Critical Issues in Psychosocial Care & Mental Health of Children in Conflict with the law ~A Practitioner's Perspective

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

Supported by
Dept. of Women & Child Development
and Integrated Child protection Scheme,
Government of Karnataka

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"Now that I'm almost home,

Will I do good or wrong?

Would I hang with my old friends, smoking and…

Or finish school and go on to college where I belong?

Now I'm almost home, it's up to me

To be what I want to be."

[From "Almost Home," written by a student in juvenile detention, as he prepared to be released. Available at: http://jjie.org/2013/04/10/why-poetry/]

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Most of all, we owe our understanding and insights in this document to the children in the observation home, whose openness and transparency, and trust and confidence in us, enabled them to share with us their life stories, their worries and vicissitudes, their dreams and aspirations. Indeed, it is to amplify their voices and to do justice to their struggles that we hope that we have captured some critical elements of who they are, how they came to be in conflict with the law and how they can transform the course of their life journeys.

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1. Introductory Note

1.1. Why this Document was Developed: Unraveling the Victim-Offender Conundrum

In March 2017, Karnataka State Legal Services Authority, Juvenile Justice Committee of Karnataka High Court, Karnataka State Commission for Protection of Child Rights, Karnataka State Integrated Child Protection Society, UNICEF and *Bachpan Bachao Andolan*, jointly organized an all-day program for Special Court Judges under the POCSO Act and Principal Magistrates under the Juvenile Justice Act. The program covered various aspects relevant to the child and law, specifically pertaining to sexually abused children and children in conflict with the law. It was also attended by the Chairperson of the Committee on Juvenile Justice, Supreme Court and of the Committee on Juvenile Justice, Karnataka High Court, ICPS staff of the Dept. of Women and Child Development staff, child care NGO staff, and members of the Karnataka Judicial Academy. The NIMHANS Community Child and Adolescent Service Project ran two sessions for the program, from a child mental health perspective: i) Interventions for Psychosocial Assistance to Children in Conflict with the Law; ii) Challenges in Implementation of POCSO. It was observed that while the session on POCSO elicited concern and empathetic response from the target audience, there was little interest or concern expressed following the one on children in conflict with the law. Some of the erudite members of the audience even acknowledged that they really did not know much about children in conflict with the law.

Upon further reflection and discussion, the NIMHANS Project team felt that it was important to develop a document that threw light on a very important child psychosocial issue i.e. children in conflict with the law. This has been an issue that was very controversial and much debated after the December 2012 Nirbhaya incident, almost pitting child rights against women's (safety) rights, although in actual fact they are not separate or contradictory agendas. In 2015, there were dramatic changes in children's law, with the passing of the new Juvenile Justice Act, under much public and media pressure and against the will of many child rights activists. But over time, as the media spotlights turned their focus to other issues, the curtains gradually descended on the issue of children in conflict with the law; it now merely finds its way sporadically into newspaper clips that report violence and antisocial activities by children and adolescents. These accounts, at best, prompt some responses of cynicism and comments on the 'values and behaviours of youth today' and at worst, exacerbate the existing intolerant and judgmental viewpoints regarding offences by children and adolescents, serving to garner more support for 2015 Juvenile Justice Act.

In recent times, there has been much discussion on child sexual abuse and Prevention of Child Sexual Offences (POCSO) Act, 2012. There is considerable public empathy and outrage on issues of child sexual abuse (CSA); many governmental and non-governmental agencies, provide medical, legal and psychosocial assistance and services to children who are sexually abused; seminars, conferences, awareness and sensitization programs abound on CSA. All this, because it is easy to view children as victims of exploitation and crime, given their developmental vulnerability, in terms of their age, size and mental abilities. Interestingly, and also unfortunately, a similar lens of vulnerability and empathy is not employed in understanding or assisting children in conflict with the law (CICL).

The Juvenile Justice (Care And Protection Of Children) Act, 2015 states its overall purpose at the very beginning of the Act: *"An Act to consolidate and amend the law relating to children alleged and found to be in conflict with law and children in need of care and protection by catering to their basic needs through proper care, protection, development, treatment, social re-integration, by adopting a child-friendly approach in the adjudication and disposal of matters in the best interest of children and for their rehabilitation through*

processes provided, and institutions and bodies established, herein under and for matters connected therewith or incidental thereto"[1].

The Act thus speaks of care and protection of all children, despite the distinction it makes between a) "child in conflict with law" meaning 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 such offence; and b) "child in need of care and protection" meaning a child who is: found without any home or settled place of abode and without any ostensible means of subsistence; or working in contravention of labour laws or begging, or living on the street; or who resides with a person who has injured, exploited, abused or neglected the child or who is mentally ill or mentally or physically challenged or suffering from terminal or incurable disease; or has no one to support or look after or who has parent or guardian who is unfit or incapacitated to care for and protect the safety and well-being of the child; or who does not have parents and no one is willing to take care of, or whose parents have abandoned or surrendered him; or who is missing or run away child; or is being or is likely to be abused, tortured or exploited for the purpose of sexual abuse or illegal acts; or who is found vulnerable and is likely to be inducted into drug abuse or trafficking.[2]

However, the characteristics of children in conflict with the law are in many ways similar to those in need of care and protection. Most children in conflict with the law, have the same risks and vulnerabilities as other groups of vulnerable children. Thus, children in conflict with the law also need to be viewed as victims, not merely as alleged offenders. In actual fact therefore, children in need of care and protection are at risk of coming into conflict with the law and children in conflict with the law continue to be in need of care and protection. Thus, children as victims or offenders are both intrinsically child rights (violation) issues. Ignoring or not recognizing the psychosocial contexts of children in conflict with the law therefore results in negating child rights violations that have led to the child developing behavioural problems and coming into conflict with the law.

Unfortunately, the lack of understanding and empathy in general public as well as medical, legal and mental health professionals, of the care and protection issues affecting children in conflict with the law has led to relatively few professionals possessing the willingness and/or the abilities and skills to assist this vulnerable group of children. In the light of these challenges, the purpose of this document 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 alleged 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.

1.2. How it was Developed

The Dept. of Child & Adolescent Psychiatry has a long history of working with children with serious behaviour problems, both in the clinic setting as well as outside, through agencies such as Echo and Centre for Child & Law, National Law School University of India, Bangalore. The Department's engagement with CICL issues comprises of clinical mental health work as well as policy and advocacy issues. It has also been providing training and capacity building to government staff as well as the judiciary on psychosocial care of CICL.

More recently, NIMHANS, Dept. of Child and Adolescent Psychiatry in collaboration with the Dept. of Women and Child has been conducting a pilot project on community-based child and adolescent mental health services (since October 2015). This project has been providing promotive, preventive, and curative care in

[1] The Juvenile Justice (Care and Protection of Children) Act, 2015
[2] Ibid.

urban and rural sites through direct service delivery and training and capacity building of child care workers from community-based governmental and non-governmental agencies/institutions and professionals, including government primary healthcare centres, schools, anganwadis, health workers and child care institution staff. The project is especially mandated to work with children in difficult circumstances, namely street & working children, orphan & abandoned children, children with disability, HIV infected/ affected children in trafficking and children in conflict with the law.

Thus, as part of the Community Child And Adolescent Mental Health Service Project, the NIMHANS team has been engaging in depth work in the Government Observation Home, Madiwala, Bangalore, providing psychosocial & mental health assessment and intervention services, at individual and group levels to CICL, as well as working with child care systems and service providers in the government and Juvenile Justice system. This document, describing the Project's assessments, analyses, interventions and methods with CICL, has been developed based on our work and experience, in the Observation Home and with the JJ system. However, the document also draws upon the Project's experience of staff training and observation homes visited in other parts of the country, particularly in the sections pertaining to critiques and recommendations regarding implementation of the JJ Act, and of practice and policy.

1.3. For Whom it was Developed

This document was developed to build awareness and sensitivity in members of the Juvenile Justice Board (JJB), staff of Observation Homes, governmental and non-governmental agencies that provide care to children in conflict with the law, counselors and mental health professionals and any other individuals or agencies providing health, education, training and rehabilitation services to these children. It aims to enable field practitioners and law and policy-makers to make decisions based on a scientific and compassionate understanding of the specific needs and vulnerabilities of this controversial group of children.

The Project has also developed two training manuals pertaining to children in conflict with the law:

- ***'Children in Conflict with the Law' Mental Health, Psychosocial Care & Protection for Children & Adolescents, Training Series 3***
  This detailed training manual is for staff, counselors and caregivers of children in conflict with the law, equipping them with the conceptual knowledge and skills to understand the vulnerabilities of these children, and to provide responses and interventions to help bring about behavioural changes in them.
- ***'Psychosocial & Mental Health Considerations in Juvenile Justice: A Framework for Judicial Response to Children in Conflict with the Law'***
  This is a training manual for use with judicial personnel i.e. to orient Juvenile Justice Board Magistrates and other legal personnel on the vulnerabilities of children in conflict with the law, so that they are enabled to facilitate juvenile justice processes that are strongly in keeping with the tennets of rehabilitative and reformative justice.
  *Both manuals are available on www.nimhanschildproject.in

It is recommended that this document is read along with or at the time when those training manuals are used of referred to by facilitators and other stakeholders. This document provides more detailed descriptions and discussions on issues pertaining to children in conflict with the law, that would provide a background for assisting these children, and better understanding the concepts outlined in the training manuals.

2. Re-Examining the Need for Assisting Children in Conflict with the Law

2.1. Old Issues, New Imperatives

The Juvenile Justice (Care and Protection of Children) Act 2015 (JJ Act) allows for juveniles 16 years or older to be tried in the adult justice system for heinous offences[3] such as rape and murder but which also include other offences which though non-violent in nature are designated to be heinous, by the law. Certain provisions in this Act, for CICL, 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-old girl in Delhi, some years ago. The reduction of age from 18 to 16 years for a juvenile to be tried in the adult justice system has been a controversial issue and 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'.

The child rights activists' position is one that is clearly against the new JJ Act. The arguments for these range from the nature of neuro-biological developments in the adolescent brain to the need to understand a child's vulnerabilities and the circumstances of his/her offence. Child rights activists thus 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). In other words, 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 existed even before the new JJ Act 2015, so there is nothing new about them per say. The new JJ Act has brought to the fore the needs and concerns of CICL, because of the seriousness of the consequences of certain offences, namely reduction of age limit for transfer to adult system. Further, the country's response and outrage following the Nirbhaya case has propelled the issue into public discourse, and consequently made it imperative for child care services and systems, including 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 last two processes, of assessment and intervention, have become particularly important in the light of the decisions to be made for transferring a juvenile to the adult criminal justice system.

The debates around the culpability of children, 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 varied (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 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.

Before moving onto further discussions on CICL, it is critical to note that the child rights activists' position outlined above in no way supports acts of violence and offence by children. In fact, this position also strongly advocates for non-violence (i.e. is against any form of violence against women and children, and indeed against men too), rights of women and children to freedom of movement and personal safety, gender equity and egalitarianism. The questions then are: **what does juvenile justice mean in such a context? And how**

[3] Heinous offences are those which are punishable with imprisonment of seven years or more.

can child care systems and services be supportive of the larger public concerns and agendas of public safety and rights (in particular of women and children) and yet work in ways to uphold child rights and promote juvenile justice?

2.2. Some Basics: Who and How?

Who are Children in Conflict with the Law?

The term 'juvenile' is also often used to refer to young criminal offenders. According to the Juvenile Justice Act 2015, a juvenile can be defined as a child who has not attained a certain age at which (s)he, like an adult person under the law of the land, can be held liable for his/her criminal acts. Juveniles or children in conflict with the law refer to individuals below the age 18 years who are alleged to have committed some offence, violating the law.

However, in order to avoid labelling children, and the extremely negative connotations that ensue, this document does not use the term 'juvenile' to refer to this group of children; we refer to them as 'children in conflict with the law' (CICL), which is also the accepted term in today's world of child rights and protection.

How are Children admitted into Observation Homes?

According to the Juvenile Justice Act, when children alleged to be in conflict with law are detained by the police, these children are first under the charge of the Special Juvenile Police Unit or the designated child welfare police officer. If such children are unable to obtain release at the police station, through some processes of compromise, they must be put in an Observation Home until they can be produced before the Juvenile Justice Board; or the Police must produce the child before the Juvenile Justice Board (JJB) within a period of twenty-four hours.

According to the Act, if these children are brought before the Juvenile Justice Board, but do not receive bail, and there is an inquiry pending against them, they are still brought to Observation Homes, which are meant for the temporary reception of such children. Children are normally detained under probation for up to 4 months in these Observation Homes. However, in reality, given pendency issues and other delays, this period could be much longer.

Who are Children in Observation Homes?

While this document reflects the needs and concerns of all children in conflict with the law, the discussion also revolves largely around those children who are within the Observation Homes. This is because those CICL in Observation Homes are likely to have a slightly different profile from those who are in conflict with the law but receive bail and do not get placed in the Home. Contrary to common (mis)perception, children in the Observation Homes are not always those who have 'committed more serious crimes'; in fact, there are those who may not even have committed offences. They are often children from lower socio-economic backgrounds, with very difficult family histories, and experiences of trauma and abuse. In short, while nearly all children in conflict with the law are or have been vulnerable in family, school and other social contexts, and/or suffer from child and adolescent psychiatric disorders of some sort, the children within Observation Homes reflect these vulnerabilities to a more extreme degree.

The NIMHANS experience shows that there are broadly two types of children in the Observation Home:

i) Those who have committed offences and violated the law (such as robbery, murder, kidnapping, sexual offences, particularly under POCSO...)

ii) Those who have not committed offences and violated the law but have either been wrongly charged or were apprehended because of friendships and associations with peers who committed offence or because by unfortunate chance they happened to be in the place where the offence was committed.

Further, the latter group of non-offending children consists of a sub-group that is made up of children who are charged under Prevention of Child Sexual Offences Act (POCSO). A relatively large number of boys, have

been charged under POCSO for being in consenting (adolescent) sexual/ romantic relationships i.e. these comprise adolescent boys who run away with adolescent girls, wherein the girl's family had got into conflict with the boy's family over the boy and girl being in a relationship and complained to the police; adolescent boys were usually charged under POCSO (despite consent and at times, instigation by their female peers) and thus convicted of sexual crime. As per the law, there has been a violation by the adolescent i.e. engaging a minor in sexual activities. However, since both parties (adolescent boy and girl) exercised their choices and made the decision, individually and/or jointly, to engage in a (consenting) sexual relationship i.e. there is no coercion, it is in actual fact not an offence (unlike children who have sexually abused younger children—and would consequently be in the category of children who have committed offences). Thus, where CICL are charged under the Protection of Children from Sexual Offences Act (POCSO 2012) the issue is more complex; it necessitates a re-examination of child sexual abuse laws.

How children who have not committed offence come into conflict with the law…as reported by children.

- Some children are wrongly accused and charged due to family feuds.
- As already mentioned, a number of adolescents get charged under POCSO for what are actually 'love affairs' rather than sexual abuse.
- Many seem to simply be wrongly charged by the police—whom it is said, find it 'easy' to apprehend and charge children and adolescents because of children's relative lack of power, poor knowledge on the law and their rights, resulting in inability to defend themselves.
- Whether the police 'let child off' or not at the police station depends on a number of considerations—amongst which social considerations are one: children from social backgrounds that are wealthy are unlikely to be apprehended even if they have committed an offence; and children from difficult socio-economic backgrounds are more easily apprehended and sent to the Observation Home.
- At times, when police are unable to charge any particular offender, they tend to find children who have previously been involved in offences (in that locality) and charge them i.e. false charges are laid on children.

The issue of how children who have been involved in offences at some point in time, are (repeatedly) subsequently scapegoated is a particularly extremely worrying one. This is because it is a reflection of a system that is steeped in child rights violation and injustice, one that bases its actions on adult-child hierarchies that allow for unfair power play. That said, the above responses are currently anecdotal (based on accounts provided by children, parents, children's lawyers, and JJ staff) rather than drawn from empirical research—more studies need to be done on the processes through which children come in conflict with the law.

It is thus important to understand the two categories of children who come into conflict with the law and/or are in the Observation Home, in order to better design assessments and interventions for this target population of vulnerable children: for those children who have committed offences, the objective of psychosocial interventions is to effect behavioural transformation; for those children who did not commit offences, interventions may target life skills deficits that have in part caused them to get into trouble (even though they did not actually commit offence) and/or any other mental health issues that emerge, even if unrelated to offence.

Above all, it is important to understand the mix of children who are in the Observation Home in order to avoid viewing them solely through the lens of culpability, and instead to view them through the lens of vulnerability.

2.3. Premises of Working with Children in Conflict with the Law

The ethical frameworks and premises for the need to assist CICL are enshrined in several laws and policies, both internationally, and within India. Article 2 of the UN Convention on the Rights of the Child states that *'State Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members'*; and article 3 states that *'In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or*

legislative bodies, the best interests of the child shall be a primary consideration'. In 1992, India became a signatory of the Convention on the Rights of the Child but nearly twenty-five years later, it appears that the CRC has had little impact on the national legislations on child rights.

While the new Juvenile Justice Act, passed in 2015, introduced provisions for transfer of 16 to 18-year-old CICLs under Section 15, this does not, in any way change the basic objective of the Juvenile Justice Act i.e. of care, protection and rehabilitation of every (vulnerable) child that falls under its purview. The rehabilitative approach to justice is also supported by Article 39 (f) of the Indian Constitution which states that all children, (and that includes CICL) have the *'right to equal opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and guaranteed protection of childhood and youth against exploitation and against moral and material abandonment'*.

From a psychosocial and mental health perspective, working with CICL is based on 4 key premises:
(i) The child is and certainly should be held accountable for the offence committed i.e. there are and must be consequences for 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 criminal systems and juvenile justice systems differ in their basic objectives: the goal of the adult system often tends to be retributive; the goal of the juvenile system, on the other hand, is to rehabilitate and serve the minor's best interest. Best interest is *not* to be interpreted as acquittal or disregarding and condoning the offence; it means enabling the child's rehabilitation and reintegration in such a manner that his/her safety and protection is ensured, including prevention from repeatedly coming into conflict with the law.

(ii) There must be an innate belief that all children including those who have emotional disorders, as well as children who have allegedly 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—and we would be hard-put to adopt the restorative and rehabilitative approaches we are required to with regard to CICL.

(iii) 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.

(iv) There must be a responsible and professional response to an existing law for CICL i.e. to the Juvenile Justice Act 2015. While people may maintain that there is no valid tool to reliably measure what is asked in Section 15 of the Juvenile Justice Act (on transfer of CICL to adult systems), the truth is that children continue to be referred for such assessments. Until such time as there are changes again, to the law, appropriate professionals must be engaged in a strategy that is based on the conviction that there are adequate provisions under the JJ Act to assist CICL.

As Harsh Mander, the human rights activist and writer says in his writings on 'Children and Crime' the Nirbhaya incident and the public demand that followed, for the juvenile to suffer adult punishment (even death penalty), *'raises profound and tangled ethical and legal questions, about the nature of childhood, criminal culpability, punishment, reform, justice and public compassion. It is fitting that these be hotly debated, on street corners, living rooms, work places, television studios, newspaper columns and ultimately Parliament. The choices we make will determine in significant ways the futures of our children, and as Mandela reminds us, the health of our souls*'. All our work on CICL requires to be predicated on the above ethical frameworks and existing laws and policies that emphasize the need for child rights, care and protection in multiple ways, and this requires continually employing a vulnerability lens to understanding and addressing their needs and problems—as this document also seeks to do, in order to contribute to the debates around CICL issues of culpability and proportionality.

3. Analyzing Psychosocial and Mental Health Concerns of Children in Conflict with the Law

3.1. Background and Introduction

One of the key objectives of this document is to provide stakeholders and service providers with a more nuanced understanding of children in conflict with the law (CICL). As mentioned erstwhile, the Community Child and Adolescent Mental Health Project provided individual and group services to CICL in an Observation Home. During the course of our work in the home, 130 children were provided with individual assessment and interventions. This chapter thus draws on the understanding and insights we obtained about CICL through individual interactions with children. First, it describes the objectives for and methods used for administering assessments to CICL, followed by an analysis of the information obtained from such assessments, to better understand their contexts and vulnerabilities. This chapter is linked to one of the three questions posed by Section 15 of the Juvenile Justice Act 2015—pertaining to the circumstances of the offence. It discusses how children's life circumstances form pathways to coming into conflict with the law.

A. Objectives

- To understand the circumstances of which children come from, including children's experiences and relationships in the family, at school, in child labour and other social spaces.
- To examine how children's circumstances and experiences form pathways to conflict with the law.
- To identify the types of psychiatric disorders and mental health problems that CICL are vulnerable to, and how these in turn, lead them to come into conflict with the law.
- To explore how children perceive their circumstances and actions, and thus further guide our intervention plan for them.

B. Location and Target Group for Assistance and Intervention

The intervention/program was located in a state observation home, which is a residential facility that caters to children from both urban and rural districts. The Home, like other child care institutions is a care and protection institution for children and falls under the jurisdiction of the Dept. of Women and Child Development, of the state goverrnment. It is staffed by a superintendent and probation officers, a house mother, two counselors, guards/ security personnel and other administrative functionaries.

In accordance with the Juvenile Justice Act 2015, those children coming into conflict with the law and placed in the observation home were included in this report. They were from urban and rural districts of the state and range from ages 13 to nearly 18 years. The children stay in this Home for a period that may range from days to months, awaiting bail or closure of case. These children are usually brought to the Home by the police following the filing of a first information report (FIR) or complaint by aggrieved parties who have reported children's actions and behaviours; following the report and complaint, before placing children in the OH, and as per JJ Act rules, children are produced before the JJ magistrate concerned.

The children are then produced before the Juvenile Justice Board (JJB), comprising of the JJ magistrate (usually the Chief Metropolitan Magistrate), and two other members from psychology, social work or law background. The JJB adjudicates and disposes of cases of CICL in accordance with the process of inquiry, as per the Juvenile Justice Act 2015, but ensuring that the child's rights are protected throughout the process of apprehending the child, inquiry, aftercare and rehabilitation. The children are also assigned lawyers, either through decisions made by their families or through free legal aid services available in the Home.

During the course of the Project's work in the observation home, as part of the assistance provided to CICL, psychosocial and mental health assessments and requisite treatment and interventions were provided to about 130 boys[4] between ages 13 and 18 years. This group of children, is a floating population i.e. each day there may be new admissions and each week, when the Juvenile Justice Board is in sitting, the children who receive bail or whose cases are closed, may leave the institution.

Although the children assessed by the NIMHANS team were selected by the OH counselor and/or the superintendent, these Home staff frequently had no specific criteria for requesting the NIMHANS team to assess a particular child—it was usually based on the counselor's difficulty in communicating with some children or her observation of a particular child being more aggressive or a child having just entered the Home and her not having had time to meet with him as yet. So, in actual fact, these children were randomly selected. In the last few months of the project's work, however, one of the JJB magistrates made several requests to the NIMHANS team to provide preliminary assessment reports for several children between ages 16 and 18 years, in accordance with the new JJ Act, 2015. Therefore, a relatively large number of 16 to 18 years olds were assessed and assisted. However, since there was no intention of purposively sampling and no criteria for selection of these 16 to 18 years olds either (other than age), thus making the selection of this sub-group also random.

C. Assessment and Interventions

As mentioned, the Project was engaged in providing interventions and services to CICL and individual assessments of children were part of this process. The NIMHANS Project team visited the institution on an average of thrice a week, over a period of 1.5 years (March 2016 to July 2017), and provided individual assessment (and interventions) to children in the OH.

Each child was interviewed using the assessment proforma that was filled out by the NIMHANS Project team. While the term 'interview' would imply the use of qualitative methodology, we use this because: i) given mandate of the Project was not research, it was service provision; ii) therefore, the process of assessment employed counseling methods and techniques in eliciting information from children i.e. the proforma was not used like a survey to rapidly gather information as per the needs of the team. Thus, the term 'interviewing' is used to reflect the information gathering process, which in this instance was essentially an interview with the child, entailing conversation and dialogue with him; it was not just to have the child answer questions, as frequently happens in interrogation processes, but to also validate the child's experiences and emotions and enable the child to reflect on the pathways that lead him to the observation home.

