board.doc adults.

It does not apply here.

(6) The sophistication and maturity of the juvenile by consideration of his home, environmental situation, emotional attitude, and pattern of living:

Post the alleged offence, the juvenile seems to have displayed some sophistication in making calls of ransom only to deflect the police attention. But the juvenile's home, environmental situation, emotional attitude and pattern of living are normal or unremarkable. Especially, his family and pattern of living are almost ideal, as per the Report.

(7) The record and previous history of the juvenile, including previous contacts with the law enforcement agencies, juvenile courts and other jurisdictions, prior periods of probation or prior commitments to juvenile institutions.

To this criterion, the answer is a clear no. The juvenile had been pursuing his education, had been under strict parental care, and has no criminal track record.

(8) The prospects for adequate protection of the public and the likelihood of reasonable rehabilitation of the juvenile (if he is found to have committed the alleged offense) by using the procedures, services, and facilities currently available to the juvenile court.

On this count, we may note that post the incident, the parents faced social opprobrium and shunning. They were forced to shift to some other place. They preferred the juvenile to be kept in the Observation Home.

91. In the Observation Home, the older juvenile's conduct is 39/44 juvenile justice board.doc reported as good. He studiously pursued his studies and even cleared the Board examination. Both the Social Investigation Report and the MH Report reveal that the juvenile has been remorseful about the event and displayed a calm, unagitated mind.

92. The explanation to Section 15 of the Act clarifies that the preliminary assessment is not a trial; it is an exercise to assess the child's capacity to commit and understand the consequences of the alleged offence.

93. In this context, if the Board's criteria of evaluation, as affirmed by the Appellate Court, are followed, then every case becomes an open and shut case. If the child is 16 or above and is capable of committing the offence and understanding the consequences, that will suffice. I am afraid it ought to be more than that. The whole endeavour of the JJ Act is to save the child in conflict with the law from the path of self-destruction and being a menace to the society. It is reformative, not retributive. Section 15, I believe, must be read and understood keeping in view the objective that permeates the whole Act and the spirit it is imbued with.

94. That to contain crime, the State must be strict and the punishment must be harsh is an intuitive assertion; but sometimes the solution to the crime are

counterintuitive. Steven D. Levitt and Stephen J. Dubner, in their popular book Freakonomics[16] , have 16[] In the introductory chapter, The Hidden Side of Everything, 40/44 juvenile justice board.doc hypothesized that the juvenile crime in a few of states of the US has come down thanks to Roe v. Wade, a judgment of the American Supreme Court that legalized abortion. Critics apart, there can be ideas that are worth exploring. It is equally worthwhile, first, to explore for ideas, instead getting stuck in a predictable, plebian approach to societal problems.

95. Let us not forget public opinion is versatile. One day it weeps for the victims and cries vengeance, sometimes more than the victims themselves want. The next, it decries prison as a 'school of crime'.[17] What Does Neuroscience Say?

96. "Weathering teenagers' adolescence often means just riding out the rough seas with them until calmer waters are reached," observes the noted neuroscientist Frances E. Jensen (with Amy Ellis Nutt), under the Chapter Mental Illness, in his book The Teenage Brain[18]. Then under the Chapter "Crime and Punishment", he quotes Steven Drizin of Northwestern University in Chicago, a distinguished legal scholar, to the effect that, "Juveniles function very much like the mentally retarded. The biggest similarity is their cognitive deficit. [Teens] may be highly functioning, but that doesn't make them capable of making good decisions." Frances E. Jensen et al supply the justification for that observation: "Teens, we now know, engage the 17[] Children Who Kill, Edited by Paul Cavadino, Waterside Press in association with British Juvenile and Family Courts Society, Ed.2002, p.173 18[] HarperCollins Publishers, eBook 41/44 juvenile justice board.doc hippocampus and right amygdala when faced with a threat or a dangerous situation--this is why they are prone to being emotional and impulsive--whereas adults engage the prefrontal cortex, which allows them to more reasonably assess the threat. We know that the risk factors for teens committing violent acts include seeing violence and being the victims of it themselves."

97. Frances E. Jensen et al endorse the view of Valerie Reyna, a teacher and researcher in the Department of Human Development at Cornell University, who summed up the competence of adolescents in the juvenile justice system when she wrote in a 2006 journal article: "In the heat of passion, in the presence of peers, on the spur of the moment, in unfamiliar situations, when trading off risks and benefits favors bad long-term outcomes, and when behavioral inhibition is required for good outcomes, adolescents are likely to reason more poorly than adults do."