It took about an hour to administer the assessment and interview the child, followed by another forty minutes to an hour's dialogue with the child to provide interventions by way of first-level responses (refer to *Chapter 6 on 'Psychosocial and Mental Healthcare Assistance: Interventions for Transformation & Behaviour Change'*). Decisions regarding referral to NIMHANS's Dept. of Child and Adolescent Psychiatry were also made at this point, so that children with severe and acute problems could avail of depth assistance through the Institute's in-patient and/or out-patient care facilities.

D. Profiling Children in Conflict with the Law

The information from the psychosocial and mental health assessment proforma developed by the Project, and used for the assessment of children (as described above) was then drawn upon, to construct a profile of CICL—that is presented in subsequent sections of this chapter.

As described in detail in Chapter 4 on *'Psychosocial and Mental Health Assessment for Children in Conflict with the Law'* the assessment proforma comprises of a combination of questions that are open and close ended i.e. that elicit single 'yes/no' and numeric responses and those that elicit descriptive/ narrative responses. However, for the purposes of profiling and analysis of vulnerabilities of CICL, some of the narrative

[4] The report does not include girls because there is no Observation Home for girls in Bangalore, where the NIMHANS Project had located its services.

and descriptive information was developed into specific themes for numerical analysis. For example, the child's account of the offence was a narrative that was converted into themes to represent the nature of the offence i.e. sexual offence/theft / murder; or the description the child provided on his family history, was converted into specific themes such as parental marital conflict and domestic violence/substance abuse in caregivers/illness or disability in caregiver etc.

For routine record-keeping and programmatic purposes, the information was systematically maintained, and analyses were drawn. Where relevant and possible, correlations and strength of association between themes were examined—so that interventions could be developed in accordance with these analyses. Furthermore, the analysis used the Project team's experiences and observations of the children in the institution, garnered through extensive individual and group interactions, by way of recreational activities and life skills training sessions. The learning and insights thus gained about the children have been used to explain the responses/ information elicited through the assessment. In presenting our findings and analyses, where possible and relevant, we have also quoted from other studies that verify or substantiate our experiences and results.

Note: The database created and analyzed was for programmatic purposes only i.e. to use the Project's routine data for understanding CICL's needs and concerns, and designing interventions in a more scientific manner. The analysis was NOT for research purposes, and consequently, not for publication purposes. Thus, it was used for the following purposes: i) Generating an in-depth understanding of CICL's circumstances and concerns; ii) Designing responses and interventions in keeping with the life realities of these children; iii) Developing training materials for judicial personnel and caregivers/counselors; iv) Informing and making recommendations for policy and practice with regard to CICL.

E. Limitations of the Work and Reporting

As already stated, the data was not collected for research purposes, but for record-keeping and reporting purposes. As mentioned elsewhere, the mandate of the Project was provision of access to mental health services to vulnerable children groups. The main objective of our engagement in the Observation Home was to provide interventions to the children and assist them with their problems. As it stands, the assessment provides sufficient information to understand children's contexts and experiences and problems and enable the JJB and counselors to plan the necessary psychosocial assistance for them. Consequently, the assessment proforma was not designed for a research study --in which case it would have needed to incorporate several details that it does not. One of the limitations of the report therefore is that the available data, as extensive as it is, does not provide for understanding on particular or more specific aspects of CICL's lives, such as their experiences of violence and abuse at the police station (commonly reported by children) and at times, in the observation home; the nature of the information is cross-sectional—we have not reported on transformation processes and the impact of psychosocial and mental health interventions.

Second, while the target group numbers in itself is not small i.e. 130 is a large enough number to be able to capture emerging trends and patterns, a larger target group would have allowed for the statistical tests to yield clearer results. The significance of certain factors impacting CICL and the differences between children acknowledging and not acknowledging their offence would have been more pronounced in a larger sample. However, as a preliminary report, we have sufficient descriptive data to be able to draw implications and recommendations for intervention, which remains the focus of our engagement with CICL.

Third, this report reflects the concerns of boys in conflict with the law but it excludes girls in conflict with the law. This is because the observation home in Bangalore serves only boys. In fact, there are very few functional observation homes for girls in the country and none at all in Karnataka. Apparently, there are relatively fewer girls who come into conflict with the law and therefore less justification to run homes for them; when there are girls, they are housed in reception centres for women or in government girls' homes set up for care and protection. The latter suggests that girls in conflict with the law are then assisted by the Child Welfare Committee, whose primary function is to assist children in care and protection; this means that many girls,

even if they have engaged in antisocial activities are not dealt with as children in conflict with the law i.e. through decisions made by a juvenile justice board. While there are likely to be many similarities between boys and girls in conflict with the law, such as socio-economic vulnerabilities, family dysfunctionality and peer influence and child labour experiences, there are also likely to be differences between them. Thus, while our report is able to profile boys in conflict with the law, and some findings could be extrapolated to girls, not all our findings would be generalizable in this way; a separate study to profile girls in conflict with the law would be necessary to identify their pathways to offence, and understand how their vulnerabilities and pathways are different from those of boys.

Fourth, the data generated is based on interviews with children themselves. All the items on the assessment proforma are administered to children (although any additional information provided by the Home staff may be recorded). While most parts of the proforma elicit information in a fairly objective manner, there are some sections, namely on peer influence and mental health problems where children provide subjective reports on the extent to which they are influenced by peers in various sphere of life, and on symptoms pertaining to anxiety, depression, attention deficit hyperactive disorder, substance use and conduct issues. Subjective reports result in risks of under-reporting or inaccurate reporting especially as children may not always have insight into their problems. In an attempt to overcome the limitations of subjective reports on mental health problems, the proforma has drawn from standardized (validated) child mental assessments such as the MINI KID tool (as described in the previous chapter).

3.2. An Analysis of Children's Risks and Vulnerabilities

With regard to CICL, there is the nature of their childhood, characterized by one or more vulnerabilities as described above. However, there is another critical issue that forms a pathway to children coming into conflict with law: the nature of the adolescent brain. Developmental psychologists report that there are differences between the thinking and behaviour of children, adolescents, and adults. Neurobiological evidence reflects that the human brain does not achieve physiological maturity until the early twenties and that adolescents simply do not have the same physiologic capability as adults to make mature decisions or to control impulsive behaviour[1]. As a result, the portions of the adolescent brain that facilitate sensory input and language functions mature earlier than the portions of the brain governing "executive functioning" capacities. Consequently, adolescents are already rendered vulnerable by their relatively lower skills in appropriate social judgement and decision-making[2]. It is important therefore to remember that this neuro-developmental vulnerability, that common to all adolescents, underlies all psychosocial and mental health factors and risks that lead children into conflict with the law (described in detail below).

A. Nature of Children's Alleged Offences

A.1. Number of Times of Coming in Conflict with the Law

A majority of children assessed, 82%, had come into conflict with the law for the first time. Of the children acknowledging offences, 70% were first-time offenders; and of those not acknowledging offences, 88% were first time offenders. 30% of children acknowledging offences had come into conflict with the law two or more times, and only 12% of children not acknowledging their offence had come into conflict with the law two or more times (Refer to table **A. 2 (a)**).

Amongst children who did not acknowledge their offences, it was found that they reported not having committed any offence the first time either. However, being in the 'wrong place' at the 'wrong time', particularly hanging out with peers who tended to engage in antisocial activities, had got them into trouble repeatedly. This shows that while these children may not have committed any offence, they are at risk of doing so or at risk of constantly coming into conflict with the law because of the peer networks they are part of.

Table A. 1 (a): No. of Times Children came into Conflict with Law

No. of Times in Conflict with Law	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	All Children (N=130)
First Time Offence	33 (70%)	73 (88%)	106 (82%)
Two or More Times Offence	14 (30%)	10 (12%)	24 (18%)

A.2. Alleged Offence

'Alleged offences' refer to offences only as per the police charge sheet and first information report (FIR) and are consequently, the reason the child came into conflict with the law. However, children may or may not acknowledge these offences to be true. Children who come into conflict with the law are usually charged with one or more of the following offences:

- IPC section 378 - Theft
- IPC Section 390 - Robbery
- IPC Section 393 - Attempt to commit robbery
- IPC section 391- Dacoity
- IPC Section 402 - Assembling for purpose of committing dacoity
- IPC Section 300- Murder
- IPC Section 307 - Attempt to murder
- IPC Section 359 – Kidnapping
- IPC Section 375 - Rape.
- Protection of Children from Sexual Offences (POCSO) Act 2012
- Narcotics, Drugs and Psychotropic Substances (NDPS) Act 1985

[Refer to Annex 1 for detailed definitions as per the Indian Penal Code (IPC)].

The JJ Act & FIRs

According to the JJ Act any complaint against a child below the age of 16 years should not be filed as an FIR. It should simply be noted at the police station in order to place the child in safe custody/ in the observation home. However, not only do police accept to file FIRs for children below age 16 years, but they also provide reports about these children to agencies where these children may have applied for jobs—so that they then lose potential opportunities. Not only are the police and general public flouting the JJ Act provisions but the consequences are detrimental to children serving to maintain them in the deprived socio-economic circumstances that often lead them into conflict with the law in the first place.

For the purposes of our understanding and analyses, we have grouped the offences into 4 major categories as follows (as below). The reason for this grouping is that from a psychosocial perspective what is important is to understand the type of offence in order to provide necessary assistance and intervention. So, while legal specificities are important, particularly to legal personnel assisting children, the psychosocial objective differs in that it is not merely concerned with bail or case closure issues; it is concerned instead with behaviour change and transformation processes. So, for example, theft, robbery and dacoity are all related to taking other's belongings without permission/using coercive methods (whether overtly or covertly, singly or in a group); murder and attempt to murder are categorized as acts of violence and aggression as they have to do with hurting or harming someone whether due to anger and emotional dysregulation or poor problem-solving or conflict resolution skills ; rape and child sexual abuse are types of sexual offences (kidnapping has been categorized as a sexual offence only because every child charged with rape or child sexual abuse was also charged with kidnapping). This categorization (along with other factors) thus has clear implications for the types of intervention used.

Categorization of Common Alleged Offences by Children

Theft & Robbery	• IPC section 378 - Theft • IPC Section 390 - Robbery • IPC Section 393 - Attempt to commit robbery • IPC section 391- Dacoity • IPC Section 402 - Assembling for purpose of committing dacoity
Violence & Aggression	• IPC Section 300- Murder • IPC Section 307 - Attempt to murder
Sexual Offences	• IPC Section 375 - Rape. • POCSO Act • IPC Section 359 – Kidnapping
Possession production, manufacture, cultivation, sale, purchase, transport, storage, and/or consumption of any narcotic drug or psychotropic substance.	NDPS Act, 1985

Violence and Aggression:

Table A. 1 (b) shows the alleged offences of CICL. The largest proportion, 51%, are in the OH for offences relating to violence and aggression i.e. murder and attempt to murder. Our understanding from children's reports is that there is seldom an intention to murder—in fact, there are very few cases where the children acknowledged intent to kill and even within this group, the act of murder occurred, in some cases, in the context of substance use and therefore in a state of intoxication; thus, the problem here would primarily be one of substance abuse rather than violence and aggression. Very few children therefore could be said, strictly speaking, to have actually (attempted to) murdered someone. This may also explain why only 19 out 67 (about 28%) children charged with violence and aggression acknowledged the offence they were charged with.

Table A. 1 (b): Alleged Offences of Children

Alleged Offence	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	All Children (N=130)
Theft & Robbery	16 (34%)	16 (19%)	32 (25%)
Violence & Aggression	19 (40%)	48 (58%)	67 (51%)
Sexual Offences	16 (34%)	11 (13%)	27 (21%)
NDPS	0	1 (1%)	1 (0.8%)
Others	1 (2%)	1 (1%)	2 (1.5%)
Not Clear	1 (2%)	3 (4%)	4 (3%)

Most children charged with violence and aggression-related offences are:

- Children who have emotional regulation problems i.e. may be children with attention deficit hyperactivity disorder, who have difficulty controlling their mood and emotions; or they are children

who simply have trouble managing and controlling emotions such as anger and anxiety (possibly also due to experiences of abuse and trauma), as a result of which they are easily provoked especially when they are bullied or provoked by their peers.

- Children who have been aggressed against by peers/ older peers and have been forced to retaliate due to the nature and extent of violence inflicted on them. In other words, some children have been attacked by neighbourhood gangs (who often under the influence of substance) and have had to retaliate in self-defense, to protect themselves from being killed even.
- Children who have been charged with murder or attempt to murder by the police who seem to do so even in cases where children may have aggressed but in relatively mild ways such as hitting out at someone once. (If this is the interpretation of murder and attempt to murder, many people, especially parents should be in prison!)

Theft & Robbery:

Of the 130 children, 32 or 25% (see table A. 1 (b)) of them were charged with theft. 16 out of 47 children (34%) acknowledging offences had committed theft or robbery. As mentioned elsewhere, theft was the most common offence among younger children, between ages 13 and 15 years, who also more readily acknowledged their offences, which accounts for why 16 out of 32 or 50% acknowledged the offence.

Sexual Offences:

Of the 130 children, 21% had committed sexual offences (see table A. 1 (b)). The sexual offences that they were charged with were broadly of two types:

(i) Children who had used coercion and engaged or attempted to engage in sexual acts with others, mainly younger children (with a significant age difference). In such instances, they were charged under the POCSO Act. These were mostly children between the ages 13 to 15 years of age, who had engaged in such acts due to curiosity and the need to experiment because of peer influences, including peer-induced exposure to pornography. Here it is important to note that of these children, there were perhaps only 1 or 2 children who were older and/or engaged in sexual acts with motivations of aggression and rule-breaking i.e. children who had poor empathy and limited prosocial skills.

(ii) Children who were in mutually consenting romantic relationships with their (female) peers and had decided to run away and get married or live together or engage in physical intimacy. Despite these being mutual decisions, and in several instances being decisions made by the girls who threatened suicide if the boy did not comply with her wishes to run away or engage in physical intimacy, the boys were charged, not only under POCSO (as the girls were minors) but also with rape and kidnapping. This group comprised almost fully of boys between ages 16 to 18 years of age.

The Controversy of Sexual Offences in Romantic Relationships between Peers:
Gender Inequity & Rejection of Adolescent Sexual Rights in POCSO Implementation

The issue of male adolescents being charged under POCSO is a complex one and has several implications. First, when applied to cases wherein adolescents are in mutually consenting sexual and romantic relationships with their (female) peers, the use of POCSO to convict them of an offence speaks of a society wherein adolescent sexual rights are not respected and convicting adolescents who are in mutually consenting sexual relationships reeks of the 'moral policing' that some sub-groups within our society are up in arms against in other (adult) contexts of romance and sexuality.

Second, there is a certain degree of absurdity in selectively convicting adolescents for being in mutually consenting relationships, based on family conflicts and complaints. If the issue of complaint really is that adolescents should not be engaging in sexual relations and all those adolescents who are doing so should be convicted, then thousands of adolescent boys would have to be convicted for 'being in love' and engaging in sexual activities—and the existing numbers of Observation Homes in the country would be unable to accommodate them!

In addition to coming from a strongly moral position, with pre-conceived notions and prejudices about adolescent sexuality and sexual rights, the application of the law is extremely gendered. Where there are mutually consenting sexual relationships between adolescents, and conflicts and disagreements around this, only the boy seems to be culpable as

he is convicted, not the girl; the girl does not seem to have to be (legally) accountable or responsible for decisions jointly made by both boy and girl. In fact, in many cases reported at the observation home, the girl was reported to have 'pressured' the boy to run away/ 'take her away' due to her family conflicts and fears that she may be married off elsewhere. The law does not take into account the girl's role and decision at all. Thus, the law becomes extremely gendered in its implementation, ensuring that only boys are convicted, irrespective of the role girls play in mutually consenting relationships.

The above issues of adolescent sexual rights lead to about how the POCSO law is framed. While its intention is to prevent/ respond to child sexual abuse, the question is how is child sexual abuse defined? A key element that determines sexual abuse is the issue of consent. It is therefore fully agreed that the law should apply to young children who, due to their developmental stage and cognitive processing, would not be able to give informed consent and of course are not biologically or emotionally prepared for sexual relationships. But can the same be said of an adolescent—who is at a different stage in his/her life cycle, with developmental needs and abilities that are so different from that of a younger child? POCSO therefore does not acknowledge or make the distinction between the developmental needs and abilities of a 6-year-old versus a 15-year-old—and this is problematic because a blanket application of a law, without consideration of age, child and adolescent development and psychology leads to unfair conviction of adolescents, thereby violating their rights.

Finally, what is both interesting and saddening is that there are exceedingly low conviction rates for adults who have committed child sexual abuse and been charged under POCSO. However, children/ adolescents seem to be quickly and easily convicted under POCSO, not granted bail even when they have been in mutually consenting romantic and sexual relationships with their peers (in fact, there appears to be little inquiry and evidence gathering around this, especially to get the peer-partner's point of view). What this shows is that a law that is essentially meant to protect children/ adolescents from abuse is being unjustly and whimsically used to convict and detain adolescents, in violation of their rights—is this really a legitimate use of a law meant to protect the rights and safety of children and adolescents?

Thus, POCSO as it is implemented currently has serious implications for the implementation for the new Juvenile Justice Act 2015 that contains the provision regarding transfer of 16 to 18-year olds to the adult system for heinous crimes. Precipitated by the Nirbhaya case and the alleged role of the 16 year old in the gang rape, the JJ Act has a list of heinous crimes for which adolescents can be tried as an adult—and sexual abuse is one of them…all the more reason to be careful as to what we define as sexual abuse under POCSO or what we judge to be sexual abuse, as this has life-changing consequences for a child charged with POCSO.

POCSO thus needs to recognize the developmental age and stage of children versus adolescents. In case of children, let us say below age 12 (pre-adolescence), POCSO can apply as it because i) children are not physiologically ready for sexual engagement; ii) they have not developed the requisite knowledge and understanding of sex and sexuality—consequently, they are not psychologically ready for physical intimacy, nor do they have the capacity for (informed) consent. Therefore, for any child under age 12 who is engaged in sexual activity, it must be considered as sexual abuse and POCSO must apply. But for adolescents, a more nuanced understanding of the situation is required—taking into consideration that adolescents are at a life stage wherein they are (unlike children) physiologically ready for physical intimacy and there is an emotional need and desire that makes them feel ready for sexual involvement. (See next point for further details).

POCSO also needs to make the distinction between situations of abuse and mutually consenting sexual relationships between adolescents. The key difference is the issue of consent—an element that is absent in case of abuse. The adolescents concerned can be interviewed to understand whether or not there was consent to engage in sexual acts/ physical intimacy. This means that boys and girls both need to be interviewed/ assessed to establish the nature of the relationship, whether or not there was consent by both parties—the onus of the relationship/ sexual act decision cannot be only on boys. Such interviewing may be done by mental health professionals. Where there is mutual consent, both the boy and girl need to continue to receive psychosocial and mental health interventions on life skills in the context of relationships and sexuality[5].

[Note: This discussion does not apply to an adolescent who may have legitimate sexual needs and desires but coerces or assaults another child or adolescent/peer in order to meet his needs—in which case the issue is unequivocally one of sexual abuse].

The 34% of children acknowledging the alleged offence they were charged with is inclusive of those engaging in mutually consenting romantic relationships with their peers. Of the 11 or 13% of children not acknowledging the charge of sexual offence, assessments revealed that most of these children had been wrongly accused of child sexual abuse in situations of inter-family/community conflicts i.e. the child's family had disagreements with another family in the neighbourhood who then took revenge by laying a POCSO charge on the child.

A.3. Child's Version of Offence

Thus far we have been discussing the child's alleged offences, which as erstwhile mentioned, may or may not be acknowledged by the child. The reason we cannot base our entire understanding and intervention on the alleged offence is because i) the alleged offence may not be a true of accurate reflection of what occurred; ii) the alleged offence only represents the knowledge and viewpoint of the complainant or the police, not that of the child. Children have their side to the story and they have the right to be heard. Furthermore, psychosocial work can only be initiated with the child based on his account and understanding of what transpired and how he came into conflict with the law. Thus, since all child psychosocial work must be approached from a child rights perspective, the child's account or version of events is critical for both legal and psychosocial processes.

As reflected in table A. 1 (c) below, of the 130 children, 47 children or 34% of children acknowledged having committed offences. Within the group of 47 children those acknowledging offences, 14% of them reported having committed theft and robbery, 13% reported being involved in acts of violence and aggression and 7% reported having been involved in sexual offence. The difference between the previous tables, which also discuss the category of children acknowledging offences, and this one is: the previous tables show the alleged offences for children acknowledging offence i.e. the children are acknowledging involvement in some offence or action, not necessarily the one they have been charged with; table A. 1 (c) below shows which offences children have acknowledged—which may not be the same as the alleged offences.

Table A. 1 (c): Children's Account of Offence

Child's Account of Offence	No. of Children	
	Acknowledging Offence (N=47 or 34%)	Not Acknowledging Offences (N=83 or 66%)
Theft & Robbery	18 (14%)	NA
Violence & Aggression-Related Offences	17 (13%)	NA
Sexual Offences	6 (5%)	NA
POCSO-Romance	9 (7%)	NA
Present at offence	NA	37 (45%)
Wrongly Charged	0	4 (5%)

*Total No. of Children=130

The remaining 83 or 66% children did not acknowledge any offences. Out of this group, however, 41 children or 49% were present at the time of offence i.e. these are children who with peers who committed the offence or simply 'went to see what was happening' and were apprehended by the police under suspicion that they

[5] The Community Child & Adolescent Mental Health Service Project, Dept. of Child & Adolescent Psychiatry/NIMHANS has developed an intervention module on this and has been successfully using it with vulnerable adolescents in various child care institutions, enabling them to acquire assertiveness, negotiation, refusal, problem-solving skills in the context of relationships and sexuality, including reflecting on issues of running away/ early marriage/ coercion and other health, safety and relationship issues. This intervention module is based on a recognition and acknowledgement of adolescent sexual rights but provides them with a clear framework for decision-making in the context of love/relationships and sexuality.

were also involved in the offence. Also, 6% of the 83 children were 'wrongly charged' or charged with offences that they were not even connected with i.e. they were not even present at the time of the offence, nor were they really acquainted with the victims of the alleged offence; some of them are therefore unsure of what charged have been placed against them.

That 66% of children were not responsible for committing any offences but have been apprehended and spend weeks and sometimes months in the observation home, awaiting justice is a serious concern. Even if one allowed for a 10% margin of error i.e. let us assume that some of these children who do not acknowledge their offence are not telling the truth, over half the children in the observation home should not be there at all. This raises questions about the ways in which the police make decisions about who they apprehend and take to safe custody.

That 45% of children not acknowledging offences were present at the time of or scene of offence is also a matter of concern. It tells us that while these children may not have committed the offence, they seem to spend time with others who commit these offences or be in spaces where such antisocial activities are carried out. This means that these children are at risk of getting involved in offences, through negative peer influences or by being coerced into certain actions by older peers or being (wrongly) accused of having been involved, by virtue of their presence in these situations. Whichever the reason, these children then become vulnerable to coming into conflict with the law even without directly committing an offence.

A question may arise about how the team conducting the assessment could 'believe' the child's account, and indeed this is a complex issue. Social desirability factors, the need and desperation to get out of the observation home, the fear that acknowledgement of offence may invite more severe punishment, including a longer stay in the home, may all cause children to be reluctant to acknowledge their offences. It must be remembered, however, here that there are many components to the assessment proforma, that seek to assess the risk the child is at of further conflict with the law. The child's family situation and relationships, experiences of child labour, abuse and trauma, susceptibility to peer influence, presence of mental health problems and life skills deficits are all taken into consideration to determine the extent to which he may have been vulnerable to committing the offence. Thus, the child's account of the offence is not the only or isolated factor in determining whether or not he has committed the offence.

Furthermore, since the Project team had a presence in the observation home and interacted extensively with the children in various group and recreational activities, the team had several opportunities to observe the children and their behaviours in spaces and sessions after the initial assessment session. Reports from the observation staff were also considered, to corroborate (or contradict) children's accounts of the offence.

B. Age of Child

Broadly, two age categories of children or adolescents come into conflict with the law and are admitted in the observation home (OH): children who are between 13 and 15 years (early adolescence) and those between 16 and 18 years of age (late adolescence). The 16 to 18-year category has also assumed a new significance following the passing of the Juvenile Justice Act 2015. Of the 130 children assessed by the NIMHANS team, 86% fell within this older age category while only 14% fell into the younger age category. (Refer to table B.1). In rare instances, children between ages 10 and 12 years have also been brought to the OH, usually for petty theft.

Table B.1: Age of CICL

Age Categories	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	All Children (N=130)
13-15 years	14 (30%)	4 (5%)	18 (14%)
16-18 years	33 (70%)	79 (95%)	112 (86%)

One possible reason for a greater proportion of children in the older category is that at the time when the NIMHANS Project was providing services in the OH, there were JJB magistrates who wished for 16 to 18 year olds to be assessed by the NIMHANS team, in accordance with the preliminary assessment requirements stipulated in Section 15 of the JJ Act 2015[6]. What is interesting here is that other JJB magistrates did not request for preliminary assessments for 16 to 18-year olds to be conducted. It appears therefore, that despite the JJ Act provision on preliminary assessment, and like the rest of the country, JJB magistrates are also divided in their opinion on this provision of the JJ Act, and consequently work, at least in part, according to their personal views and opinions on the child and the law. We know, through personal communication with several magistrates that many do not believe that children should be tried as per the adult criminal justice system and so they have taken a position not to use this provision in the JJ Act; other magistrates, however, indicate a preference for going strictly by the rule book and request preliminary assessments to be completed[7].

That said, even if we were to factor the requests from the JJB magistrate to assess 16 to 18 year old children, it appears that a majority of the children who come into conflict with the law are between 16 and 18 years old; relatively fewer children come into conflict with the law at younger ages. The reason for a large proportion of children in the OH being between 16 and 18 years is that there are certain risks and vulnerabilities that this group is more prone to than younger adolescents:

i) Parents and caregivers are less able to exert control and supervision over 16 to 18-year olds as compared to younger adolescents who still tend to spend more time at home and are required to follow rules about going out/ being with friends etc.

ii) 16 to 18-year olds are therefore out of the house to a much greater extent, staying out days and nights with their friends, and therefore more exposed to peer influences and substance abuse, factors that lead them to committing offence.

iii) Offences by adolescents are usually committed in groups. Even if one or two adolescents in a given peer group committed the offence, the others with them tend to be apprehended by the police. This would explain the large numbers of 16 to 18-year olds (who are out more with their friends and peer groups than younger adolescents are) as well as the numbers of children who do not acknowledge their offences.

iv) Adult offenders frequently select 16 to 18-year olds to assist them in the commission of crime—because this age older adolescent age group is young enough to manipulate (especially if rewards of money and substances are offered to them) and old enough to provide them with certain types of assistance that young adolescents could not do. (While our program data did not record it, there were many older adolescents who were with adult offenders when they were apprehended—the adolescents were sent to the observation home and the adult offenders were in prison).

Another finding relates to age and acknowledgement of offences. Within the 13 to 15 age group, 14 out of 18 children i.e. 78% acknowledged their offences compared to only 29% of 16 to 18-year olds. There is a significant association between age and acknowledgement of offence in case of younger children[8] who seem to be more likely to acknowledge their offence. One reason for this is that as per our observation, younger children tend to more readily acknowledge their offence, possibly because they are less fearful as they are less aware of laws and consequences than older children—indeed the nature of their offences pertained mainly to petty theft; so, their reasons for committing an offence, as reported by them, are more to do with deprivation, curiosity and experimentation, and peer influence than any deliberate intent to harm. Counselors also experienced that it was easier to build trust and rapport with younger children, thus facilitating the latter's disclosure. Another reason for this may also be that 16 to 18-year olds have been accused of alleged offences

[6] According to the new JJ Act 2015, the Juvenile Justice Board, will have a judicial magistrate and two social workers as members, will decide whether a juvenile criminal in the age group of 16–18 should tried as an adult or not. This decision may be based on a preliminary assessment.

[7] Personal communications to the NIMHANS team during a workshop conducted for JJB magistrates of Karnataka, in November 2016, at the Karnataka Judicial Academy.

[8] Younger children between ages 13 to 15 years are more likely to acknowledge their offence.

that they genuinely have not committed and therefore cannot acknowledge (as discussed in subsequent sections of this chapter).

Table B. 2 (b): Children's Age and Alleged Offence

Alleged Offence	No. of Children		
	13-15 years (N=18)	16-18 years (N=112)	Total (N=130)
Theft & Robbery	9 (50%)	23 (21%)	32 (25%)
Violence & Aggression-Related Offences	2 (11%)	65 (58%)	67 (51%)
Sexual Offences	8 (44%)	19 (17%)	27 (21%)

When age is correlated with alleged offence, it shows that theft and robbery is most commonly the alleged offence of younger children (50%), in the age group 13 to 15 years while violence and aggression form the largest proportion of alleged offences for children in the 16 to 18 years group. A higher proportion of children (44%) in the younger age group are allegedly charged with sexual offences than older children, where only 17% are charged with alleged sexual offences. As explained previously, children in the younger age group appear to be more vulnerable to committing sexual offences because of adverse peer influences that expose them to pornography and exacerbate their curiosity and the need to experiment with their sexuality; older children are mostly charged with alleged sexual offences that are in the nature of engaging in mutually consenting romantic relationships with their peers, including running away or 'getting married'.

Community-based theories that explain offence (and are subsequently detailed in this chapter) suggest that the nature and strength of community-context influences (levels of community capital and collective efficacy) on the individual development of propensity and motivation to offend *varies by developmental phase*. These theories hypothesize that *the community influences on development of tendency to offend decrease from infancy to adolescence, while its influence on motivation increases from infancy to adolescence*[3]. This is because cognitive and emotional characteristics that determine morality and self-control develop maximally in the early years of a child's life, after which they gain a certain stability[4],[5].

As children grow older and enter adolescence, their activity fields expand outside the home, and therefore their risk of exposure to criminogenic behavior settings in their neighborhood and in the wider community outside their neighborhood increase. The community context thus influences an individual's motivation to offend, as well as through socialization processes an individual's life style, thus increasing the risk of offence over the childhood period[3].

C. Vulnerabilities and Pathways

In order to better understand children's vulnerabilities and pathways to offence, we will first examine some theories relating to offence. There are developmental and psychological theories of offending. Developmental theories concern themselves with: i) development of offending and antisocial behaviours from birth to death; ii) influence of risk and protective factors at different ages; iii) effect of life events on individual development. Psychological theories concern themselves with: i) individual's early childhood experience and its influence on his/her likelihood of committing future crimes; ii) behavior modeling and social learning; iii) how an individual's perception and its manifestation affect his/her potential to commit crime.

Developmental Theories

(i) **Developmental propensity theory** explains development of conduct disorder and juvenile delinquency with a childhood and adolescent focus. According to this theory, the factors that contribute to antisocial propensity are: low cognitive ability (especially verbal ability), and three dispositional dimensions: prosociality

(including sympathy and empathy, as opposed to callous-unemotional traits); daring (uninhibited or poorly controlled); and negative emotionality (e.g. easily frustrated, bored, or annoyed)[6].

(ii) Adolescence-limited versus life-course-persistent offending theory proposes that there are two qualitatively different groups of antisocial people: the life-course-persistent (LCP) and adolescence-limited (AL) offenders[7]. LCPs start offending at an early age and continue to do so across their life span; they also commit a wide range of offences including violence. The factors that prompt offending by LCPs are cognitive deficits, an under-controlled temperament, hyperactivity, poor parenting, disrupted families, teenage parents, poverty and low socio-economic status (SES). ALs, on the other hand, offend only during their teenage years and their offences comprise largely of 'rebellious' non-violent offences such as vandalism. The risk factors for ALs are the 'maturity gap' (their inability to achieve adult rewards such as material goods during their teenage years) and peer influence (especially from the LCPs). Thus, ALs stop offending when they enter legitimate adult roles and can achieve their desires legally[8].

(iii) Interactional theory focuses on factors influencing antisocial behaviour at various ages. At early ages (birth to 6 years), the three most important factors are neuropsychological deficits and difficult temperament (e.g. impulsiveness, negative emotionality, fearlessness, poor emotion regulation), parenting issues (e.g. poor monitoring, low emotional bonding, inconsistent discipline, physical punishment) and structural adversity (e.g. poverty, unemployment, and disorganized neighbourhood). However, for children who start to offend between ages of 6 and 12 years, neuropsychological deficits are not so critical—instead, neighbourhood and family factors are particularly important; and deviant opportunities, gangs and deviant social networks are important for onset of offence at ages 12–18 years of age[9].

(iv) Age-graded informal social control theory suggests that the strength of bonding with family, peers, schools and, later, adult social institutions such as marriages and jobs influences whether or not people commit offences i.e. the stronger these bonds are, the less likely individuals are to commit offences. It assumes that individuals commit offences to satisfy their desires and need for pleasure and so proposes that offending is inhibited by social bonds and affiliations. It also asserts that even where there are differences in the early childhood experiences of offenders and non-offenders, adult bonds to work and family produced similar outcomes in both groups i.e. desistance from offence at later stages in life, even in case there was offending from childhood to adulthood[10].

Psychological Theories

(i) Bowlby's Attachment theory takes the perspective that a person's inner world of subjective experience is structured, shaped and organized by patterns of attachment and interpersonal interactions into representational models. His theory explains how childhood experiences of separation and loss result in distress, followed by protest, despair, and emotional detachment. He says that when a child experiences death, abandonment or separation, all of which are loss experiences, the child goes through a period of grief and mourning, which is facilitated in the family context of attachment. If the child receives sympathetic and supportive responses from the family, the child is able to process the grief, accept and resolve the anxiety and detachment that follows, it in a manner that allows him/her to form new attachments again. However, if the family and caregiver relationships are not supportive, the child develops feelings of anger and ambivalence in the context of loss and trauma, in the absence of a trusted attachment figure, the child becomes emotionally detached. In such a situation, the child develops a representative model of the world as being untrustworthy and hostile, and behaves in ways that do not foster attachment or interpersonal relationships[11].

Eysenck's Personality theory views offending as natural and rational. It assumes that human beings seek pleasure and avoid pain. From these assumptions follow the view that acts of violence and theft are pleasurable or beneficial to the offender. However, the reason why everyone then does not commit offence is because of conscience. According to this theory, conscience is built during childhood, when a child commits

acts that elicit disapproval or punishment from the parents; by a process of classical conditioning, a child learns to associate fear and pain with certain undesirable actions, which, over time they then stop committing. This conditioned fear response is in fact the conscience, and is also subjectively experienced as guilt in case the action is committed. According to the theory, people who commit offences have not built up strong consciences due to poor conditioning. Some of the barriers to proper conditioning are: extraversion—they have low levels of cortical arousal, which results in poorer abilities for conditioning; neuroticism—their general levels of high anxiety interferes with conditioning; psychoticism—characterized by emotional coldness, low empathy and high hostility, result in poor conditioning and are conducive to offence[12].

Social learning theory explains the development of conduct problems using the paradigm of coercion, which refers to pattern of conflict that occurs between disruptive school age children and their families. In a given coercive cycle, the parent and child both behave in ways that are aversive to each other in order to control one another's behaviour. As the child behaves in increasingly difficult ways, the parent intensifies power assertion methods and which in then cause the child's aversive behaviours to increase. These cycles eventually lead to openly defiant behaviours and later to behaviours such as being away from home excessively, lying, stealing, and more serious behaviors such as fire-setting[13].

Lifestyle theory proposes that development of criminal life style occurred due to motivations for pleasure, excitement seeking and personal advantage. Criminal life style includes social rule breaking, irresponsibility (in relationships/job), self-indulgence (eg. substance use), and interpersonal issues (eg.violence); this life style is based on certain cognitions, self-beliefs and thinking styles. The change model linked to this theory therefore focuses on how people changed their behaviours by focusing on self-concept, taking responsibility, increasing self-confidence and understanding the impact of their actions on others[14].

C.1. Family Factors

Low Socio-Economic Status:

Of the 130 children, most of them, 84% were from low socio-economic background. Children acknowledging and not acknowledging offences were almost equal in proportion, 87% and 82% respectively. What this means is that the parents and caregivers of these children are daily labourers and wage earners, some with seasonal or irregular incomes; caregivers have low levels of literacy and education (most of them have not completed school), and many children are first generation learners; they live in slum communities wherein gangs and violence are the neighbourhood norm.

Since our program database consists only of children from the Observation Home, we do not have the advantage of being able to compare CICL from lower and higher socio-economic strata, and the fact is that children from higher socio-economic strata also have conduct disorders and rule-breaking behaviours. However, there are reasons why children from lower socio-economic backgrounds tend to get to the OH and those from socio-economically better-off families do not. For instance, there are several children who are brought to NIMHANS's Dept. of Child & Adolescent Psychiatry Centre, from higher socio-economic groups, who if their behaviours had been reported to law authorities, would have come into conflict with the law. However, because their caregivers have access to greater resources and power, they do not get reported to the police and legal authorities; when they do get reported, their caregivers are able to use their position and resources in processes of compromise at the police station, so that the child is released immediately.

Children from lower socio-economic strata, whose families also tend to be disempowered, however, do not have the knowledge, position or resources to engage in such processes of compromise at the police station. We also know anecdotally that police personnel tend to give these children's parents incorrect information to the effect that if they 'accept' the child's offence (and sign off on the written complaints), the 'case will be closed faster' and that their child 'will get less punishment'. Parents, because they have no awareness of the law, and do not want their children to be further harassed and beaten by the police, tend to comply with the police's advice. These are some of the immediate reasons for children from poorer socio-economic strata coming to the observation home.

That said, there are other distal factors that affect the group of children who come into conflict with the law, including those in the OH, and these pertain to geography. The role of the community has emerged as a key factor influencing crime. The community may be defined as a social or physical/spatial environment of an individual. Each community has certain structural characteristics or residential population characteristics and composition, which vary in their levels of poverty, ethnic heterogeneity, family disruption and residential stability; there are also variations in layout of buildings and spaces, which influence the activities conducted within them. There are certain social mechanisms by which these structural characteristics influence individuals living within the community, and their development:
(i) Community resources—the external social and economic support that individuals in a community draw upon in their everyday lives. The level of access to social capital or resourceful social relationships as well as educational institutions and health facilities, for instance, may enable or hinder human action or development accordingly. Thus, community resources affect the ability of individuals to realize their desires and also influence people's daily routine and behaviours, impacting the life choices they make[3].

(ii) Community rules—are norms and conventions that residents tend to follow in daily life. Communities vary in their norms and conventions, their values and expectations, according to which they decide on sanctions and interventions[3]. *Collective efficacy* refers residents' willingness to intervene for the common good or exercise social control when required, as a result of shared expectations and mutual trust in the community[15]. Community rules influence the norms that individuals internalize and the social bonds that residents they share, including their desires and interests, thus impacting the actions they take on a day-to-day basis. Weak community resources also hinder the creation and maintenance of community rules for behaviour; the converse is also true, wherein weak collective efficacy adversely impacts access to community resources, through high levels of social disorder and crime, causing residents and institutions with higher socio-economic resources to move out of the locality[16].

(iii) Community routines—are patterns of activities by time and place that occur in a community, including activities related to family life, education, work and leisure, essentially to meet people's biological and social needs[3]. Community routines are largely determined by community resources and rules. The settings and events that people encounter daily will influence individual's development and actions. According to Bronfenbrenner's theory of ecology of human development[17], an individual's daily routine and activities, *'the objects to which he responds and the people with whom he interacts on a face-to-face basis'* directly influence his/her development. In the ecological context, *place of resident and neighbourhood,* are key determinants to the types and characteristics of behavioural settings that children and adolescents are exposed to. Neighbourhood-based behaviour settings may play an especially important role for youth and their actions[3].

Table B. 1: Family Vulnerabilities IN CICL

Family Vulnerabilities	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Low Socio-Economic Status	41 (87%)	68 (82%)	109 (84%)
Parental Marital Conflict/Domestic Violence	10 (21%)	9 (11%)	19 (15%)
Substance Use in Caregivers	21 (45%)	16 (19%)	37 (29%)
Illness/Disability in Caregivers	8 (17%)	21 (25%)	29 (22%)
Single Parent/ Orphan/Adopted Child	15 (32%)	22 (26%)	37 (29%)
Caregivers Involved in Crime	2 (4%)	1 (1%)	3 (2%)
Parenting Styles	9 (19%)	15 (18%)	24 (19%)

In summary, the above-described community-level theories propose that higher rates of children developing low self-control and values among those living in areas with weak community capital and low collective efficacy; and higher rates of adolescents developing risky lifestyles among those living in areas with weak community capital and low collective efficacy—both of which explain the link between low socio-economic status and children's offence in our work.

Parental Marital Conflict and Domestic Violence

Of 130 children, 15% report parental marital conflict[9] and/or domestic violence at home. The proportion of children acknowledging offences reporting such conflicts within the family is nearly double (21%) that of the proportion of children not acknowledging offences (11%). While the sample size may not have allowed the difference to be statistically significant, the descriptive statistics suggest that children acknowledging offences appear to have been exposed to considerably more such conflicts at the family level.

Studies have shown that conflict between adults is upsetting to children and that repeated exposure to parental disagreement is stressful for children. There are different ways in which this stress factor can impact children's development and behaviour. Studies have shown that frequent intense and poorly resolved parental marital conflicts have particularly adverse effects on boys, with teachers reporting higher levels of externalizing behaviours in them[18]. Marital conflicts also adversely impact children's emotional regulation mechanisms, negatively affecting their self-soothing abilities[19]; such difficulties in emotional regulation are manifested as increased impulsivity and aggression (externalizing behaviours) or increased anxiety and depression (internalizing behaviours)[20].

Children actively observe and interpret events in their environment and develop emotional and cognitive responses based on these experiences and interpretations[20]. One way in which this plays out is that violence and aggression get legitimized in a household where marital conflict and/or domestic violence occurs. Children grow up understanding and learning that use of aggression to respond to or resolve conflict is acceptable and so this becomes the norm for them. Consequently, they use violent and aggressive methods in various spheres of their lives to resolve conflict. Children whose parents use strategies to control, dominate and intimidate, model their behaviours on that of their parents and this has serious impacts on their social behaviours[11], for, they use similar (age-appropriate) methods with their peers[20].

Parental marital conflicts also lead to inconsistencies in parenting behaviours. Parents may be unable to agree on rules and child-rearing practices, thereby undermining any discipline that one or the other parent tries to impose on the child. Such disagreements may also lead to one parent withdrawing altogether from the parenting role[20]. Such parental inconsistencies lead to confusions in the child, regarding social rules and discipline, which then indirectly forms a pathway to offence.

Lastly, when there is marital conflict or domestic violence, the quality of parent-child relationships is compromised, as are family relationships overall, given that marital conflict also results in children having to 'take sides'. Severe marital conflict also causes physical and emotional neglect of the child as parents engaged in conflict are unable to spend quality time with the child and provide the necessary supervision, thus placing the child at higher risk of antisocial behaviours and conflict with the law.

[9] The term marital conflict is refers to overt disagreements, both verbal and physical, between caregivers, and observable to the child. It excludes marital strain or discord and general disharmony between caregivers that may exist but that the child may not be aware of and therefore not significantly affected by.

Substance Use in Caregivers

Nearly one-third of children in the OH reported substance use in parents/ caregivers. Of these a significant proportion of children with parents using substances, 45%, were in the group of those acknowledging offences, as compared to only 19% of children whose parents did not use substances and did not acknowledge offences. There is a significant association between children who acknowledged offence and whose parents were substance users. Most children stated that their fathers used alcohol or nicotine.

The finding that nearly half of the children acknowledging offences have parents who use substances can be explained in several ways. Perhaps the most obvious effect would be seen in cases of severe alcohol dependency or bouts of intoxication in the parent, wherein children report how their fathers are unable to go to work regularly and earn an income. This places an enormous financial strain on the family—one of the reasons why children are compelled to work i.e. engage in child labour activities, to sustain the family.

However, even in cases where children say *'my father drinks but he doesn't beat anyone…he just quietly comes home at night after drinking, every week or so…'* and children in fact do not perceive their fathers' substance use to be a problem, there are other impacts, particularly on children. Parental substance use is directly and indirectly associated with early adolescent substance experimentation[21]. Substance using parents provide models for drinking or smoking and access to substances to their children; also, parent drug use impairs parental monitoring of children's behaviours and activities. Lower supervision and monitoring has also been associated with children's involvement in peer groups that engage in substance use and antisocial behaviours[22].

Emotional availability and responsiveness of the caregiver to the child is how attachment and bonding take place within child-family relationships; and it is the nature of these relationships that bring about feelings of security in the child, from which stem abilities to cope with stress and regulate emotions[23],[24]. Studies have found that parents using substance display lower levels of warmth and responsiveness in their relationships with their children, than parents who do not. Fathers who are alcoholic are at higher risk of poor parenting styles and less warmth and connectedness, than fathers who do not use substances[25]. Similarly, mothers who have alcoholic partners have been found to be less warm and sensitive in their engagement with their young children[26], thus showing how substance use in the father can also can indirectly affect children adversely, by compromising children's relationships with their non-substance using mothers too .

Further, parental substance use is one of the key risk factors for physical abuse and maltreatment, particularly of neglect, of children by parents[27], and many children in the OH report being physically abused, particularly by their fathers, at times when they have consumed alcohol. Studies have shown that children whose parents use substances and misuse alcohol are 3 times as likely to be physically, emotionally, or sexually abused and 4 times as likely to be emotionally or physically neglected[28],[29].

Thus, substance use in parents is likely to lead to inconsistency in parenting, parental conflict and stress, disruption or lack of healthy family routines and rituals; consequently, children of substance-using parents, also at higher risk of being abused or neglected, are often denied the security that is associated with structure and stability provided by appropriate parenting. As a result, children of parents with substance abuse are also at risk of various behavioural problems, including substance abuse, all of which places them at risk of coming into conflict with the law.

Illness and Disability in Caregivers

About one-fifth of children in the OH reported having parents or caregivers with some form of illness and disability. These range from physical or locomotor disabilities to chronic illnesses such as tuberculosis. 17% of children with parents having illness and disability are those who acknowledge their offences; but a slightly higher proportion of children, 25% reporting parents with illness and disability are children who do not acknowledge offences.

Based on this data and on literature about impact of parental disability and chronic illness on children, it is difficult to draw any conclusions about children's alleged offences. Most commonly, parental illness and disability are likely to have emotional impacts on children, causing children to develop internalizing disorders such as anxiety and depression. However, some literature reflects that when parents have health problems, children may develop a combination of externalizing, internalizing, social, identity-related problems[30]. We also do not know, based on the children's reports, whether any parents also had mental illness—which, depending on the nature and severity of the illness could have serious impacts on family functioning, childrearing and parent-child relationships, all of which impact children's psychosocial well-being. Since nearly a third of children report substance use in parents, it is also likely that these parents have other psychiatric disorders or co-morbidities that often occur with substance use disorders.

What we have observed though at the observation home, in those children having parents with illness and disability, is that often these children have higher prosocial skills than others. They are more considerate towards other children around them, and that have many anxieties about their parents' health. They report how they have had to take on additional responsibilities at home and outside, due to their low socio-economic status and the financial difficulties that result from having a non-working/ non-earning parent. In fact, such children also have higher levels of insight into their (both offence and non-offence related) problems, and higher motivation levels for behaviour change because they feel the urgent need to return to caring for their families.