98. Merely on the premise that the offence is heinous and that it lends to the societal volatility of indignation, we are bracing for juvenile recidivism. Retributive approach vis-à-vis juveniles needs to be shunned unless there are exceptional circumstances, involving gross moral turpitude and irredeemable proclivity for the crime. Condemned, any juvenile is going to be a mere numeral in prison for a lifetime; reformed, he may redeem himself and may become a value addition to the Society. Let no child be condemned unless his fate is 42/44 juvenile justice board.doc foreordained by his own destructive conduct. For this, a single incident not revealing wickedness, human depravity, mental perversity, or moral degeneration may not be enough. Just deserts are more than mere retribution.

99. The Society, or restrictively the aggrieved person, views any problem ex post; it wants a wrong to be righted or remedied to the extent possible. The courts, especially the Courts of Record, view the same problem ex ante. "It involves

looking forward and asking what effects the decision about this case will have in the future"[19]. To be more accurate, the courts balance both perspectives. I reckon Section 15 of the Act requires us to balance both the competing perspectives: ex post and ex ante.

100. So I conclude that the Board, in the first place, has mechanically relied on the Social Investigation Report and MH Report, without analysing the older adult's case on its own. Similarly, the Appellate Court has also endorsed the order in appeal, without exercising the powers it has under Section 101. So both fail the legal scrutiny; they have failed to exercise the jurisdiction vested in them. About the Younger Juvenile:

101. Given the reversal of findings for the older juvenile, I reckon the younger juvenile's case requires little cogitation. Suffice it to say, that his role in the alleged crime came after the baby's death. In 19[] The Legal Analyst, Ward Farnsworth, The University of Chicago Press, Ed. 2007. P. 5 43/44 juvenile justice board.doc that context, both the Board and the Appellate Court have felt that he would be chargeable under Section 201 of IPC. That applied, it does not amount to heinous crime.

102. Prima facie Section 302 IPC does not apply to the younger juvenile. And how Section 34 IPC applies is too premature a question that needs no answer right now. In Virendra Singh v. State of M.P.[20] , the Supreme Court has held that vicarious or constructive liability under Section 34 IPC can arise only when two conditions stand fulfilled: the mental element or the intention to commit the criminal act conjointly with another or others; and the actual participation in one form or the other in the commission of the crime. Thus, Section 34 concerns the question of constructive criminality, and it is a matter of trial. Then, Section 385 attracts a maximum sentence of two years. Finally remains Section 201.

103. As we have already discussed, a heinous offence is the offence for which the minimum punishment is seven years or more. But under Section 201, seven years is the maximum punishment, not the minimum. Therefore, the ratio of Saurabh JalinderNangre can be applied.

104. Even the Board and the Appellate Court have held that the younger juvenile must be tried only a juvenile. And that finding needs no interference.

20[] (2010) 8 SCC 407

Result:

Appeal No.1153 of 2018 is dismissed; WP No.1346 of 2018 is allowed, as a result of which the Order, dt. 21st February 2018 passed by the learned Special Judge for Greater Mumbai in Criminal Appeal No. 680 of 2017 is set aside. So the older juvenile, too, shall be tried as a juvenile. No order on costs.

(DAMA SESHADRI NAIDU, J) L.S. Panjwani, P.S.

Annex VII
Suggested Training Schedule

Time	Topic	
9:00—9:15	Introduction & Objectives	
9:15—10:00	Setting the Tone	Re-Connecting with Childhood
10—10:45	Opening Reflections on Juvenile Justice	Critical Examination of the juvenile justice system & its Responses to CICL
10:45—11:00	Coffee Break	
11:00—12:00	Identifying Pathways to Offence	Understanding & Analyzing Vulnerabilities of CICL
12:00—1:00	Further Analysis of Vulnerabilities of CICL	
1:00—2:00	Lunch	
2:00—3:00	Further Analysis of Vulnerabilities of CICL	…Continued
3:00—3:50	Psychosocial & Mental Health Assessment of CICL	• Orientation to Psychosocial & Mental Health Assessment Proforma • Demonstration of Methods of Assessment
3:50—4:05	Coffee Break	
4:05—5:20	Preliminary Assessments	• Use of Preliminary Assessments • Discussion& Perspective-Taking onRelevant High Court Judgment
5:20—5:45		• First Level Responses • Depth Interventions • Referral Criteria
5:45—6:00	Last Thoughts…	

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