Single Parent/ Orphan/Adopted Children

Almost one-third of the children were orphans or from single-parent families; a couple of them were also adopted children. Given that 32% of children acknowledging offences and 29% of those not acknowledging offences were orphaned or from single parent families, the two groups were similar in terms this type of family vulnerability. Since almost a third of the children in the observation home have a background of being orphaned or of single-parenting, it appears that this family vulnerability is one that affects children coming into conflict with the law.

Parental rejection, and the lack of parental supervision and poor parent-child involvement are some of the most powerful predictors of children coming into conflict with the law; this might therefore explain why children who are orphaned or from single-parent families, are at greater risk of conflict with the law[31]. Many children in the observation home who came from single-parent families, whether raised by single-mothers or single-fathers, who themselves were struggling to cope with difficult socio-economic situations, were not always able to provide the emotional care and involvement that children required. Given that single-parenting can be both demanding and stressful, it has also been observed in several CICL, that single parents tend to be stricter and feel greater pressure to enforce discipline on their children; consequently, less quality time is spent doing joint activities or expressing affection towards children, thereby reducing the psychological availability of the parent. Studies have also shown that competent mothers i.e. mothers who are self-confident, consistently affectionate and non-punitive in discipline reduced the probability of their children engaging in antisocial and legal activities[32].

Caregivers Involved in Crime

A relatively small proportion of children (3%) had parents who were involved in criminal activities. Only 4% of children acknowledging offences and 1% of children not acknowledging offences reported that one or the other of their parents had come into conflict with legal authorities. In our database, this variable refers to parents who are overtly recognized as engaging in criminal activities, such as theft and murder and who are therefore in police custody or prison for their activities. In actual fact, domestic violence is an offence or criminal activity that is subject to court trial. Although domestic violence and conflicts have occurred in the families of the children in the observation home, there has been no legal reporting of the same (at least according to the children interviewed); consequently, some of the parents who engage in domestic violence have not been apprehended for criminality. If they had, the proportions of children having parents involved in criminal activities may have been higher than they currently reflected in our data.

Parenting Styles

Parenting issues refer to certain parenting styles that may have led children to developing difficult behaviours and coming into conflict with the law. For instance, highly permissive parenting styles often lead children to developing a sense of rights and entitlement that is limitless and infringes upon the rights and entitlements of others—such children are used to (instant) gratification of their needs and engage in behaviours that enable them to do so. Children who have needs relating to material things and forcefully or otherwise, without permission, take others' belongings and children who engage in acts of violence when their demands are not met whether in terms of sexual or material needs, are examples of probably permissive parenting—where over the years, parents have given into any kind of demand that the child had, thus enabling the children to learn that they are entitled to their needs and demands, at any cost, even when these are hurtful to others.

Parental inconsistencies relate to this style of parenting. Inconsistent parenting can broadly occur in two ways:
(i) When there is parental (or marital) conflict and the two parents differ in their parenting styles, often with one being extremely permissive and the other being extremely rigid or strict; in such instances, when parents cannot agree, particularly on child-rearing issues, children become confused about rules and boundaries (which are set differently by each parent) and may also get into manipulative patterns with the more lenient parents, to get their demands met.
(ii) Even in the case of a single parent, when there is no consistency of rules and boundaries i.e. the given parent oscillates between leniency and strictness, with no clarity on which rule applies when or when no rule applies across situations; here also, children develop a blurred sense of rules and boundaries, as they have no predictability about how a given rule may apply in a situation.
In either type of parental inconsistency, what essentially happens is that children (from a very young age), do not develop a clear understanding of rules and boundaries. As they grow, it is therefore difficult for them when they have to make more complex social decisions and judgements, since they have no guiding frameworks of rules. Such children are therefore at greater risk of coming into conflict with the law.

Yet another issue that was observed in the children we assisted was that of parental over-protection. As a risk factor, this one appears less obvious than permissive parenting (frequently assumed to be the case with children having behaviour problems) or parental inconsistencies. However, it influences certain aspects of child and adolescent development and life skills, namely those pertaining to decision-making, problem solving and assertiveness skills. When parents are extremely over-protective, they tend to be highly controlling of their children's physical mobility (not allowing them to go out or to play and interact with peers) as well as their children's day-to-day decision-making processes (not allowing them to make decisions about what they eat or wear, how they manage their study-leisure-recreation time, ways in which they conduct themselves). So, while such parents feel that they are doing a great job disciplining their children, the fact is that they are eliminating opportunities for children's social learning and identity development, which in turn are critical to developing the above-mentioned life skills. Thus, after years of seclusion within the protected sphere of the family, and/or lack of engagement in any kind of decision-making, when such children are exposed at some point, to the outside world, and suddenly confronted with situations of peer pressure and substance use, they are simply not equipped to respond appropriately—which is when they get into trouble with the law.

Finally, there is the issue of punitive or authoritarian parenting, wherein parents may be harsh, rejecting or physically and emotionally abusive. Studies have shown that families who are economically disadvantaged at the family or neighborhood level are likely to (a) experience more distress and poorer mental health[33], [34], [35]; (b) have lower capacity to parent in a supportive, consistent, and involved manner[36]; (c) use more hostile and coercive parenting styles, including physical punishment[36][14]. Low levels of positive parenting and high levels of negative parenting have constantly been associated with behaviour problems in children[37], [29].

While an average of 19% of children interviewed report parenting styles that are permissive, inconsistent, over-protective or abusive, we do not believe that this is an accurate reflection of the life situations of these

children. This is because our information is drawn from the subjective reports of children, and there is likely to be under-reporting of parenting issues, as children are not really aware or cognizant of parenting issues. Thus, this variable, of how (and what types of) parenting styles form pathways to offence, requires further examination. For this, information would need to be elicited from CICL's parents, to be able to understand the child-raising ideologies and practices and disciplining methods they have brought to parenting their children.

C.2. Educational Factors

Of the 130 children, only 2% or 3 children never went to school. However, more than half of them, or 61%, were school drop-outs. In all, 85 children or 65% of the children in the program records were not attending school (refer to table B. 1 (a)).

The reasons for non-attendance or drop-out can broadly be classified as: (i) financial difficulties, wherein children are the breadwinners in their families and need to go to work, and therefore cannot attend school; (ii) low motivation, wherein children themselves decide not to go to school either due to academic difficulty or lack of interest in studies; poor motivation may also be because of adverse peer influence. It is interesting that a higher proportion or 55% of children (55%) do not attend school due to low motivation as compared to 44% of children who do not attend due to financial difficulty.

Table B. 1 (a): Educational Vulnerabilities in CICL

Educational Vulnerabilities	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Never went to school	2 (4%)	1 (1%)	3 (2%)
School Drop-Out	33 (70%)	49 (59%)	82 (61%)
Total	35 (41%)	50 (59%)	85 (65%)

There are also some differences between children acknowledging and not acknowledging offences with regard to reasons for non-attendance: 60% of children acknowledging offences versus 50% of children not acknowledging offences, report financial difficulties as the main reason; only 34% of children acknowledging offences versus a much higher proportion of 52% of children not acknowledging offences report low motivation as the reason(See table B. 1 (b) below). One possible conclusion we may draw from this is that children acknowledging their offences actually have higher motivations to study but are from financially more difficult circumstances, which then do not allow them to pursue their education.

While the drop-out rates are slightly higher for children acknowledging offences versus those who did not, the difference is not significant. This may be explained by the previous discussions on how nearly all CICL are from low socio-economic families which are hindered from accessing community resources and consequently unable to maintain community rules and routines. The neighborhoods that these children live in place them at risk of adverse peer group influences i.e. these children are often with peers who encourage them to engage in truant behaviours and finally quit school.

Table C. 1 (b): CICL's Reasons for Not Attending School/ Drop-Out

Reasons for Not Attending School/ Drop-Out	No. of Children not Attending School/Drop-Out		
	Acknowledging Offences (N=35)	Not Acknowledging Offences (N=50)	Total (N=85)
Financial Difficulties	21 (60%)	25 (50%)	37 (44%)
Low Motivation	12 (34%)	26 (52%)	47 (55%)

Nearly a third of children reported having academic difficulties (See table B. 1 (c) below); a higher proportion of 38% of children acknowledging offences (versus 24% of children not acknowledging offences) report having had academic difficulties—which may also account for their low motivation to attend school. Indeed, it is well-known that government schools (and indeed many private schools too) have not the skills or resources to assist children with learning difficulties, whether such difficulties are due to neuro-developmental issues such as specific learning disabilities and/or attention deficit hyperactivity disorder (ADHD) or due to underlying emotional concerns. Government school teachers are barely aware of schemes such as the National Institute of Open Schooling (NIOS) which children with learning difficulties could avail of[10].

Table C. 1 (c): CICL's Problems at School

Problems at School	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Academic Difficulties	18 (38%)	20 (24%)	38 (29%)
Truancy Behaviours at School	26 (55%)	19 (23%)	45 (35%)
Corporal Punishment at School	3 (6%)	1 (1%)	4 (3%)
Bullying at school	2 (4%)	3 (4%)	5 (4%)
School Refusal	2 (4%)	1 (1%)	3 (2%)

The links between academic under-achievement and behaviour problems have been long established. Studies show that while children may already have behaviour problems before they are detected with reading disabilities and other academic difficulties; however, the failure to read and achieve academically exacerbates the existing behaviour problems[39] and also leads to antisocial behaviours[40],[39]. Further, children who are academically under-achieving also tend to have self-esteem deficits, problems in language skills, and interpersonal difficulties, all of which place them at greater risk of developing externalizing problems[41], that eventually make them vulnerable to coming into conflict with the law.

In the relative absence of special needs education resources in schools, the Project has made considerable efforts to explore vocational training opportunities for children who are not academically inclined, but such facilities are very few. Oddly enough, most vocational training centres ask for an 'VIIIth or Xth class pass—which defeats the very purpose of vocational education—for, were a child able to achieve those levels of academic qualification, then it is less likely that they would require vocational training opportunities. In 2015, Government of India launched the "National Skill Development Mission", and the Pradhan Mantri Kaushal Vikas Yojana (PMKVY), a flagship demand-driven, reward-based skill training scheme of the Ministry of Skill Development and Entrepreneurship, aims to skill young people who lack formal certification. However, the vocational training institutions who are implementing such schemes often have an age criteria and/or VIII class pass criterion for children to apply for these training programs. Consequently, even non-formal education and skill training programs that are meant specifically to cater to the needs of youth, are not able to make it through formal systems of education, and place these adolescents at risk of

[10] Established in 1989, India's National Institute of Open Schooling (NIOS) is the largest open schooling system in the world. It aims to provide relevant, continuing and holistic education up to pre-degree level through open and distance learning systems, to cater to the educational needs of prioritized target groups so as to promote equity and social justice. Its objective is to develop need-based curricula and self-learning materials for open basic education, secondary and senior secondary education, and vocational education and training programmes with focus on skill development. This the NIOS can specifically cater to children who are school drop outs as well as those who are in school but have learning difficulties.

conflict with the law. Needless to say, CICL also get left out of such programs which they urgently require as part of psychosocial rehabilitation and prevention of recidivism.

A small proportion of children reported experiences of corporal punishment in school (i.e. physical abuse by the teacher), bullying by peers/classmates and school refusal (an anxiety disorder). While 6% of children acknowledging offences and 1% of children not acknowledging offences report that they have suffered corporal punishment, these numbers are questionable. Usually higher proportions have suffered corporal punishment but there is frequent under-reporting by children due to lack of knowledge and understanding of actions that constitute corporal punishment by teachers. For example, children often think that it refers only to physical abuse, not knowing that corporal punishment also occurs in the context of mental harassment and discrimination, such as ridiculing, belittling or humiliating children in any manner[42]. Further, the culture of physical and verbal violence that is prevalent in most parts of Indian society, particularly with regard to children, unfortunately often legitimizes these methods of interaction and/or disciplining of children at home and at school, so that children learn that these as being legitimate ways of dealing with conflict or others' disagreeable behaviours. If one were to trace the pathways of the 16-year-old accused in the Nirbhaya case, other than a mentally ill parent and other difficult family circumstances, the child made a decision to leave school because his teacher hit him—following which he left home and went to Delhi and became child labour. In other words, if the teacher had not hit him and the child had found some support at school, he may not have dropped out of school…and consequently, he may not have left home to go and find work…and he may not then have come into conflict with the law…and the so, the new Juvenile Justice Act 2015, with its provision on preliminary assessments may not have happened.

Over a third of children reported irregular attendance to school i.e. that they 'bunked' school and went off to watch films or hang out in the neighbourhood with their friends; Twice the proportion of children acknowledging offences (55%) reported truancy behaviours as compared to children not acknowledging offences (23%) and the difference is statistically significant. The reasons for truancy are related to low motivation, which in turn is linked to academic difficulties and corporal punishment. When children are out of school, whether due to truancy behaviours or due to suspension or expulsion as punishment for inappropriate behaviours, they have a lot of unstructured time on their hands, that then tends to lead children to seeking the company of other peers who are out of school, entertainment (films etc), and use of substance. Sustained engagement in such activities requires monetary resources, and has thus served as a major reason for stealing. Thus, children who are out of school and not engaged in any gainful activity or employment are therefore at higher risk of coming into conflict with the law.

Studies have shown that when children and adolescents are not engaged in supervised activities, as happens when in school, they are more likely to engage in certain anti-social behaviours; and that being in school decreases the amount of property offence committed by children[43]. Our interviews with children from the Observation Home show that children who are truant or out of school tend to spend time with other children who are also out of school. This leads to interaction between like-minded children or peers, who then encourage each other to stay out of school, and away from academics. They also influence each other to engage in substance use and other antisocial activities, during the unstructured, unsupervised time they spend together.

When children are in school, however, they are exposed to and interact with a mix of peers, some of whom may engage in antisocial activities but others who do not, and yet others who are prosocial in their behaviour; engagement with multiple types of peers, versus a single type of peer group when out of school, reduces the risk of antisocial activities. Further, being in school presents children with opportunities for learning other than academics as well as opportunities for goal-oriented behaviour, which also mitigates the risk of antisocial behaviours.

The Right of Children to Free and Compulsory Education Act or Right to Education Act (RTE) enacted by the Parliament in 2009, mandates free and compulsory education for children between the age of 6 to 14 years

under Article 21A of the Indian Constitution. Given the importance of schools and education in keeping children safe and preventing them from coming into conflict with the law, it would also be useful for the Right to Education (RTE) Act to extend the age limit to at least 16 years, so as to ensure that children are in school, rather than out of it or engaging in child labour activities.

The above school-related issues also lead us to wonder about the education system that CICL are able to access, primarily government schools; these educational institutions often tend to attribute poor attendance to low socio-economic status of families and to child labour, but it appears that this is a simplistic understanding of the school attendance issue. The real question is whether educational institutions offer curriculums and pedagogies that are tailored to the needs, abilities and interests of various children. In other words, what are schools doing to keep children motivated to attend? Krishna Kumar, an Indian academician, wondered whether socialization is a 'closed process' and if it is, then it leads to the view that '*the school and community should be complementary to each other in socializing the young*' but that this contradicts the view that '*education is an agency of change*'. He therefore believes that schools should actually be agencies of 'counter-socialization' i.e. that schools should not be institutions working in harmony with the community or the larger society; that in fact, they should be *'in conflict with the community's code of socialization'*[44]. This idea is particularly relevant to CICL because they come from families and communities that socialize them in ways that do not favour their development or future; however, if schools were able to act as agents that challenge the environmental influences and learning of CICL, whether they pertain to neglect, violence or adverse peer influences, they would then be providing alternative ways of thinking and behavior, which would also play a critical role in the value that children see in attending school. Currently, however, this is often not the case—we live in a milieu where teachers are short-sighted rather than sensitive in their understanding of the limitations of CICL's home and community influences, judgmental and condemnatory, where they should be proactive and child-centric, in their responses to these children's behaviours.

C.3. Other Social Vulnerabilities

About 11% of CICL have, at one or the other time in their lives, been institutionalized or spent time in hostels that are either part of educational institutions or residential child care institutions. Many of them reported being sent to hostels, by their parents, for education purposes, especially where parents have had concerns about their children 'not studying at home and getting into bad company instead'—this may also explain why nearly double the proportion of children acknowledging offences (15%) were institutionalized as compared to children not acknowledging offences (8%). The former group, due to (emerging) difficult behaviours at home, it appears, was more likely to be placed forcibly in institutions (many said they disliked it and ran away from these institutions) as part of parental disciplinary or corrective measures.

Table B. 3 (a): Social Vulnerabilities in CICL

Educational Vulnerabilities	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Child Labour Experiences	35 (74%)	54 (65%)	89 (69%)
Institutionalization	7 (15%)	7 (8%)	14 (11%)

Overall, nearly 70% of CICL, with 74% of children acknowledging offences and 65% of children not acknowledging offences, are engaged in child labour activities i.e. there is no significant difference between these two categories of children with regard to child labour as nearly all of them come from low income families. Children work in a variety of places and occupations, that require unskilled or semi-skilled labour, such as mechanic shops/garages, small shops and businesses and construction sites, mainly as day labourers. Some of them have also reported working under powerful community money lenders, who got children to go around the community and coerce and threaten people to collect the money loaned to them by

money lenders. Children worked for such antisocial elements in return for money and also for drugs and substances that such leaders were able to provide them with.

Table B.3 (below) shows how children engaging in child labour activities are more influenced by their peer groups then those who are not engaged in child labour: 61% of child labourers (compared to 49% of non-child labourers) spend more time with their peers and 57% of child labourers have older peers as friends (compared to 46% of non-child labourers). While the difference between child labourers and non-child labourers is not substantial for certain variables such as for days and nights spent outside the home with friends and children's decisions on school attendance, the differences appear considerable with regard to substance use. Nearly double the proportion of child labourers (53%) report engaging in substance use with their friends/ peer groups versus non-child labourers (27%); similarly, higher proportions of child labourers report that their decisions on smoking (37%) and alcohol use (17%) are influenced by their peer groups as compared to non-child labourers whose decisions on smoking (25%) and alcohol use (7%) are influenced by peer groups to a lower extent.

It is important to recognize the 'push' and 'pull' factors, common to both children acknowledging and not acknowledging offences, for child labour. The 'push' factors are difficult home circumstances, with family dysfunction, poor nurturance and lack of developmental opportunities; the 'pull' factors are peer influence and how when children see their peers working and earning money, and enjoying the money they make, they are tempted (to drop out of school) and work too. In other words, work can also be attractive to children (more so than school) because it gives them a sense of power and self-identity that they cannot otherwise come by so easily in the family and social milieus, and liquidity, which enables them to satisfy various material desires (including for substances).

Table C. 3 (b): Child Labour and Risk of Peer Influence in CICL

Peer Relationship Factors	No. of Children	
	Child Labour (N=89)	No Child Labour (N=41)
More time with peers	54 (61%)	20 (49%)
Stayed out nights	24 (27%)	12 (30%)
Stayed out days	19 (21%)	7 (17%)
Have Older Peers as friends	51 (57%)	19 (46%)
Substance use with peers	47 (53%)	11 (27%)
Decisions on School Attendance	20 (23%)	9 (22%)
Decisions on Rule-Breaking Behaviours	15 (17%)	7 (17%)
Decisions on Smoking	33 (37%)	10 (25%)
Decisions on Alcohol Use	15 (17%)	3 (7%)
Decisions on Other Drug Use	13 (15%)	7 (17%)
Decisions on Sexual Behaviour	5 (6%)	2 (5%)
Consequence—adult authority	20 (23%)	9 (22%)
Consequence (Police)	56 (63%)	23 (56%)

While child labour places children at risk of various forms of abuse and exploitation, it may also serve as a pathway to coming into conflict with the law. When children and adolescents work in what are essentially adult settings, they are:
i) Exposed to high risk behaviours, such as substance use and sexual activities (which the adults they are surrounded by engage in);
ii) Either tempted to experiment with high risk behaviours themselves and/or they are coerced into engaging in these behaviours by older peers and adults working with them;
iii) Manipulated by older peers and adults to commit antisocial activities because of their relative lack of knowledge and decision-making skills i.e. adults get children to perform illegal actions and when the authorities come to inquire, the former become invisible, squarely laying the blame on children, who then face the consequences of decisions that they did not really make.

It is for the above-listed reasons that the Child Labour (Prohibition and Regulation) Act, 1986, amended in 2016, is debatable: as per this law, a "Child" is defined as any person below the age of 14 and the Act prohibits employment of such a person. However, children above the age of 14 years (until 18 years) are also vulnerable, not only to exploitation and maltreatment but by way of exposure to many risks in the work place, as described—and 'hazardous' work is not constituted not just be factories and mines where children's physical health is compromised but by any setting where children are exposed to adults, and related situations of risk and manipulation. For this reason, as discussed elsewhere in this document, the minimum age that children should stay in school and receive compulsory education should not be 14 years (as envisaged by the Right to Education Act) but be about 17 to 18 years. Ensuring that children are at school, not in a place of labour, is one of the first steps to ensuring child safety, including prevention of children coming into conflict with the law.

Again, let us consider the Nirbhaya case in terms of child labour as a pathway to offence. The 16-year-old was accused of 'being the most brutal of them all' by the media, in the rape committed by the group of males, on the bus. We need to understand on what basis such conclusions are drawn. Furthermore, we need to consider the possibility that the adolescent may have been incited and urged to commit the offence in certain ways. It is not uncommon, in a culture governed by patriarchy and related notions of masculinity, for older peers and adults to spur adolescents to experiment with or engage in misogynistic behaviours, which engender (sexual) violence against women. Phrases such as *'Be a man…'* or *'A real man would…'* or *'growing up entails experimenting with…and learning how to'* are common refrains that are used to influence or even mock adolescents into engaging in antisocial activities, whether they pertain to violence and sexuality or to substance abuse.

C.4. Experiences of Trauma and Abuse

77 children, nearly 60% of the 130 children in our services, report having one or the other experiences of trauma, pertaining to separation, loss, grief issues and/or physical, emotional or sexual abuse. Within this group, 27% of them reported trauma related to loss and grief, by way of death of a parent or caregiver; 40% report experiences of physical abuse, either at home, by parents and caregivers or to a lesser extent, at school, by teachers; 17% report being emotionally abused, by way of being rejected or humiliated (by adults) at home or at school and only 2% report being sexually abused. Experiences of trauma and abuse are higher for children acknowledging offences as compared to those not acknowledging offences.

While only 17% of CICL report emotional abuse, this number is likely to be higher if children were aware of what this constitutes. Unfortunately, use of verbal abuse, rejection, humiliation, and discrimination are all legitimized in the name of disciplining children at home and in school; so much so, that children grow accustomed to these methods over time, and so are unable to understand them as being wrong or abusive.

Table B. 4: Trauma & Abuse Experiences in CICL

Trauma & Abuse Experiences	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Separation/Loss/Grief Experiences	15 (32%)	20 (24%)	35 (27%)
Physical Abuse	21 (45%)	31 (37%)	52 (40%)
Emotional Abuse	11 (23%)	11 (13%)	22 (17%)
Sexual Abuse	3 (6%)	0 (0%)	3 (2%)

2% of the group that availed of our services at a certain point in time reported sexual abuse. There are, however, some grey areas when it comes to this issue. If an adult exposes a child to pornography, then this would be considered a (non-contact) form of child sexual abuse. However, the matter is more ambiguous when adolescents are exposed to pornography by their peers—despite value judgements about viewing pornography, it is common enough to normalize it when adolescents (especially male adolescents) engage in viewing it i.e. it is considered a part of normal sexual development, almost like a rite of passage for adolescent males. But if any of these adolescents were to engage in sexual activity, particularly one that entailed touch and contact, it would be considered abuse. The reason this contradiction is relevant is that most of the CICL who engaged in sexual abuse of younger children reported that they had been shown pornographic videos by their peers, and egged on by them 'to try' similar activities. In such situations, would CICL's vulnerability be understood as being experiences of sexual abuse or as being adverse peer influences? And, how we understand and interpret the vulnerability and pathway matters because that is what determines how we design our interventions for these children.

Trauma and Inappropriate Sexual Behaviours

Youth having problem sexual behaviours are, contrary to common belief, are a heterogeneous group. Sexual behaviour meets a range of needs—from curiosity and experimentation to eroticism, the desire to pursue and be pursued, to be nurtured and held, or as obligation and duty. Service providers' assumptions and positions on sexuality ideologies influence how they respond to sexual behaviours in youth. In this background, if there is an intersection of trauma such as these children being the subjects of anger, power or control, this constitutes a cumulative neuro-developmental issue. Such children have hypervigilance, are immune to internal cues, have mood dysregulation, attachment difficulties, memory disturbances, and numbing of responsiveness. Therefore, it is important to address trauma symptoms, for new learning and new narratives to emerge, and also to focus on new attachments. Thus, offence-focused responsivity is not useful. The ecology of CICL is constituted by the above-mentioned realities, and it has been observed that increased self-esteem, life skills training, mentoring, educational and vocational programs—in other words, diversion—reduces anti-social thinking.

Although many children who experience trauma may be resilient and do not necessarily develop behaviour problems, there are a number of children who become vulnerable to serious developmental problems and negative long-term issues such as substance abuse, risky sexual behaviour, poor academic performance, mental health pathologies and offence behaviours[45],[46],[47].

There is much literature on parental abuse and neglect and children's offence behaviours. The abuse may be physical, emotional or sexual[48]. Many studies have found correlations between aggression, violence and physical punishment by parents and aggression on the part of children[49]. Individuals who had been physically abused in the first 5 years of life were at greater risk for being arrested as juveniles for violent, nonviolent, and status offenses[50]. Abusive parenting leads to children and adolescents being shamed and blaming others, both of which are actually trauma outcomes; and such children are more likely to commit offences particularly those that are violent and aggressive[51]. There is also considerable evidence to suggest that adverse early-life experiences have a profound effect on the developing brain. Neurobiological changes that occur in response to problematic early-life stress can lead to life-long psychiatric issues. Children who are exposed to sexual or physical abuse or the death of a parent are at higher risk for development of depressive and anxiety disorders later in life. Preclinical and clinical studies have shown that repeated early life stress leads to alterations in central neurobiological systems leading to increased (mal) responsiveness to stress[52].

Recent theories of psychopathology in CICL, therefore, conceptualize trauma as a pathway to psychological disturbance. There are models that propose that traumatic experiences overwhelm the decision-making functions of the brain , causing impairments in thoughts, behaviours and emotions[53]. Especially in cases of chronic trauma, when difficult experiences continue over time, an adolescents' resources become depleted and they certain develop rigid patterns of thought and behaviour, including decreased ability to regulate emotions and learn coping strategies.

If adolescents' stress and symptoms continue to be ignored (as happens in the case of most CICL coming to the observation home), they then move towards what is called 'victim coping'—wherein they adopt any means they can to avoid re-victimization. Victim coping mechanisms range from loss of empathy, inability to self-regulate, distorted cognitions, lack of impulse control, and other characteristics that increase adolescents' tendencies for offence behaviours[53]. Patterns of thought and behaviour that are coloured by traumatic experiences can be as follows:

- A normal degree of emotional support will not be adequately met by others.
- Others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage.
- One is defective, bad, unwanted, inferior, or invalid in important respects.
- One is helpless and disempowered, and therefore unable to handle responsibilities
- One is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction.
- One needs to always gain approval, recognition, or attention from other people, or fit in, (at the expense of developing a secure and true sense of self).

Trauma, Attachment and Emotional Dysregulation

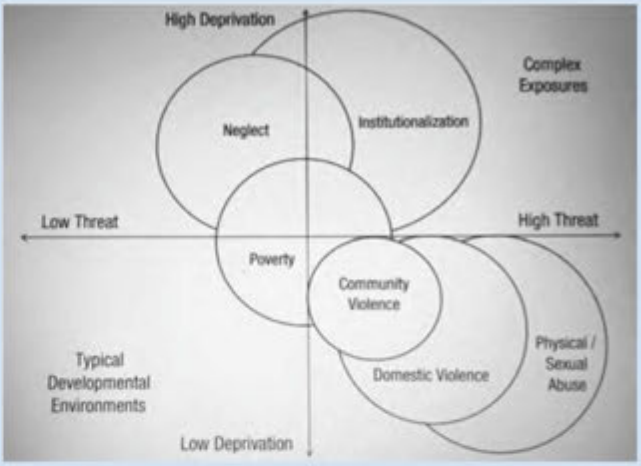
Developmental insults such as emotional abuse, loss, impaired caregiving, exposure to trauma, neglect and physical abuse give rise to attachment pathology, which manifests as hyper-arousal state of trauma.

The kind of attachment needs a child has i.e. frequent and timely response from caregivers with regard to food, shelter, healthcare and other survival needs as well as emotional needs of love, security and encouragement/ appreciation, have often not been met even during infancy and early childhood, for CICL.

Children first learn appropriate emotional regulation i.e. the ability and skills to control anger, fear and sadness through responses (usually of love, caring, soothing and reassurance) provided by their caregivers. For many CICL, who come from low socio-economic contexts and dysfunctional families, their early experiences of the world, represented by their caregivers, are at best, inadequate and at worst, hostile; and so their emotional regulation mechanisms are already somewhat dysfunctional.

As these children then continue to grow in these difficult home environments, their mistrust and anxieties are exacerbated by the often difficult, sometimes violent and always unpredictable nature of the home environment—and this worsens their abilities to control and manage difficult emotions. This helps explain why many of them, even those accused of violent offences, did not intend to kill or maim, and that their violent actions were actually a result of their poor emotional regulation abilities.

The above are some of the ways in which trauma can manifest in terms of thought and behaviour, and so if these serve as the frameworks for decision-making and actions in one's life, they are often likely to be decisions and actions that are socially inappropriate and/or individually damaging, as happens in the case of CICL.



CICL's experiences of trauma and abuse can also be understood through the use of a model that identifies how developmental processes disrupted by childhood adversity. This model focuses on two dimensions of adversity, each of which distinctively influences emotional, cognitive and neurobiological development of children[54]. As shown in the diagram alongside, the model differentiates between experiences of threat and experiences involving an absence of expected inputs from the environment. Experiences involving threat refer to observing community violence, witnessing domestic violence, and being the victim of chronic physical abuse; these may vary in the severity of threat involved but they all involve threat or harm. Deprivation refers to varying degrees of poverty, neglect, and institutional rearing, each of which involve an absence of expected cognitive inputs (e.g., complex language), social stimulation, and consistent interactions with or supervision by adults[54].

This model of childhood adversity then argues that exposure to threat plays a critical role in fear learning. Children who are exposed to threat demonstrate poor discrimination of threat and safety cues during fear conditioning i.e. when learning to predict aversive events; they exhibit similar responses to threat and safety cues. Children without adversity exhibit stronger fear responses to threat than to safety cues. While there is no disputing that childhood adversity, including deprivation and threats, together are more likely to result in psychopathology, poor performance in school and socio-economic difficulties[55],[46], this model delineates specifically how the threat dimension i.e. trauma and abuse experiences impacts children in that, it is this dimension (not deprivation) that is associated with externalizing psychopathology[56]. This model thus explains specifically how children exposed to experiences of trauma and abuse are also at risk of conduct and other behaviour problems, which lead them to come into conflict with the law.

C.5. Peer Relationships

One of the most significant pathways for children to come into conflict with the law is peer influence. There are considerable differences between children acknowledging and not acknowledging offences. Those acknowledging offences have more peer relationships at their workplace (30%) versus those not acknowledging offences (only 18%)—this might also explain how child labour makes children vulnerable to adverse peer influences which lead them to offence behaviours.

64% of children acknowledging offences have friends who are older than them as compared to 48% of children not acknowledging offences—this explains how the former group may have been more vulnerable to influence by older peers. it is also interesting that 17% children acknowledging offences and this finding is statistically significant, versus only 4% of children not acknowledging offences have younger children as friends—in fact, this what this means is that children acknowledging offences engage younger children, who are more malleable or easier to coerce into various antisocial activities (just as older peers/adults do to those children); children not acknowledging offences, on the other hand, possibly do not bother engaging with younger children as they have no need to influence or engage them in any way.

A high proportion (83%) of children acknowledging offences report spending more time with friends than with family versus children not acknowledging offences (42% only), with significant difference between the two groups.

Table B. 5 (a): Issues of Peer Relationships in CICL

Issues of Peer Relationship		No. of Children		
		Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Contexts of Peer Relationships	School/classmates	19 (40%)	33 (40%)	52 (40%)
	Neighbourhood	40 (85%)	69 (83%)	109 (84%)
	Workplace	14 (30%)	15 (18%)	29 (22%)
Age of Peer Group	Older children	30 (64%)	40 (48%)	70 (54%)
	Children of same Age	43 (91%)	68 (82%)	111 (85%)
	Younger children	8 (17%)	3 (4%)	11 (9%)
Time Spent with Peers	More time with friends than with family	39 (83%)	35 (42%)	74 (57%)
	Stayed out nights	23 (49%)	13 (16%)	36 (28%)
	Stayed out days	22 (47%)	4 (5%)	26 (20%)
Activities Engaged in with Peers	General Recreation only	17 (36%)	55 (66%)	72 (55%)
	General Recreation with Substance Use	30 (64%)	28 (34%)	58 (45%)

Similarly, 49% of children acknowledging offences have stayed out with friends several nights, compared to only 16% of children not acknowledging offences; 47% of children acknowledging offences have stayed out with friends for many days at a time (without information to or permission from their parents and caregivers) compared to only 5% of children not acknowledging offences. Overall nearly three-fourths of all CICL report spending more time with friends than with family. While this may be natural given their (adolescent) developmental stage, in the case of CICL, the peer groups are often a risk factor—children who acknowledge offences have frequently influenced by peer decisions and actions and children not acknowledging offences have been part of peer groups that have engaged in antisocial activities or in places where their peer groups have done so i.e. in the latter case, even if children have not been directly been responsible for committing an offence, they have been in the 'wrong place, at the wrong time' usually with their peer group.

Another significant finding is that 64% of children acknowledging offences versus 34% of children not acknowledging offences engage in substance use activities with their peers (P=0.001). Similarly, 66% of children not acknowledging offences mostly tend to engage only in general recreation activities with their peers, such as sports, film watching or 'hanging out in the neighborhood', while only 36% of children acknowledging offences engage in general recreation activities with their peers i.e. without substance use. This leads us to conclude that children engaging in offences are significantly influenced by their peers in the activities they engage in, namely substance use. As discussed in subsequent sections, nearly all substance use activities are initiated within peer groups that encourage children to experiment with, and then proceed to use, substances for recreational purposes.

Another dimension of peer influence that the program explored for intervention purposes was the impact it has on decision-making in certain areas of a child's life. Again there are significant differences between children acknowledging offences and not acknowledging offences: the proportion of children acknowledging offences (49%) who attribute school drop-out/ truancy decisions to peer influence is 7 times that of children not acknowledging offences (7%);. Similarly, the proportion of children acknowledging offences (43%) who attribute rule-breaking decisions (such as stealing/ breaking into homes etc) to peer influence is nearly 21 times that of children not acknowledging offences (2%).

With regard to high risk behaviours such as substance use and inappropriate sexual decision-making behaviours also, there are statistically significant differences between the two groups: the proportion of children acknowledging offences (55%) who attribute smoking decisions to peer influence is 2.5 times that of children not acknowledging offences (20%). The proportion of children acknowledging offences (30%) who attribute alcohol use decisions to peer influence is 6 times that of children not acknowledging offences (5%). The proportion of children acknowledging offences (38%) who attribute other drug use (such as cannabis) decisions to peer influence is 19 times that of children not acknowledging offences (2%). Finally, the proportion of children acknowledging offences (13%) who attribute inappropriate sexual behaviour decisions to peer influence is much higher than that of children not acknowledging offences (1%).

Table C. 5 (b): Peer Influence on Decision-Making in CICL

Peer Influence on Decision-Making	No. of Children		
	Acknowledging Offences (N=47)	**Not Acknowledging Offences (N=83)**	Total (N=130)
Decisions: School Attendance	23 (49%)	6 (7%)	29 (22%)
Decisions: Rule-Breaking Behaviours	20 (43%)	2 (2%)	22 (17%)
Decisions: Smoking	26 (55%)	17 (20%)	43 (33%)
Decisions: Alcohol Use	14 (30%)	4 (5%)	18 (14%)
Decisions: Other Drug Use	18 (38%)	2 (2%)	18 (14%)
Decisions: Sexual Behaviour	6 (13%)	1 (1%)	7 (5%)

It is evident therefore that children who acknowledge offences are far more easily influenced by their peers in several areas that pose risks to their lives than their counter-parts who do not acknowledge offence. What this then means is that children who have poor life skills, especially assertiveness and refusal skills, are more at risk of engaging in antisocial activities because of peer influence. These findings also provide us with important longitudinal information as we assess children and make decisions about their bail and/or case closure: children who are less susceptible to peer influence and/or have better assertiveness and refusal life skills are less likely to engage in antisocial activities. For those CICL not acknowledging offences, it could therefore mean that they were simply at the 'wrong place at the wrong time' as bystanders, who have been wrongfully accused.

Further, the nature of relationship that adolescents have with a friend affects the extent to which they are influenced by the friend. Close relationships ('best friend'), that are more valued by the adolescent, are more likely to cause him/her to change behaviours to please the friend[57]. This explains why children in the observation home have often shared how they would 'do anything, whatever it took for the sake of a good friend'; many of them have also spoken about how these 'good friends' have helped them in times of need so that when they ask for something to be done, they would do it almost unquestioningly, without considering

the consequences of the actions being requested of them. Also, it has been found that peer acceptance and peer influence are related—those with no reciprocated friendships are more likely to be influenced by a friend than those whose friendships are generally reciprocated by others; and that therefore those outside the school social groups may be motivated to follow the behaviours of desired friends to try and become a part of the latter's group[47]. This might also explain our finding of how CICL acknowledging offences report decision-making with regard to school attendance (including truancy and drop-out)—that these children (perhaps due to their behavioural issues) have found it difficult to fit into social groups at school (that might comprise of more socially appropriate peers). And that as a result, they find friends outside of school (usually children who engage in school drop-out and truancy behaviours) and are motivated to follow the behaviours of these out-of-school groups.

The other dimension of peer influence that was analyzed pertains to its consequences in terms of getting into trouble with school or other adult authorities and with the police or other legal personnel (refer to table B.5 (C)). 40% or nearly half of children acknowledging offences report that they have had problems with various types of adult authorities such as those at home or at school over recent years i.e. before they were admitted to the observation home, significantly different from children not acknowledging offences (just over 10%) who report trouble with adult authorities. This is important longitudinal information about children's lives, reflecting how many children acknowledging offences have been in trouble with the authorities before i.e. they have a history of behaviour problems, unlike children not acknowledging offences, most of whom have no indicators therefore of behaviour problems. Thus, such information is also a part of understanding the circumstances of the offence. This is because children with long-standing behaviour problems, who have already been in trouble with adult authorities, are at greater risk of coming into conflict with the law. Studies have also shown that boys who are already at risk for behavior problems will be more susceptible to deviant peer influence[59].

Table C. 5 (c): Adverse Consequences of Peer Influence in CICL

Adverse Consequences of Peer Influence	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Problems with School/ Adult Authorities	19 (40%)	10 (12%)	29 (22%)
Problems with Police & Legal Personnel	30 (64%)	49 (59%)	79 (61%)

Lastly, peer influence and how it operates depends on the age of the adolescent. Our data shows that those between ages 13 and 15 years of age i.e. in early adolescence, are more susceptible to peer influence and associated risk behaviours than those between ages 16 to 18 years i.e. in late adolescence (see table 5 (d)).

Research has shown that resistance to peer influence increases linearly over the course of adolescence, especially between ages 14 and 18, and that this resistance to peer influence does not occur as much either before or after this age period[60]. First, increased orientation to peers in early adolescents i.e. between ages 10 and 14 years, is also because adolescents are developing emotional autonomy from parents during this time period, and so adolescents' dependence on parents is not replaced by independence but by dependence on peers[61]. Therefore, since this is the period during which adolescents are striving most strongly to achieve emotional autonomy, they would not have any resistance to peer influence[60]. Once the individuation process is completed and adolescents move on to identity development, a shift that usually happens towards late adolescents, they may have developed the ability to assert themselves in the wake of peer influence[62]—which would explain how peer resistance occurs later between ages 14 and 18 years.

There is also extensive literature on the impact of negative peer influence on adolescent behaviour and on children coming into conflict with the law. 'deviancy training' refers to when youth spend time in groups with peers, when their interactions reinforce rule breaking, and their norm-violating talk increases future problem

behaviors[63]. Longitudinal research shows that 'deviancy training' within adolescent friendships predicts increases in delinquency, substance use, violence, and adult maladjustment[64]. Studies comparing the impact of peer influence on risk behaviours and decisions in adolescents, youth and adult have shown that: risk taking and risky decision making decreased with age; individuals took more risks, focused more on the benefits than the costs of risky behavior, and made riskier decisions when in peer groups than alone; and that peer effects on risk taking and risky decision making were stronger among adolescents and youths than adults. Such findings support the idea that adolescents are more inclined toward risky behavior and risky decision making than are adults and that peer influence plays an important role in explaining risky behavior during adolescence[65].

It is therefore necessary to understand some basics of peer influence mechanisms. Developmental theories reflect that adolescence is characterized by increases in the: i) frequency of peer interactions[66]; ii) the adoption of more complex interpersonal behaviours, new social roles and experiences[67]; iii) motivation to develop a stable sense of identity (self)[68]; iv) young people's dependency on peer feedback as a source of identity and self-evaluation[69, p.]. For these reasons, the peer context takes on utmost importance in adolescence and success among peers becomes critical to them[70].

There are two theoretical models that help to explain socialization effects in this salient peer context. First, there are social learning theories which explain how within an important social context, individuals adopt new behaviours through modeling, social reward and punishment, and vicarious reinforcement of valued peers[71]. For example, adolescents who observe that popular peers use substances, will also do so in order to gain similar popularity status among peers, which then becomes the social reward. Second, there are identity-based theories, in social psychology, that suggest that imitation of valued or idealized behaviour and adherence to perceived social norms within a valued reference group help an individual to gain a sense of self, which is intrinsically rewarding[72].

Thus, theories suggest that adolescents are dependent on peers as primary sources of emotional and social support, and that they use feedback and acceptance from their peers as they develop self-identity. In conforming to peers' behaviour, adolescents engage in behaviours that i) are associated with high peer status; ii) match the social norms of a desired social/ peer group; iii) lead to extrinsic behavioural reinforcement within a social or peer context; iv) contribute to an intrinsically rewarding sense of self-concept[70]. We are discussing these concepts and theories on peer influence in order to make the point that CICL are no exception to the normal developmental trajectories that all adolescents follow. However, what renders these adolescents vulnerable to coming into conflict with the law is their exposure to deviant peer groups that often reside in low socio-economic community settings and the fact that they are ill equipped with the life skills to make decisions about what types of peer groups to belong to i.e. in ways that keep them safe and happy. These factors combined with neglect and lack of adult /parental supervision and support, result in such vulnerable children being more intensively and adversely impacted by peer influences, than other children who are without vulnerabilities related to family dysfunction and frequent exposure to deviant peer groups.

In conclusion, however, it is important to understand that the above discussions on peer influence in CICL are not intended to be critical of adolescents or their friendships and life choices; nor are we saying that all adolescents are adversely influenced by their peers or that all peer influence is negative. On the contrary, we believe in the power of peer influence—that it can work positively, that it does not invariably engender truancy, rule-breaking and substance use behaviours; and that peer networks can be supportive, and form safety nets for adolescents, depending on the ideology of a particular peer group.

Finally, our reference is the group of children we interacted and worked with and we speak for them, from their perspective, when we discuss how they have been impacted by adverse peer influences; the fact is that there are thousands of other children out there—the so-called peers, who tend to be vilified, but are also vulnerable, for the same reasons that this group of children we are acquainted with are—it is just that they

may have not come into conflict with the law or in contact with the JJ system or a child care agency for assistance.

C.6. Mental Health Issues

As expected, CICL have a number of mental health issues or psychiatric disorders, of both internalizing and externalizing types. Whether these disorders are neuro-developmental in nature or whether they have developed in the context of difficult family backgrounds and lack of supervision and opportunity, these are indications of a vulnerable child sub-population. And, mental health disorders have also made them vulnerable to coming into conflict with the law. In fact, the antecedents of offence or criminality and mental problems are the same.

In all, 103 of the children in the observation home, that is, nearly 80% of them, met the diagnostic criteria for one or more psychiatric disorder such as anxiety, depression, conduct disorder(CD), attention deficit hyperactivity disorder (ADHD) and substance abuse; Only 27 children, about a third of them, had no psychiatric disorders. This finding corroborates with other studies conducted of psychiatric disorders in youth in juvenile detention homes[73], [74], which also suggest the need to improve treatments and reduce health disparities in the juvenile justice and mental health systems.

In the CICL service program: 55% had substance use disorder, 28% had conduct disorder, 16% had attention deficit hyperactivity disorder (ADHD), 32% had anxiety issues and 17% had depressive symptoms. While having externalizing issues such as ADHD and CD does not preclude a child from also having internalizing issues such as anxiety and depression, a higher number of children not acknowledging offences had internalizing issues.

Table C. 6 (a): Child & Adolescent Mental Health Disorders in CICL

Child & Adolescent Mental Health Disorders		No. of Children		
		Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Internalizing Disorders	Anxiety-Related Issues	14 (30%)	28 (34%)	42 (32%)
	Depression Symptoms	8 (17%)	22 (26%)	30 (23%)
Externalizing Disorders	Attention Deficit Hyperactive Disorder (ADHD)	11 (23%)	10 (12%)	21 (16%)
	Conduct Disorder	27 (57%)	9 (11%)	36 (28%)
	Substance Abuse	31 (66%)	41 (49%)	72 (55%)
	CD and ADHD	1 (2%)	0	1 (1%)
	CD and Substance Abuse	16 (34%)	5 (6%)	21 (16%)
	ADHD and Substance Abuse	1 (2%)	4 (5%)	5 (4%)
	CD, ADHD and Substance Abuse	7 (15%)	4 (5 %)	11 (9%)

Reasons for anxiety and depression symptoms were: i) upsets about being unjustly accused, especially in cases of children who reported that they had not offended; ii) concerns about bail and case closure, which form major pre-occupations of all children in the observation home, and are a consequence of the poor legal awareness programs conducted for children there; iii) worries about how their families were emotionally and financially affected by their coming into conflict with the law. Some of the children who had anxiety symptoms were also found to have these symptoms for several years, even before coming into conflict with the law, in the context of temperamental vulnerabilities and/or difficult home and family circumstances. Unlike externalizing disorders (conduct and other behaviour problems), anxiety and depression may not seem as disorders that obviously lead to coming into conflict with the law; however, the presence of anxiety and depression adversely impact children's life skills, such as decision-making and problem-solving, and also place them at risk for substance abuse disorders, thus increasing the likelihood of coming into conflict with the law.

The prevalence of externalizing disorders was higher in children who acknowledged the offences compared to children not acknowledging offences: ADHD was nearly twice as common in those acknowledging offences (23%) than those not acknowledging offences (12%); conduct disorder was four times more common in the former group than in the latter group, and difference was significant; children acknowledging offences were five times more likely to suffer from both CD and substance use (34%) than non-acknowledging children (6%) and this difference was also statistically significant. These numbers tell us that children with (untreated) externalizing disorders such as CD, ADHD and substance use are, unsurprisingly, at greater risk of engaging in offences. Therein lies the importance of health treatment, both for children to protect those who may not have come into conflict with the law (as yet), as well as those who are already in the observation home, so as to prevent recidivism.

It is estimated that 45% to 75% of the young people in the juvenile justice system have one or more mental health disorders[75],[76] including emotional and behavioral disorders, learning disabilities, and developmental disabilities. The most common diagnoses are ADHD, learning disabilities, depression, developmental disabilities, conduct disorder, anxiety disorders, and posttraumatic stress disorder (PTSD). It is important to understand why and how certain psychiatric disorders render children vulnerable specifically to coming into conflict with the law.

Conduct Disorder (CD)

Conduct disorder (CD) comprises of behavioural problems involving violation of major rules, societal norms, and laws. Its prevalence peaks in mid-to-late adolescence. The most important risk factors that predict CD and antisocial behaviours include impulsiveness, low IQ and low school achievement, poor parental supervision, punitive or erratic parental discipline, cold parental attitude, child physical abuse, parental conflict, disrupted families, antisocial parents, large family size, low family income, antisocial peers, high delinquency rate schools, and high crime neighbourhoods[77]. As described in previous sub-sections also, a majority of the children at the Observation Home have these characteristics and are therefore (if they do not already have it), at risk of conduct disorder.

Studies have shown that having preschool behavior problems was the single best predictor of antisocial disorders at age 11, thus suggesting that childhood behavior problems are the best predictors of later antisocial outcome[78]. Early conduct problems were also significantly associated with later substance; children with conduct problems at age 8 consumed 1.5 to 1.9 times more alcohol and had rates of alcohol-related problems, daily cigarette smoking, and illicit drug use that were 1.9 to 2.0 times higher than children with low conduct problem scores[79], and substance use, in turn increases the risk of children coming into conflict with the law.

Some research also argues that CICL comprise two types of children: a relatively large group that engages in antisocial activities during adolescence; and a much smaller group that continues to engage in antisocial activities throughout adulthood—this group comprises of individuals who have had a stable history of antisocial behaviour from early childhood. It is proposed that a vulnerable and difficult infant reared in adverse

circumstances is at risk for life-course-persistent pattern of antisocial behaviour[7]. The challenge of coping with a difficult child evokes a chain of failed parent-child interactions[80]. It is acknowledged that children exert important influences on their social environment[81], and so, personality and behaviour is shaped to a great extent by interactions between the person and the environment[82],[83].

Children with neuropsychological problems can prove to be challenging for even the most loving, patient and resourceful families. Parents report greater difficulties in dealing with low birth weight, premature infants whom they say are more difficult to feed, less pleasant to hold and overall, more demanding to care for than healthy babies, thus adversely impacting parent-child attachment from a very early age. The parents of such children also have less realistic expectations about the achievement of these children's developmental milestones, which may also contribute to dysfunctional parent-child relationships at a later stage[84]. Indeed, we have observed in cases of adolescents with ADHD and or CD that their parents are (by the time the adolescent lands in the Observation Home) in a state of both despair and disinterest. It is these parents who, due to their children's repeated behaviour problems and consequent trouble with authorities, do not wish for bail to be granted; on the contrary, they do not come when called by the Juvenile Justice Board and/or tell the JJB, instead, that their child is 'better off' or 'safer' in the Observation Home than outside.

Attention Deficit Hyperactivity Disorder (ADHD)

Among juvenile offenders, it is estimated that more than 30% may have ADHD[85], and 40% of boys with untreated ADHD will be arrested for a felony by the time they reach their 16th birthdays[86]. ADHD is also categorized (along with conduct disorder and oppositional disorder) under a group known as disruptive behavior disorders.

Characterized by high impulsivity and poor social and decision-making skills, ADHD forms one of the pathways to coming into conflict with the law. One study, for instance, which examined boys described as aggressive-only, hyperactive-only, and aggressive-hyperactive, indicated that while "pure" aggressiveness did not appear to be associated with impaired cognition, hyperactivity was associated with a more general, long-term, cognitive deficit[87]. What this could mean is that children with ADHD, due to cognitive errors, are at greater risk of making judgements and decisions that are socially inappropriate and that may lead them to conflict with the law.

ADHD is a neuro-developmental problem, requiring medication/ behaviour training, often unrecognized & untreated in CICL. The symptoms include:

- 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.

It leads to consequences such as increased conflict with peer group and/or being easily influenced by peers, poor decision-making skills and sensation-seeking activities such as substance abuse, inappropriate sexual behaviour and other high risk behaviours.

As mentioned elsewhere in this chapter, while academic under-achievement is associated with externalizing behaviours, recent investigations reveal that ADHD and conduct issues are frequently comorbid[88]. In early and middle childhood, there is a clear link between hyperactivity-inattention and underachievement, and aggression (along with learning problems) occurs comorbid to attention-hyperactivity[89]. However, by adolescence, there are links between antisocial behaviour and variables related to academic achievement. This progression suggests that ADHD and aggression are linked, and that they frequently co-occur[90]. Such analyses are relevant to understanding pathways of CICL because they imply that children with ADHD are at greater risk of aggressive and antisocial behaviours, thus placing them at risk of conflict with the law. While the presence of ADHD alone does not necessarily mean that children and adolescents will engage in high risk behaviours that will lead them to conflict with the law, the symptoms of ADHD, namely risk of academic failure, substance use and involvement in impulsive, socially unacceptable behaviour, may them into contact with the Juvenile Justice system[91] ,[63]. Also, approximately half of young people with ADHD also have oppositional or conduct disorder[92], with rates of antisocial acts and use of substances such as cigarette and marijuana considerably higher among ADHD children than others[90]. In fact, studies predict persistence

of criminal offending beyond adolescence for those children having ADHD and who have come into conflict with the law[93].

In our program, 30% of the children we assessed had come into conflict with the law more than once—this is because untreated ADHD, especially at moderate and severe levels, means a continuation of impulsive, socially inappropriate behaviours that repeatedly lead these children into conflict with the law. Thus, recidivism levels for children with ADHD may also be relatively high. An equal proportion of 30% of children with ADHD had problematic consequences due to peer engagements, and with adult authority. 62% of children with ADHD had run into problems with the police due to their peer engagements i.e. even if not directly engaged in offence, children with ADHD were found to be easily influenced by their peers to either implement or support socially inappropriate activities, thereby getting them into trouble with legal authorities. Thus, there are serious implications for unidentified and untreated ADHD in children as this mental health disorder forms a key pathway to conflict with the law.

Studies have shown that ADHD and conduct disorder (CD) are both disorders of childhood and adolescence that often extend into adulthood. Both disorders are significant risk factors for the development of antisocial behavior. Higher levels of defiant and/or aggressive behavior lead to antisocial acts as compared with lower levels of defiance and antisocial acts. Boys diagnosed with ADHD have higher felony rates than those without these disorders. While ADHD is not nearly as strong a predictor of offending behavior as is CD, the presence of both CD and ADHD contribute to antisocial behaviour, and it is likely that early intervention in both disorders will reduce the prevalence of antisocial behavior[94].

Substance Abuse

Adolescence is associated with the inclination to take greater risks, which is also why this life stage is associated with experimenting with new types of behaviour and situations. Maturational changes in the brain lead to certain adolescent behaviours, including a greater propensity to use drugs. Consequently, adolescence is the developmental period at which individuals are at highest risk for alcohol and other drug use problems[95]. For substances such as alcohol, tobacco and cannabis, the age at which a drug is first used, is a predictor of later misuse[96]. For instance, children who first use alcohol at relatively younger ages, between 11 and 14 years, are at greater risk of subsequently developing alcohol dependence[97].

Table B. 6 (a): Substance Abuse in CICL

No. of Substances Used	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
No Substances Used	16 (34%)	43 (52%)	59 (45%)
Using at least one substance	9 (19%)	29 (35%)	38 (29%)
Using two or more substances	22 (47%)	11 (13%)	33 (25%)

As already stated earlier, in our CICL services, 55% of the children assessed had substance use disorder. 45% of all children reported using no substances, and within this group, a higher proportion of 52% form children who do not acknowledge offences. It is also evident (see Table B.6 (a)), that a higher proportion of children acknowledging offences (47%) also report using two or more substances, than children not acknowledging offences (13%). Also, the proportion of children acknowledging offences, who report using only one substance is relatively quite low (19%). This shows that children acknowledging offences have serious substance abuse issues. Also, overall, for the 37 children (out of 130) who reported substance use in their parents, 25 of them (68%) of the children have substance use issues.

As shown in Table B.6 (b), a greater proportion of children acknowledging offences use various types of substances as compared to children not acknowledging offences. Despite a higher tobacco use in children acknowledging offences (66%) versus children not acknowledging offences (44%), there was no statistically significant difference with regard to tobacco use (or cigarette smoking). It thus appears that cigarette smoking is fairly common amongst CICL.

Table C. 6 (b): Substance Abuse in CICL

Types of Substances Used	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Tobacco	31 (66%)	40 (48%)	71 (55%)
Alcohol	17 (36%)	8 (10%)	25 (19%)
Cannabis	12 (25%)	5 (6%)	17 (13%)
Cocaine	5 (11%)	0 (0%)	5 (4%)
Inhalants	12 (25%)	2 (2%)	14 (11%)
Sedatives/ Sleeping Pills	3 (6%)	0 (0%)	3 (2%)

However, when these two groups of children are compared in terms of use of other types of substance, there are significant differences: 36% of children acknowledging offences reported using alcohol versus only 10% of children not acknowledging offences; 25% of children acknowledging offences reported using cannabis versus only 6% of children not acknowledging offences; similarly, 25% of children acknowledging offences reported using inhalants versus only 2% of children not acknowledging offences. Thus, the numbers of children acknowledging offences and using substances such as alcohol, cannabis, inhalants and cocaine are 3 to 4 times or more than those not acknowledging offences and using such substances.

As is evident, the use of cigarettes and tobacco is most common due to easy accessibility; the use of alcohol and cannabis are relatively lower overall because they are harder for children to access, especially due to their higher costs. Many child users who reported using these substances were engaged in child labour activities. They said that they would use alcohol once a week, usually on pay day, when they would go out with friends for a meal comprising of meat and alcohol.

Inhalants are being abused by large numbers of people throughout the world, particularly children and adolescents. According to one research study, the mean age of the initiation of inhalant use is 11.6 years though it can vary from 9 to 18 years. Initial use by most adolescent users, of inhalants, is due to the need for experimentation, usually introduced by friends/ peer groups[98]. This study found conduct disorder, ADHD, and psychosis as comorbid psychiatric conditions in adolescents with inhalant abuse. Other studies have reported depression, suicidal behaviour, conduct disorder and delinquency among adolescents with inhalant use[99], [100], [101].

The number of cocaine users is comparatively very low also due to the high cost of cocaine; however, although the proportion of children using cocaine is very low, it must be borne in mind that access to cocaine is relatively very difficult, due to high levels of monitoring, in accordance with the Narcotic Drugs and Psychotropic Substances (NDPS) Act[11]. It is therefore a serious concern if despite such strict monitoring, the drug is still accessed by even a few adolescents.

[11] Narcotic Drugs and Psychotropic Substances Act, 1985, commonly referred to as the NDPS Act, is an Act of the Parliament of India that prohibits a person to produce/manufacture/cultivate, possess, sell, purchase, transport, store, and/or consume any narcotic drug or psychotropic substance.

According to the Gateway Theory of Drug Use, there is a systematic sequencing in the use of psychoactive drugs[12], running from alcohol and cigarettes, then to cannabis and finally to 'hard drugs' such as cocaine, heroin and LSD. Cigarettes are a 'gateway' to cannabis', which in turn is a 'gateway' to hard drugs. While all cigarette smokers do not go on to using cannabis and all cannabis users did not necessarily smoke cigarettes first, cigarette smokers have found to be more likely to use cannabis (than non-smokers). Similarly, it has been found that cannabis users are more likely to use hard drugs later on (than non-cannabis smokers)[102]. Therefore, for the in the children assessed by our services, that over half of them smoke cigarettes is concerning—as this is likely to serve as a gateway (and already has in several instances) to the use of other substances.

Individual assessments showed that for children acknowledging offences, substance use forms a pathway to offence in the following ways:
(i) Children may commit offences such as stealing or robbery, in order to get money to buy substances as they may be dependent or addicted;
(ii) They may commit offences (such as acts of violence) in a state of intoxication i.e. given how mental states and decision-making abilities are adversely impacted when under the influence of substances, children's abilities to control their impulses and make appropriate social judgements are compromised.
(iii) Children who use substances tend to spend a lot of time with peers who engage in substance use. These peers are often engaged (either for or because of substance use) in antisocial activities, thus leading the others both to use substances as well as engage in other (usually socially inappropriate) activities that follow the norms of the group.
(iv) Some children have also used substances for coping with stress and difficult emotions in the wake of traumatic life situations such as death of a parent. Even in these situations, children have often 'heard' from or been advised by peers to try using substances as they are told by them that substances help to 'forget' and deal with difficult situations.

Research has also established the links between substance use and ADHD, and conduct disorder. Studies show that the greatest risk factor for the development of antisocial behavior and drug abuse is the maintenance of ADHD symptoms[103]. Substance use disorders followed the onset of conduct disorder in the overwhelming majority of the cases[104]. Considering that ADHD is characterized by impulsivity and poor social judgement, children with ADHD are likely to be far more vulnerable to peer influences i.e. when their peers suggest engaging in substance use and other antisocial activities, children with ADHD are frequently unable to think before they act or weigh the risks and consequences as they make decisions, thus landing them in trouble.

Many studies have found strong associations between conduct disorder and substance use[105],[74], . While some literature indicates that CD precedes or coincides with the onset of substance use[103], other studies have shown that early onset of substance use predict later criminality. Thus, substance use and CD appear to have a reciprocal relationship, each exacerbating the manifestation of the other[106]. This may explain why in our services, over a third of acknowledging offences have both conduct disorder and substance use.

Studies have also found that excluding those adolescents having conduct and oppositional defiant disorders, 85% of the substance abusers versus 65% of the non-substance abusers have psychiatric comorbidity. Adolescent substance abusers had a higher incidence of dysthymia, major depression, and anxiety-related problems. Such data indicates that adolescent substance abusers are at high risk for comorbid psychopathology and need to be assessed for psychiatric comorbidity and provision of requisite treatments[106].

[12] A psychoactive drug, psychopharmaceutical, or psychotropic is a chemical substance that changes brain function and results in alterations in perception, mood, consciousness or behavior.

Table C. 6 (b): Influence of Substance Abuse on Time Spent with Peers in Children Acknowledging Offences

Time Spent with Peers	Substance Use (N=31)	No Substance Use (N=16)
Children who spend more time with friends	28 (90%)	11 (69%)
Children stay out at night with peers	21 (68%)	2 (13%)
Children stay out for days with peers	20 (65%)	2 (13%)

Our information also shows that of a greater number of children who stay out with their friends at night and of those who stay out for days with their peers (without informing their parents and caregivers) engage in substance use. In other words, children who spend most of their time with peers are significantly more likely to use substances; there is also a significant association between substance use and children who stay out of home for several days with friends, and those who stay out nights, with the greater numbers of children who are out of the house days and nights being engaged in substance use. This is also because the peer groups they spend time with are characterized by rule-breaking behaviours, ranging from being away from home without information to family to substance abuse and other antisocial activities. In fact, substance use frequently starts through experimentation in peer group contexts, wherein children having lower refusal and assertiveness skills are persuaded to use substances by others who may already be more experienced in this activity. Gradually, frequency of use increases, as children move from experimental to recreational use of substances. The increased use of substance also results in increased tolerance, which in turn leads to the need for procurement and consumption of increased quantities of substance, finally resulting in dependence and addiction.

A two-stage model of peer influence in adolescent substance use has been used to explain how children are susceptible to substance use through peer influence. The first stage of this model is about how selection of friends influences decisions on substance use[57]. Adolescents are significantly similar to their friends on behaviors, attitudes, and personality[107]. Actually, these similarities exist before the decision to be friends occurs, suggesting that similarity leads to the friendship rather than resulting from it. So, most adolescents have friends similar to themselves in terms of substance use[108]. However, dissimilar adolescents may also become friends as happens when non-using adolescents (accidentally) acquire friends who are substance users. In the latter situation, non-using adolescents, unintentionally, may be exposed influences that get them to begin cigarette or alcohol use[57]. (It is these instances of dissimilar friends that give rise to comments about 'bad company' and 'bad peer influence' that apparently corrupted an otherwise 'innocent' adolescent).

The second stage of the model is about how the influence of the friend leads to decisions on substance use. While some adolescents may have friends who use substances to a greater extent than they do, they may not necessarily be influenced by them[57]. Whether or not adolescents are influenced by them depends on individual characteristics such as perception of the harm of substance use, sensation seeking self-esteem and their sense of social values[109]. Those who are more sensation seeking are more willing to try a new behaviour such as smoking if a friend were to provide an opportunity; those with low self-esteem feel the need to be accepted by peers and are therefore easily persuaded to engage in any activity they are invited to try and those who do not perceive the harm in substance abuse are likely to engage in it. Likewise, when there is strong social bonding and commitment to social values, an adolescent may be less easily influenced by peers to engage in substance abuse[57].

Furthermore, according to this peer influence and substance use model, the nature of relationship that adolescents share with a given friend affects how much they are influenced by that friend. For instance, a high-quality relationship (a close friendship) is more valued by an adolescent who then is more likely to change his/her behaviour to please the friend. Such friendships also mean that more time is spent with the friends, with each other, increasing opportunities to model each other's behaviours[57]. General peer

acceptance may also have an influence, wherein adolescents who do not have their friendships reciprocated are more susceptible to peer influences than those who have their friendships reciprocated[58].

Referral

In all, 28 out of 130 children (23%) of CICL evaluated at the Observation Home, were referred to a tertiary child and adolescent mental healthcare facility (i.e. to Dept. of Child & Adolescent Psychiatry, NIMHANS), for depth treatment and interventions. 21 children or 46% of children not acknowledging offences were referred for psychosocial and mental health issues such as substance abuse, inappropriate sexual behaviours (mainly abuse of others) and conduct disorders; and 7 children or 8% of children not acknowledging offences were referred mostly for internalizing disorders such as anxiety and depression.

C.7. Life Skills Deficits

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[13].

Life Skills Framework		
Skill Domain	Sub-Skills	Specific Skills
Communication & Interpersonal Skills	Interpersonal communication	• Verbal/Nonverbal communication • Active listening • Expressing feelings; giving feedback (without blaming) and receiving feedback
	Negotiation/Refusal	• Negotiation and conflict management • Assertiveness skills • Refusal skills
	Empathy	• Ability to listen and understand another's needs and circumstances • Express that understanding
	Cooperation & Teamwork	• Expressing respect for others' contributions and different styles • Assessing one's own abilities and contributing to the group
	Advocacy	• Influencing skills & persuasion • Networking and motivation skills
Decision-Making and Critical Thinking Skills	Decision making & problem solving	• Information gathering skills • Evaluating future consequences of present actions for self and others • Determining alternative solutions to problems • Analysis skills regarding the influence of values and attitudes of self and others on motivation
	Critical thinking	• Analyzing peer and media influences • Analyzing attitudes, values, social norms and beliefs and factors affecting these • Identifying relevant information and information sources
Coping and Self-Management Skills	Increasing internal locus of control	• Self-esteem/confidence building skills • Self-awareness skills including awareness of rights, influences, values, attitudes, strengths and weaknesses • Goal setting skills • Self-evaluation / Self-assessment / Self-monitoring skills
	Managing feelings	• Anger management • Dealing with grief and anxiety • Coping skills for dealing with loss, abuse, trauma
	Managing stress	• Time management • Positive thinking • Relaxation techniques

[13] 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.

Life skills deficits form one of the major basis of CICL's problems. As shown in Table B.7 (a), there are high levels of life skills deficits are amongst children acknowledging offences: 83% of them have difficulty with decision-making in a variety of contexts such as when they pick the option of theft when in financial difficulties or commit acts of violence as they have not thought of social and legal consequences of such acts, or choose to be part of harmful peer groups and activities.

53% of children acknowledging offences them have difficulty with emotional regulation, mainly trouble with controlling anxiety and anger—the latter especially leads them to impulsively commit acts of violence with unintended and usually unplanned consequences of harm. Indeed, most children we assessed for violent behaviour said that they were extremely provoked and were unable to control their anger, but that their intention had not been to kill or seriously injure the other person. In the light of the importance that POCSO and other sexual offence laws have taken in the country, in recent years, decision-making in the area of sexuality and relationships was recorded separately. Also, while children who have difficulty making decisions in sexual contexts are likely to have difficulties in most other (general) contexts; however, children who have difficulty making decisions in various general life contexts do not necessarily have trouble with decisions in the sexual context, which is a separate domain.

Conflict resolution and problem solving is a skill that is closely related to decision-making and emotional regulation, and 62% of children acknowledging offences, when confronted with difficult situations, are unable to generate alternatives, let alone evaluate them and select the appropriate option.

Table C. 7 (a): Life Skills Deficits in CICL

Life Skills Deficits	No. of Children		
	Acknowledging Offences (N=47)	Not Acknowledging Offences (N=83)	Total (N=130)
Decision-making in Sexual Context	16 (34%)	2 (2%)	18 (14%)
Decision-making in General Contexts	39 (83%)	50 (60%)	89 (68%)
Assertiveness & Peer Pressure	35 (74%)	35 (42%)	70 (54%)
Conflict Resolution/ Problem-Solving	29 (62%)	33 (40%)	62 (48%)
Emotional Regulation	25 (53%)	22 (26%)	47 (36%)
Empathy & Interpersonal Relationships	8 (17%)	1 (1%)	9 (7%)

When children and adolescents have deficits in these life skills, it results in limited abilities to perceive, analyze, process and solve problems. When children are unable to think through problems, they have the urge either to retaliate or subdue the situation, through the use of aggressive (rather than non-aggressive) forms of conflict resolution. Inability to perceive and analyze problems also results in attribution biases i.e. children then have distorted perception of events. Such misinterpretation of events and problems lead them to 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. And finally, the failure to perceive,

analyze and process problems results in the inability to generate alternative options and solutions, evaluate and select the appropriate option or course of action i.e. the one that is least harmful to the self and others. This last difficulty consequently leads to engagement in high risk behaviours pertaining to sexuality, substance use and self-harm.

Life skills relating to assertiveness and response to peer pressure refers to children's ability to - say 'no', especially to their peers, when necessary. 74% of children acknowledging offences have deficits in such assertiveness and refusal skills, which is what makes them vulnerable to peer pressure and engagement in activities frequently suggested by their friends. When assessed, these children said that even when they knew that certain activities were wrong, it was difficult for them to refuse to join their friends or peer groups when asked to do so.

Lack of empathy and interpersonal skills means difficulty recognizing other people's feelings and little or no insight into how one's actions (usually of cruelty or violence and abuse) may have caused hurt or harm to others; children who lack these skills also frequently tend to get into conflicts with family and peer groups, unable to negotiate relationships in ways that are emotionally beneficial to them and others. What is interesting is that only 7% of all children and only 17% of children acknowledging offences had deficits in life skills relating to empathy and interpersonal relationships. Contrary to common perceptions and prejudices about CICL, these children are not 'cruel and un-empathetic'. The low number of CICL with empathy and interpersonal skills deficits thus implies that these children basically have difficulty with emotional regulation and decision-making. In fact, several children that our services have worked with, both in care and protection institutions and at NIMHANS's Dept. of Child and Adolescent Psychiatry also present with similar life skills deficit issues—many of them have also behaved in ways that would have, had they been reported, brought them into conflict with the law; but due to family or socio-economic status, or just chance, in several instances, these children have not been reported to police and legal authorities and therefore do not come into conflict with the law.

There are also significant differences in life skills deficits between children acknowledging offences and those not acknowledging offences. Significant differences were found between the two categories of children in decision-making in sexual and other contexts, in conflict resolution and problem solving, assertiveness and dealing with peer pressure, emotional regulation and inter-personal skills. Children not acknowledging offences have consistently, and in case of most skills, substantially, higher levels of life skills than those acknowledging offences.

However, while children acknowledging offences have greater life skills deficits than those who do not acknowledge offences, the latter also have gaps in life skills. Even if most children in this group did not actually engage in offences, they came into conflict with the law because of life skills deficits pertaining to decision-making, conflict resolution and emotional regulation. One of the most common areas of life skills deficits in children not acknowledging offences is in assertiveness and dealing with peer pressure, as a result of which, even though they did not actually commit the offence, they were with others who did so. Thus, children not acknowledging offences also have difficulties with making decisions about who it would be safe to be friends with and spend time with, whether or when to go with these groups when called upon to do so and how to say 'no' when they did not have full information on what these peer groups with antisocial behaviours, had planned. Thus, children not acknowledging offences come into conflict with the law because they were often 'in the wrong place, at the wrong time'—a consequence of life skills gaps.

Coming to the reasons why CICL have gaps in life skills, we go back to their socio-economic backgrounds wherein parents with substance use and other economic stresses of their own, are not always present to be able to provide the necessary supervision and guidance for children to develop appropriate life skills. This does not mean that parents need to spend inordinate amounts of time theorizing and moralizing to children about things they should or should not need to do. The issue is that parents often have not the time to have conversations with their children…discussions about people, everyday events, daily experiences, things that appear in the newspaper or are witnessed in the street or neighbourhood; for, it is through the processing of

such sights and experiences, that children take positions on various issues and make decisions about actions they would take—this is how the consolidation of knowledge of the world and the development of life skills occurs. Thus, the risk of life skills deficits is also frequently also present in children from privileged backgrounds. The nature of adult-child relationships, governed by the tenets of instruction *('I will say and you do')*, expectation *('As my child, I expect you to do certain things…and if you do not…')* and obedience *('as your parent, you must do as I tell you to…')* does not easily allow for such conversations and deliberations to take place. In a culture where children are not encouraged to reflect, and engage in dialogue and discourse, or express their opinions and viewpoints, it is difficult for life skills learning to take place.

Understanding the Basis of Inappropriate Sexual Behaviours…

Public outrage, as it has occurred in the Nirbhaya case and other instances, although valid does not reflect a nuanced understanding of what factors lead adolescents to commit acts of sexual abuse (and these are quite different from those that cause adults of engage in sexual abuse).

The first of course is the cliché' that everyone is familiar with—adolescence is the life stage at which body and hormonal changes take place, and with puberty, major developments in sexuality take place. This is not to say that puberty leads adolescents to sexual abuse but that it leads adolescents to feel sexual attraction and desire (which they may wish to act upon).

Curiosity and experimentation are some of the most common reasons, as also found in the CICL our program worked with, for engaging in sexual abuse (of younger children). As already discussed elsewhere in this document, adolescence is the age of risk-taking and experimentation. Add to this, peer influence, which in the sexual context may entail i) exposure to pornography and other sexually explicit materials; ii) peer groups urging their members to experiment because 'everyone does it and you should also know what it is all about (how can you not?)' and/or because 'real men do these things'. In other words, the peer pressure to conform and be 'one of us' and to prove one's manhood, in keeping with gender stereotypes and societal notions of masculinity, cause many adolescents to comply with suggestions to experiment with sexual expression or gain sexual experience. This group of factors, comprising of the need to experiment, along with the difficulty of pushing back on peer pressure is also reflective of life skills deficits in decision-making, assertiveness and refusal.

A third reason for sexually inappropriate behaviour in some adolescents is attention deficit hyperactivity disorder. As discussed elsewhere in this document, ADHD is characterized by (high) impulsivity and poor judgement. Thus, adolescents with (untreated) ADHD are more likely to succumb to peer pressure and their own emotional dysregulation (also a consequence of ADHD), thereby leading them to engage in inappropriate sexual activities.

A fourth reason to look for in CICL who engage in sexually inappropriate behaviours is intellectual disability. Adolescents with mild to moderate intellectual disability, due to cognitive and social impairments, may be unable to discern between appropriate social and interpersonal behaviours and act on any physical desires or impulses that they experience. Also, such children and adolescents are at risk of being influenced and manipulated by peers and adults (who exploit such children for their own gains and pleasures), to perform sexual acts.

Sexual abuse by adolescents, due to rule breaking, aggression and lack of empathy, does occur, but to a much lower extent than we imagine. As our data shows, only 8 out of 47 children acknowledging offences (17%) and 9 out of 130 children (6%) had deficits in life skills relating to empathy and interpersonal relationships—and these proportions are not reflective of children involved in sexually inappropriate behaviour alone. This means that the numbers of children engaging in sexually inappropriate behaviours are due to lack of empathy and interpersonal skills are even lower.

Lastly, it is important to understand that several of the children charged with sexual offences or under POCSO were in consenting romantic relationships with their peers. Running away with and 'marrying' their peers occur due to life skills deficits relating to decision-making and problem solving, wherein adolescents wishing to engage in emotional and physical intimacy have not thought through the implications of a marriage or (unprotected) sexual engagement. These behaviours also occur due to lack of assertiveness and refusal skills (in the wake of peer pressure) as well as the lack of knowledge about legal age for marriage. In several instances, the boys assessed in our program reported that they were pressured and threatened by their female peers, who said that they would commit suicide if the boys, if they did not run away with them. The unfortunate gender bias in POCSO does not hold their female peers accountable for the decisions made.

D. Potential for Transformation

There is a framework for how we approach or plan interventions with CICL. This framework comprises of five parts:

- ***Context:*** Why and how the child came to be in the observation home…which refers to the offence and related incidents that took place.
- ***Insight:*** What, according to the child, is the problem he/she has…the child's understanding of the gaps or deficits he/she has (and that might require addressing)
- ***Motivation:*** Why, according to the child, the problems he/she has need to be addressed…the child's reasons to want to transform or change (current) behaviours
- ***Strategies for Behaviour Change:*** Skills that the child has for changing behaviours, so as to prevent recidivism (or not come into conflict with the law again)

The potential for (behaviour) transformation depends on the level at which the child is vis-à-vis each of the above-described variables. For instance, if the child has higher levels of insight and motivation, the interventions may need to be less extensive, as the child may be more ready to embrace behaviour change strategies; if a child is at lower levels of insight and motivation, the counsellor and treating team would have to provide more intensive interventions to enable the child to arrive at the requisite insight and motivation levels, before even suggesting skills or strategies for behaviour change. Thus, the four variables which combine to arrive at potential for behaviour change are not intended to be a critical or judgemental perspective on the child, not even when insight and motivation are low; they are simply meant to provide an objective assessment of where the child is at before the necessary interventions are provided, in order to be able to pitch the interventions at levels that meets the (current) state of the child. Thus, sub-section is purely for the purposes of mental health assistance, and is not meant for legal decision-making, especially at the time of assessment of the child (when baseline information is being recorded and analyzed).

The application of this framework lays the basis for assistance to CICL, in terms of the child's context, insights, motivation and skills for behaviour change and is therefore critical for design of interventions. However, we have included data on insight, motivation and skills for (re)offence prevention as part of the profiling of CICL and analysis of their circumstances because insight, motivation and skills for behaviour change are also an outcome of their life circumstances. CICL, given the backgrounds they come from, have very little scope for reflectiveness; most of them do not have the experience of a relationship wherein they discuss and receive guidance, on a regular basis, about their life issues and contexts. Therefore, they often find it hard to specify a context to the situation or trouble they are in. If there are serious attachment and neglect issues, regulation problems, and other adversities and unmet developmental needs, as in the case of CICL, it is also difficult for such children to have insight into their problems, and motivation for behaviour change. As a result, there is often the question in their minds of 'why am I being problematized?' and this view affects the extent to which they feel the need for assistance and intervention.

For children acknowledging offences, nearly 40% had very low insight and a slightly higher proportion of 47% showed some insight regarding how they had come into conflict with the law; a very small minority of 15% had higher levels of insight into their offence and the reason for their coming into conflict with the law. Similarly, the motivation for behaviour change, although higher than insight, was low or moderate for about 70% of the children; only a third of them having high levels of motivation to take action for behaviour change. As expected, given relatively low insight and low motivation, this category of children also had low levels of skills for (re)offence prevention—with over 90% of children falling in low and moderate levels of skills to prevent them from coming into conflict with the law.

For children not acknowledging offences, 59% (49 out of 83 children) had no problems that required to be addressed. The remaining 41% (34 children) had problems pertaining to substance use, internalizing disorders such as anxiety and life skills deficits. These problems may or may not have led to coming into conflict with the law for the first time around, but they were seen as issues that certainly placed them at risk of coming into conflict with the law (in the future). For instance, even if substance abuse had not led them to committing an offence up until now, one cannot rule out the possibility in the future; or poor assertiveness

skills had (already) led them to joining peer groups that engaged in antisocial activities; or anxiety and emotional regulation problems would place them at risk of inappropriate decisions and responses which could bring them into conflict with the law for a real offence, in the future. Therefore, the issue of insight, motivation and skills for prevention of offence also applied to children not acknowledging offences.

Table D. 1 (a): Potential for Transformation in CICL

		No. of Children		
Potential for Transformation		**Acknowledging Offences (N=47)**	**Not Acknowledging Offences (N=34)***	**Total (N=81)**
Child's Insight	**Low Extent**	18 (38%)	6 (18%)	24 (30%)
	Some Extent	22 (47%)	19 (56%)	41 (50%)
	High Extent	7 (15%)	9 (26%)	16 (20%)
Child's Motivation	**Low Extent**	13 (28%)	8 (24%)	21 (26%)
	Some Extent	20 (43%)	14 (41%)	34 (42%)
	High Extent	14 (30%)	12 (35%)	26 (32%)
Child's Skills for (Re)Offence Prevention	**Low Extent**	37 (79%)	18 (53%)	55 (68%)
	Some Extent	7 (15%)	11 (32%)	18 (22%)
	High Extent	3 (6%)	5 (15%)	8 (10%)

*Total No. of Children Not Acknowledging Offences=83; 49 children evaluated were found to have no problems to be addressed. Therefore, questions on insight and motivation could only be applied to the remaining 34 children. (N=34)

Children not acknowledging offences differed from children acknowledging offences mainly on two parameters: first, only 18% (as compared to 38% in children acknowledging offences) had low insight and 26% (as compared to 15% in children acknowledging offences) had insight into their problems. Second, 53% (versus 79% of children acknowledging offences) had the lowest level of skills for offence prevention and 15% (versus 6% of children acknowledging offences). Thus, about double the proportion of children not acknowledging offences had higher levels of insight and skills for prevention of (re)offence than children acknowledging offences.

However, the two groups of children did not differ much in terms of motivation for change. This lack of motivation can be broadly understood in three ways:

i) For children acknowledging offences, their lack of motivation is due to low insight i.e. when they cannot really see the deeper reasons for why what they have done is a problem, there is little imperative to change; also, these children tend to have a history of difficult behaviour and have over a period of time been labelled as 'bad' or 'difficult'. Consequently, there tends to be a hopelessness that leads them to decide to conform to these labels and they accept the ('bad and difficult') identity imposed on them and continue to behave accordingly for, there can only be reason to change if people around them believed that they could have an alternative identity.

ii) For children not acknowledging offences, while they have insight into some of their problems and difficulties, perhaps this insight is not deep enough to lead to motivation for change. Since some of the difficulties they have may not have led them directly to commit the offence (and indeed that is what these children are saying—that they did not 'do anything wrong'), they find it hard to perceive why they need to change behaviours i.e. they find it difficult to link their problems to the risk of future offence or coming into conflict with the law. And, as mentioned before, perception of risk and ability to make judgements is also a matter of physiological and brain development, which in adolescents is still incomplete.

iii) Ultimately, both groups of children, those acknowledging and not acknowledging offences, who come to the observation home, are drawn from the same kind of socio-economic background. As already discussed, there are various limitations in the families they come from, particularly pertaining to lack of parental supervision and guidance on life skills acquisition. Therefore, both groups are probably on par when it comes to abilities of reflection and introspection, thereby showing similar gaps in motivation for behaviour change. The implication for intervention therefore is that psychosocial processes have to work with CICL to facilitate insight and motivation for change, before moving to actually suggesting behaviour change strategies. If children do not acknowledge that they have a problem, understand why it is a problem (to themselves and others), have reasons to want to make individual and life changes, then there would be little purpose in suggesting strategies that would help them transform behaviour, an important but later step in the behaviour change process.

3.3. Conclusions and Implications for Interventions

For various reasons, children and adolescents are more likely to come into conflict with the law than adults: children and adolescents tend to be less experienced at committing offences; they commit offences in groups; they commit offences in public areas and close to where they live. Further, the nature of their offences tends to be more episodic, unplanned and opportunistic[110]. Child and adolescent offending is characterized by risk-taking, peer influences, mental health problems, substance use as well as family dysfunction and educational problems. While adults offending may share some of these characteristics, they can cause greater problems among young people, who are more susceptible—physically, emotionally and socially—to them. Many of these problems are compounded by adolescents' psychological immaturity, given that this is a developmental stage of complex physiological, psychological and social change[111].

Given the vulnerability of adolescents, it has therefore also been observed in other countries that any legislative and policy changes are likely to disproportionately affect adolescents and young people and increase their contact with the police[112]. In India, following the passing of the Juvenile Justice Act 2015, which include provisions on transfer of children between 16 and 18 years, for heinous crimes, to the adult system, we have generally observed (no empirical data is available as of now) that there is a tendency on the part of the police to charge children below 16 years in a given offence—this is because there is a notion that the quantum of punishment will be less for this younger age group, as they do not fall under the 16 to 18 years age category, which is at risk of transfer and possibly more intensive punishment.

We have engaged in an exercise of descriptive and statistical analysis that we believe will be useful in helping us identify some trends and patterns in the life circumstances of CICL, with a view to developing appropriate preventive and curative interventions. Our data base highlights certain pathways to offence, namely peer influences and substance use as being significantly common ones—and from various accounts, these are common to children everywhere in the country. However, other experiences of abuse and trauma, though not so strongly reflected in our program database is likely to be reflected in a larger database. Given their vulnerabilities, CICL require intensive life skills training with regard to skill development in problem solving, decision-making and emotional regulation; the contexts of these skills require to be (though not limited to) sexuality, substance use, and peer pressure.

Additionally, family counselling i.e. counselling of parents and caregivers of CICL is critical, especially for children to sustain any change or gain resulting from individual counselling. For instance, children require parental/ family support to follow up on counselling sessions, and to attend educational and vocational training facilities and services; parents and caregivers also need to play an active role in monitoring and supervision of these children on a day-to-day basis, ensuring that they follow appropriate daily routines and remain protected from adverse adult and peer influences.

Ultimately, in field practice, it is important to view every child in conflict with the law as an individual (rather than merely as part of a vulnerable sub-group, which he/she also is), with specific life circumstances that are unique to him/her. This means that we apply the pathways framework systematically to every child in conflict with the law but also remember that every child, despite commonalities and patterns within the sub-group, will be different in terms of his/her pathways to offence. It is these distinctive characteristics and life circumstances that will enable us to tailor interventions to meet the needs of individual children and their life circumstances.

Finally, in the words of Harsh Mander: *'If our aim is to take revenge for grave crimes that some children undertake, like rape and murder, by all means let us imprison, even hang them. But if our aim is to help reform the child, as we would our own, an adult prison is the least likely site in which a child's intrinsic capacities for goodness can be reclaimed. To deter offences by children in future, the way is not to send them to adult jails or the gallows. Juvenile crime is best prevented by reaching out on time to children deprived of adult protection, with hundreds of open and caring residential schools for these children, ensuring food, education and protection. Harsher punishments for juvenile offenders will only brutalise them more'.*

4. Psychosocial & Mental Health Assessments for Children in Conflict with the Law

4.1. Objectives of Assessment

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

- To examine the (seriousness of) circumstances that the children come from and address the vulnerability issues therein.
- To identify children with psychiatric and/or life skills issues and accordingly implement psychological, social and other rehabilitative interventions.
- 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.

4.2. How the Assessment Proforma was Developed

The proforma was developed based on a vulnerability-pathology-consequence framework applied to understanding CICL's psychosocial issues. As per this framework,

- 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;
- 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);
- Consequences refer to the offence committed, including acts of aggression, stealing, and coming into conflict with the law.

Essentially, the assessment elicits information on vulnerability and pathology to understand how they led a given child to committing offence or come into conflict with the law. The care plan, also a part of the assessment, is designed in accordance with the vulnerability and pathology issues, to assist the child to change behaviours and make other life changes that prevent him/her from coming into conflict with the law in the future.

The proforma was administered to over 150 children in the observation home and continues to be administered to many more even within the Dept. of Child and Adolescent Psychiatry (in addition to other clinical proformas used in the hospital). Through a process of iteration and revisions, additions and refinements were made to it multiple times, to bring it to its current version.

A guide has been written to accompany the assessment proforma, in order to provide support to all who work with children in conflict with the law and are likely to use the proforma. 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.

Like all assessments developed by the NIMHANS Community Child and Adolescent Service Project, this assessment is not primarily aimed at arriving at a diagnosis as per the Diagnostic Statistical Manual (DSM) or International Classification of Diseases (ICD 10) i.e. the two systems frequently used for classifying mental

disorders, although identification of mental health problems is part of the purpose of the assessment. The assessment is mainly geared to helping child care workers and service providers to identify and understand children's problems and vulnerabilities, with a view to helping them to access the appropriate and requisite interventions i.e. for mental health and rehabilitation purposes. The use of the proforma requires a child care worker to have a basic knowledge of child development, common child mental health disorders, and child interviewing skills—all this in the backdrop of an understanding of CICL and their vulnerabilities. Therefore, while the assessment maybe used by child care service providers of different cadres, it would be ideal for them to be trained in the use of the proforma, so that it is administered in the most effective manner possible i.e. to be able to elicit history and information accurately from children.

Challenges & Considerations in Developing the Mental Health Assessment Proforma

While it might appear to be a simple and logical undertaking, the mental health assessment proforma for CICL was developed amidst many challenges, with due consideration to several conflicting agendas and viewpoints.

Challenges...

- To work against a position taken by some child care workers, service providers and activists that no assessments should be done because the information obtained may be used to transfer children to adult systems of trial i.e. against the best interests of CICL...or that assessments may be too technical and therefore difficult for use by 'lay' persons i.e. those without formal training qualifications is in child psychiatry, psychology or social work.

  The fact is that even the apparently qualified mental health professionals do not necessarily have specialized experience in child mental health, much less in working with children in difficult circumstances, let alone with a complex group such as CICL. So, any assessment proforma that is developed for CICL, would entail training, even of mental health professionals, also to ensure generation of standardized assessment reports.
- 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.

  The Social Investigative Report (SIR) that is used for assessment in most Observation Homes across the country is so basic and simplistic that it fails to provide details that are unique to each child who is assessed, in terms of specific vulnerabilities and needs. It contains some demographic details and an account of the child's offence but this is not adequate to understand the child's pathways to offence and areas for assistance and rehabilitation.

Considerations...

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

4.3. Psychosocial & Mental Health Assessment & Guidance Notes

Below are described the various items on the assessment proforma along with guidance notes, to enable a clear understanding of why certain types of information need to be collected from a given child, and how this information can be used to identify pathways and areas of vulnerability, and subsequently in developing care plans and designing psychosocial and mental health interventions, including in making decisions about placement of the child.

***Refer to Annex 2 for the proforma and Annex 3 for an Example of a Completed Psychosocial & Mental Health Proforma for Children in Conflict with the Law.**

- 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.
- Ideally, this assessment should be administered to the child within a week of coming to the Observation Home i.e. so that it serves as a baseline for identification of existing issues and allows for planning of interventions.

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

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

The 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).

Guidanc 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

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

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

i. **School/ Classmates**

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

iii. **Friends in your neighborhood**

iv. **Others**

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

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

d) **Age of friends?**

"Most of them are…."

i. Older than you

ii. Younger than you

iii. Same age as you

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

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

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

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

g) **Consequences of peer influences**

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

Guidance Notes

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

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

relating to school and education (the child's academic performance, motivation and regularity of school attendance, for instance) and with the quality of the child's family relationships and supervision (which also determines the adequacy of the child's life skills).

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

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

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

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

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

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

3.1. Loss, Death & Grief

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

3.2. Physical, Emotional & Sexual Abuse

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

a) Physically hurt you and caused you injury?

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

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

Guidance Notes

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

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

Section 5: Mental Health Concerns *(Ask Child)

5.1. Anxiety

U1. (Screening Questions)

For the past six months...

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

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

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

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

Generalized Anxiety Disorder: Yes/ No

5.2. Depression Issues

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

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 complaints14. ADHD and CD may both be considered as externalizing behaviours i.e. disruptive, negative behaviours that are directed at the environment.

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

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

Conduct disorder is an overarching term used in psychiatric classification that refers to a persistent pattern of antisocial behaviour in which an individual repeatedly breaks social rules and carries out aggressive acts that upset other people, including stealing and acts of violence and cruelty. A high proportion of children and young people with conduct disorders grow up to be antisocial adults with impoverished and destructive

[14] 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.

lifestyles. It is therefore important to identify conduct disorder in children and adolescents so as to provide them with interventions that will prevent criminality and antisocial behaviours in the future as well.

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

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

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

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

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

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

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

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

[15] 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 Scalell (Journal of Studies on Alcohol 40: 291-300, 1979) and Moberg and Hahn's —Adolescent Drug Involvement Scalell (Journal of Adolescent Chemical Dependency, 2: 75-88, 1991).

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: "Maybe 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 emotions16.

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

Thus, this sub-section is to filled in based on the counselor's understanding and analysis of the i) child's account of his/her circumstances ii) the offence he/she has been apprehended for; iii) insight into the problem, motivation for change and skills to avoid re-offence. Here are some examples on how to analyse what types of life skills deficits children have:

- Emotional Regulation: Children who have difficulty controlling anger and anxiety, children who get into violent fights.
- Development of empathy/ interpersonal relationships: children who have difficulty recognizing other people's feelings and have little or no insight into how their actions (usually of cruelty or violence and abuse) may have caused hurt or harm to others; children who frequently get into conflicts with family and peer groups, unable to negotiate relationships in ways that are emotionally beneficial to them and others.

Coping with Stress (Coping with financial difficulties at home/ finding alternatives to running away from home or school…)

- Assertiveness (Ability to say 'no' to peers when necessary.): children who use substance because of peer pressure, have been involved in gangs, have participated in theft, violence and other antisocial activities due to persuasion by peers.

Problem Solving and Conflict Resolution (When confronted with difficult situations, to be able to generate alternatives/ evaluate them and select the appropriate option): children who have resorted to theft or violence when they have been unable to find other means to get their needs met or resolve difficulties they are facing.

Decision-making in various life contexts (Evaluate available options and select appropriate ones in a given situation): children who have little insight and have been unable to make informed decisions by evaluating the various options available to them and thinking through the consequences of each option—children who pick the option of theft when in financial difficulties or children who have committed murder as they has not thought of social and legal consequences of such acts.

[16] 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.

Decision-making in contexts of romance/ relationships/ sexuality (making decisions about sexual/ relational issues with due consideration to health, safety, consent, emotional contexts of relationships) children who have sexually abused other/younger, failing to make a decision on the basis on empathy and/or of social and legal consequences that would follow; older children who have run away with their peers or with older adolescents/ adults to get married or have physical intimacy and have not thought through the implications of a marriage or (unprotected) sexual engagement.

6.2. Other Observations

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

Guidance Notes

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

Section 7: Summary and Intervention Plan

7.1. Summary

Based on the above assessment, summarize the main problems and concerns of the child, including **Vulnerability[17], Pathology[18] and Consequence[19].** 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.

Guidance Notes

Summary refers to a statement of the main problems and concerns of the child, using the vulnerability-pathology-consequences framework (described at the beginning of this document):
- Vulnerability needs to include significant information social history i.e. family, school, institutional, peer and child labour issues as well as abuse and trauma experiences that the child may have undergone. (Vulnerability refers to the circumstances of the offence from a longitudinal or life cycle perspective).
- Pathology should include any mental health disorder and/or substance use issues that the child may have.
- Consequences should include child's behaviours/actions, including the offence committed by the child.

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

Care Plan refers to the counselor's response to the child's problem, both in terms of initial inputs provided to the child at the end of the assessment, with regard to his/her problem as well as those planned for implementation in the immediate/near future. It includes:
(a) First level responses20 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)

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

[18] 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.

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

[20] 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.

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 required for diagnostic and intervention purposes; pharmacotherapy may also be necessary for children depending on the type and severity of the mental health problems).

(d) Recommendations and/or referral for depth therapeutic work with the child (which can be undertaken either in the Home or at a tertiary care facility, depending on the skills and resources of the counsellor).

(e) Referral to other medical and health facilities in case the child is suspected of having other medical issues (based on the child's report as well as an understanding of his living arrangements and conditions in the recent past—for instance, a street child with poor access to food, shelter and healthcare over a long period of time, and having a life style with high risk behaviours may be at risk of ceratin communicable diseases for which he/she may need to be examined).

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

5. Implementing Section 15: Preliminary Assessment Reports for Children in Conflict with the Law

5.1. Placing Section 15 in the Historical Context of Juvenile Justice in India

In order to better understand Section 15 of the Juvenile Justice Act 2015, it is both necessary and interesting to trace the history of juvenile justice in India, to reflect upon the shifting ideological positions of the country, and consequently of its laws, over time. The Apprentices Act, 1850 was the first of its kind, which punished 'delinquent children' under the age of 15, who were involved in petty offences as apprentices. Later, the Reformatory Schools Act, 1897 provided that children up to the age of 15, sentenced to imprisonment, may be sent to reformatory schools rather than prison. The Madras Act initiated the establishment of separate juvenile courts and residential institutions in 1920, and these policies were then followed by many other Indian states. The first central legislation, namely the Children Act, 1960 became the model law in the country. This law established separate adjudicatory bodies to deal with children in conflict with law and children in need of care; It prohibited imposition of death penalty or sentence of imprisonment or use of jails or police station for keeping children under any circumstance. It also did not recognize the right to appoint a lawyer in the proceedings before the children's court[113].

It is therefore evident that India moved, over the years, from more retributive to more reformative and rehabilitative forms of justice, over the years, in the context of children in conflict with the law. Despite the separate categorization of children in conflict with the law, this shift towards reformative justice continued as the Juvenile Justice Act 2000 was enacted. Under this Act, no child, for any reason could be lodged in a police lock-up or in jail; and the Committee or any police officer or special juvenile police unit or the designated police officer had to hold an inquiry in the prescribed manner; after the completion of such inquiry, if the Committee is of the view that the said child has no family or ostensible support, it could allow the child to remain in the children's home or shelter home till suitable rehabilitation is found for him or till he attains the age of 18[113]. Thus, the position that individuals below 18 years should be dealt with or treated as children i.e. by providing them with psychosocial support and opportunities to reform, continued through the years, until 2015.

In India, the issues pertaining to juvenile offence, particularly those of proportionality and culpability, were propelled into public discourse, into domains of mental health, protection, law and child rights, following the Nirbhaya incident in which a juvenile was part of a gang rape of a 23-year-old woman in Delhi, in December 2012. The rights of CICL, how their behaviours should be understood and how juvenile justice should therefore be administered when adolescents allegedly commit such offences were hotly debated in the country, almost pitting child rights against women's (safety) rights, although in actual fact they are not separate or contradictory agendas. In the wake of much public frenzy and pressure, the Government of India enacted the new Juvenile Justice Act 2015. It was then, for the first time in many decades, that India indicated a shift, from reformative and rehabilitative justice towards retributive justice, in the context of children in conflict with the law.

Section 15 into the JJ Act 2015 introduces a provision to conduct a preliminary assessment of a child between 16 and 18 years, for alleged heinous offences committed, and make decisions accordingly for transfer of the child to the adult criminal justice system. It states that the JJB is required to 'evaluate the role of the child in the alleged offence, as well as his mental condition and background', in terms of three main questions, namely:

i) Does the child have the mental and physical capacity to commit such offence?

ii) Did the child have the ability to understand the consequences of the offence?

iii) The circumstances in which he/she allegedly committed the offence.

Through Section 15, the JJ Act 2015 thus reduces the age of transfer to adult court—a measure that has also been taken by legal systems in most parts of the United States of America in the late 70s and 80s in response to youth violence and homicide, many American states adopted laws to transfer a greater number of juveniles, at younger ages, to criminal court[114]. The JJ Act 2015 is also different from the earlier JJ Act 2000 in that it clearly defines and classifies offences as petty, serious and heinous, and defines different processes for each category. Thus, the JJ Act 2015 has special provisions to tackle heinous offences committed by children in the above-stated age group[113].

However, it is important to also remember that the basic objective of the Juvenile Justice Act, 2000 to provide care, protection and rehabilitation to vulnerable children, including children in conflict with the law, remains unchanged in JJ Act 2015; the introduction of Section 15 therefore does not change the essence of the JJ Act 2015, nor its interpretation and implementation with regard to assisting vulnerable children through rehabilitative and reformative actions. As also mentioned in Chapter 2 of this document, one of the premises on which CICL work is based is the existing law and that the relevant professionals need to be able to use the legislation, namely the Juvenile Justice Act, 2015, to address CICL needs and 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 (and so that these children are not transferred to the adult criminal justice system).

This chapter therefore presents a structured proforma, as developed by the NIMHANS project team, for conducting preliminary assessments of CICL from a mental health and vulnerability perspective, as well as the context and background in which this proforma was developed.

5.2. Why Child Rights Activists and Child Mental Health Professionals Disagree with Section 15 of Juvenile Justice Act 2015

Like in the context of the detailed psychosocial and mental health assessments for CICL, the issue of preliminary assessments for CICL has been much debated and it is ridden with even greater controversies than the psychosocial and mental health assessments (discussed in the previous chapter). While not all child mental health professionals may have disagreed with Section 15 as it appears in JJ Act 2015, many have, including the authors of this document. Broadly, the reasons pertain to neurobiological, psychological and sociological, all of which together have a bearing upon the rights 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[115]. 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 is not fully developed until around the age of 25, 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. Because the prefrontal cortex is still developing, adolescents rely more on the amygdala to make decisions and solve problems i.e. more than adults rely on the amygdala. 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 control and social judgement, are not fully developed in 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 control and social judgement is akin to expecting an individual without a leg to run fast (or a 7-month-old infant to walk)!

Thus, if we were to base our juvenile justice laws and policies on psychology and neuroscience research and knowledge, it is challenging to conduct a preliminary assessment with regard to a child's mental and physical capacity to commit such offence, ability to understand the consequences of the offence. The reasons are 3-fold.

First, factors such as impulsivity, susceptibility to peer influence, reward seeking and a tendency to focus on immediate consequences of decisions versus future ones majorly influence adolescent decision-making[116] [116]. These are attributable to normal adolescent development and brain functioning; since adolescents are not fully mature, they tend to be pre-disposed to high risk behaviours. However, this is not to say that all adolescents will engage in criminal activities; on the contrary, most adolescents limit their offence behaviours to substance use. A relatively small proportion who engage in various types of more serious offences may be understood in terms of individual differences pertaining to biology, social and family environment, peer influences and other life experiences that then affect the frequency and intensity of their offences. But whatever these risk factors may be, the pathways to criminal involvement in adolescents are different from others[117]—thereby rendering laws (and associated processes such as preliminary assessments) that transfer children to adult systems for trial meaningless.

Second, only a small proportion of adolescents persist with offending in adulthood (Farrington, 1989). Since developmental influences play a major role in adolescent criminal activity, most youth are likely to outgrow their tendency to get involved in crime, unless the juvenile justice interventions hinder their successful transition into socially appropriate adulthood[117]. Thus, preliminary assessments are unlikely to be required for most children, as the processes of maturation are likely to help them out-grow their socially inappropriate behaviours. Further, if preliminary assessments are used to transfer children to adult systems for trial, instead of ensuring that children remain within the juvenile justice system and receive requisite counselling and mental health interventions, the risk of re-offending is likely to increase; this is because adult systems do not offer age-appropriate interventions that would help children transform their behaviours.

Third, adolescence is a transitional stage in which individuals acquire skills and capacities to prepare them to assume adult roles. Therefore, a socially healthy environment with sufficient developmental opportunities for (life) skill acquisition is important for adolescents. For CICL, the types of opportunities i.e. programs and facilities, they are provided with access to are critical[117]. Merely administering a preliminary assessment for purposes of deciding whether the adolescent should be transferred to the adult trial system is not therefore proactive or what these vulnerable adolescents need. In fact, if adolescents transferred to the adult trial system do not receive bail, they may be placed in adult prisons; if they do receive bail, they return home to homes and communities or neighbourhoods. Both situations are not conducive to facilitating either (life) skill acquisition or healing and transformation opportunities for adolescents.

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.

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 were not taken into consideration. Consequently, the framing of the law in JJ Act's Section 15, is

perhaps not in keeping with the rights of one of the most vulnerable child populations. We use the term 'most vulnerable' in the context of CICL, also because when they enter the system for child protection and vulnerable children (and there are many—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 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 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. 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.

5.3. Why a Preliminary Assessment Proforma was Developed

For now, Section 15 is here to stay

As discussed above, the position of the authors of this document (also the developers of the preliminary assessment), on Section 15 remains unequivocal, in that we are against transfer CICL to be tried as adults. However, whether or not we (and other child rights activists and mental health professionals) agree with Section 15 or not, the law has been passed, and for now, it is here to stay. Judicial personnel have their own individual opinions about Section 15 too 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.

Poor Definitional Specificity in Section 15

Although it has been nearly five years since the passing of the Juvenile Justice Act 2015, which incorporated Section 15 and the preliminary assessment report for CICL, in addition to its design being problematic, its implementation has consequently been equally problematic, resulting in exacerbating the vulnerabilities of CICL.

One of the reasons for problematic implementation is related to the design, namely the lack of specificity and detail in Section 15: it does not explain how to determine whether children have the mental and physical capacity to commit an offence or whether they have an understanding of consequences of the offence or how to assess the circumstances of the offence. The Social Investigation Report (SIR) developed in most instances by the Observation Home Counselor, whose skills are usually inadequate, tends to be a simplistic and generic account of the child's circumstances, with no analysis of his/her vulnerabilities—and therefore a document that is of little use to the JJB in make decisions based on proportionality and culpability. Thus, at a first level, the implementation of the law does not lay the basis for making a just decision for a child.

Lack of Standardized and Skilled Implementation of Preliminary Assessment

Combined with the lack of specificity and direction in the law, is the paucity of knowledge of mental health and psychosocial issues and of skill and methods to engage and work with children in general, even in mental health professionals. The two main types of professionals engaged in the implementation of Section 15 thus have varied and relatively limited capacities at present, to address the needs of this vulnerable child population, with mental health professionals knowing very little about child protection and legal issues, and legal professionals understanding very little about child mental health and psychosocial care impacts and

needs. Consequently, the implementation of the Act has been somewhat random and scattered, thus necessitating the development of a standardized protocol for preliminary assessment, along with consistent ways of interpreting and implementing the assessment.

While we are still not suggesting that Section 15 is a desirable provision of law (for the reasons erstwhile discussed), it appears that the current manner of its implementation is likely to result in greater injustice to CICL, because of differential ways of its implementation.

Given this scenario, we believe that there is little point in child rights activists and professionals (especially those who are deeply concerned about CICL) in disengaging in preliminary assessment processes due to personal and professional ideologies. Such disagreements and disengagements will only result in increased arbitrary assessments provided by persons with inadequate knowledge and skills. It is in this backdrop that some of us, despite our ideological positions on Section 15, engaged in direct work with CICL to develop preliminary assessments that would best assist them and uphold their rights.

Thus, the effort of developing the preliminary assessment proforma was a proactive one: to comply with the existing JJ laws and stay within the parameters of Section 15, but to view preliminary assessment from a mental health perspective, thus ensuring retention and reformation of children within the JJ system itself.

Also, when a request is sent to a mental health system, for assessment of CICL, by a JJB magistrate, a system is duty-bound to respond to the request or order of a judicial authority. There is therefore an imperative, on the part of a system (and the individuals responsible for it) to conduct the necessary assessment and respond in keeping with existing laws. However, this assessment has been structured, keeping mental health principles in mind, based on an understanding of the largely vulnerable backgrounds from which these children come. Thus, it is clearly geared towards assistance to these children, through a retention in the JJ system, under the provisions already existing under the JJ Act. 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.

5.4. How the Preliminary Assessment was Developed

There was of course, much deliberation and thought on how the preliminary assessment proforma should be constructed, both within the NIMHANS team as well as through conversations with other parties with legal expertise; due attention was paid, over a course of months in public forums and professional meetings to viewpoints expressed by varied professionals, in favour of, as well as against preliminary assessments. Considering the importance of the preliminary assessment and the bearing it will have on an individual child's case, the report was developed with consideration of all opinions and concerns, along with advice and guidance from legal experts, to ensure that the questions in the JJ Act were answered but in a manner that ensured that best interests of the child i.e. giving him/her a chance for transformation and rehabilitation[21].

In conceptualizing a preliminary assessment proforma, the NIMHANS team reflected upon critical legal principles of proportionality, culpability, excuse and mitigation that govern all law pertaining to offence and criminality; it considered the JJ Act on the one hand, i.e. adherence to the provisions outlined in Section 15 of the JJ Act, as well as the rehabilitation objective of the Act, and the child's best interests i.e. his/her mental health and psychosocial rehabilitation, so as to prevent the child from recidivism or again coming into conflict with the law.

[21] It is to be noted that the Dept. of Child & Adolescent Psychiatry 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 not in favour of Section 15 of the new JJ Act 2015 i.e. regarding the transfer system for 16+ year olds.

a) 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.[22]

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.[23,24]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.**[25] For instance, if the individual has mental illness that 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.[26]

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.

b) Interpreting Section 15 of the Juvenile Justice Act, 2015

Interestingly, while Section 15 lays out the (erstwhile mentioned) three questions regarding capacity, circumstances and consequences, it did not unequivocally define the terms, such as 'physical and mental capacity', 'ability to understand the consequences…' or 'circumstances'. There could be multiple ways of defining these terms—which has also been one of the challenges in implementing Section 15 in a uniform

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[22] Scott, E.S, Steinberg, L. (2003). Blaming Youth. *Texas Law Review, 81*, 799.

[23] Robinson, P. (1997). *Criminal law. New York: Aspen*. New York: Aspen.

[24] Wasik, M. (1977). Duress and criminal responsibility. Criminal Law Review, 453–74.

[25] 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=D48D35D7946E1A1A0BBE62DBC603E8D7?doi=10.1.1.334.9858

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

and standardized manner. For instance, if physical capacity refers to loco-motor disability, what degree of severity of locomotor disability would actually serve as a hindrance to committing an offence? Does mental capacity refer to intellectual disability or would it also include mental illnesses, and mental functioning that cannot be termed as illness, but results in functional impairment of inter-personal relations, and decision-making and problem-solving skills? Do circumstances refer to events and factors at the time the offence was committed or a more longitudinal understanding of a child's life circumstances (i.e. events and factors that can be traced from birth onwards)?

Since the JJ Act 2015 did not elucidate these terms, the NIMHANS team interpreted the them using a vulnerability lens i.e. one that is based on the tenets of empathy and compassion, and child rights, thereby necessitating assistance and rehabilitation; this also appears to be the lens adopted by the JJ Act in its framing, as it outlines various provisions for the care and protection of vulnerable children by the state. Based on these interpretations, for the purposes of the proposed preliminary assessment, our definitions of key terms are as follows:

- **'Mental capacity' is defined as the child's ability to make social decisions and judgments, for, these are the critical executive functioning abilities that operate in the social context that offence takes place in. Thus, reporting on the child's 'mental capacity' would draw on all the variables in the mental health and psychosocial assessment that pertain to mental health disorders, including substance use, and life skills deficit.**
- **'Circumstances' are defined as all the psychosocial vulnerabilities, including life events and mental health problems that children are afflicted with i.e. factors relating to family, school, peer relationships, trauma and abuse, mental health and substance use. Circumstances, therefore, do not refer merely to the immediate circumstances of the offence itself i.e. the last event that occurred and led the child into conflict with the law. In fact, the offence and the whole offence incident, including its immediate circumstances, are a (cumulative) consequence of a whole plethora of other circumstances that have been occurring over relatively long time periods of children's lives (sometimes since very early childhood). Thus, we take a longitudinal (versus a cross-sectional) perspective of circumstances of the offence.**
- **'Knowledge of Consequences' refer to children's knowledge and/or understanding of social or inter-personal and legal consequences of their actions.**

c) Reading Section 15 in Conjunction with Section 18 of the JJ Act

Section 15 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 section 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".*

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 to 18-year-old children to the Children's Court and conduct trial of the child as an adult. However, when article 15 and 18 are read, it also appears that the JJ Act states that preliminary assessments is to be used not to make decisions regarding trial but to make decisions that assist children with rehabilitation and reformation (as evident in article 18).

d) Situating the Preliminary Assessment in the Mental Health Domain

Based on the psychosocial and mental health vulnerabilities that lead a child to coming into conflict with the law, the preliminary assessment proforma was therefore situated in the mental health domain to encompass the following principles:

- The best interests of the child, so as to ensure the child's safety and retention within the JJ system.
- Child rights, so as to allow CICL to receive similar opportunities to other vulnerable children who fall within the JJ system.
- An 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.
- Ensuring assistance to CICL, by way of treatment, rehabilitation, transformation and (social) reintegration.

e) Addressing the Challenge of Self-Incrimination

Article 20(3) of the Indian Constitution provides immunity to an accused against self-incrimination under– '*No person accused of an offence shall be compelled to be a witness against himself*'. 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. However, this would not happen if JJB magistrates (and children's lawyers) were trained to interpret the preliminary assessment as intended, and in keeping with the JJ Act. In the interests of the child's mental health i.e. rehabilitation and reformation, the provision on self-incrimination must not be applied in the juvenile justice system. Indeed, if this provision is applied and children are encouraged to 'hide the truth' about their actions, they will have no chance to change their behaviours; and if they do not reform or change their behaviours, they are likely to continue to engage in the adverse behaviours that brought them into conflict with the law. There are two larger problems if we implement the law in ways that children are unable to avail of opportunities for behaviour and life change: i) the essential objective of the Juvenile Justice Act i.e. care, protection and rehabilitation of vulnerable children, would not be achieved; ii) lack of transformation of children, leading then to recidivism—this would not be in keeping either, with a safe or crime-free society, which is one of the key aims of any legal or justice system.

Furthermore, 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.

In other words, for the preliminary assessment to initiate opportunities for children's transformation, JJB magistrates and the judicial system as a whole has 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. The requisite orientation and perspective is predicated on the acknowledgement that the JJ system is designed to serve children and not adults, and that dispensation of justice in children's systems are very different from those in adult systems. 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.

5.5. Suggested Implementation of the Preliminary Assessment

Like the detailed mental health and psychosocial assessment proforma, the preliminary assessment should be implemented within the first two weeks of the child being admitted in the Observation Home, after the detailed mental health assessment has been administered. Unlike the detailed mental health assessment, which is administered to the child, the preliminary assessment is not administered to the child—it merely uses the information from the detailed mental health assessment proforma (which has already been used to elicit information from the child) to develop what is also called the preliminary assessment report, which is submitted to the JJB magistrate.

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 to committing the offence).
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.

The development of a standardized protocol and methodology for preliminary assessments, though necessary, would not in itself, be sufficient in ensuring a more fair and child-centric system for dispensation of juvenile justice. Orientation and training of the main stakeholders in the administration of the preliminary assessment, namely legal personnel, such as the juvenile justice board members, and mental health professionals is critical to the development of the preliminary assessment report such that it points the system in the direction of the child's need for reformation and rehabilitation (rather than transfer). Training content should, for both sets of stakeholders, include[27]:

- Knowledge of child development theories, in particular of the adolescent life stage and the basis of its emotional and behavioural challenges
- An understanding of CICL's pathways to vulnerability (including their difficult family backgrounds, experiences of abuse and trauma in various contexts such as home/family, school, at the work place, challenges in coping with peer influences and how each of these factors place a given child at risk of coming into conflict with the law)
- Administering/ understanding psychosocial care and mental health assessments that help identify the vulnerabilities and needs of CICL

[27] Training programs for each type of professional must be adapted to fit the scope of work and the role of the professional. For instance, more depth work would require to be done with mental health professionals on counselling of CICL, mental health assessments and methods of therapeutic intervention—which may not be required in detail for legal personnel.

- Developing the preliminary assessment report (through use of the standardized protocol)
- Essential psychosocial care, mental health and rehabilitation interventions and services that are available or may be accessed to assist CICL

Thus, training cannot focus merely on the development of the preliminary assessment report—which needs to be a part of a broader and deeper initiative that helps legal and mental health professionals understand issues pertaining to CICLs as well as equips them with the skills to respond to these children in accordance with the scope of their roles and professions. This will ensure that the legal, child welfare and mental health systems use the preliminary assessment reports to provide children with opportunities for transformation and rehabilitation rather than solely for legal purposes of transfer. Such an approach would be in keeping with the care and protection objectives as envisaged by the Juvenile Justice Act.

Other measures to ensure uniform implementation of the preliminary assessment would include training and empaneling the District Mental Health teams to conduct preliminary assessments when required—again, to avoid random, uninformed opinions professed by various mental health professionals (the JJB magistrates report that currently they receive one-liners to say 'child is mentally and physically fit').

Therefore, 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.

No Matter What, No Transfer!

The preliminary assessment does not contain any facts of the case because: i) for legal decisions, the JJB will 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; 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 directing their attention to it before they arrive at any decisions about transfer.

Thus, 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. Thus, even in some instances where children, 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'**. 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.

5.6. Preliminary Assessment Report & Guidance Notes

The preliminary assessment uses information from the detailed psychosocial and mental health assessment (that is done first) and presents that information as outlined below. Below are the items in the preliminary assessment report developed by the NIMHANS team—they are presented with guidance notes that help explain which parts of the (individual) mental health and psychosocial care assessment to draw information from to fill out the preliminary assessment report questions; they also explain how each question or variable on the preliminary assessment report has been interpreted, to be able to implement Section 15 in a manner that favours the best interests of the child.

***Refer to Annex 4 for a copy of the Preliminary Assessment Proforma and to Annex 5 for Examples of Completed Preliminary Assessment Proformas.**

A. Mental & Physical Capacity to Commit Offence

The mental capacity i.e. 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 contains 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.

In our experience and observation, through our many training workshops with judicial personnel across the country, the presentation of the above thinking and approaches on Section 15 and preliminary assessments, have been received in relative silence, perhaps tinged with some palpable doubt and discomfort. Thus far, we have not had any major objection or disagreement, by these personnel, on the development and use of the preliminary assessment proforma in terms of a) any logical flaws or confusions pertaining to the vulnerability lens adopted; b) issues of legal incorrectness or our approaches being inconsistent with the exiting law (section 15). They have also agreed, even stated, that when at times they have referred children to mental health personnel accessible to them, they have received unsatisfactory and unhelpful preliminary assessment reports (which have not used the methods we propose). There is also no judicial personnel so far who has been able to propose or share an alternative method for implementing the preliminary assessment—on the contrary, they frequently acknowledge that this is a 'grey area' and one that is both challenging and confusing for them.

Yet, there appears to be a hesitancy and reluctance to move forward with the suggested approaches and methods. One possibility is that despite professional training, and an academic acquiescence that CICL are vulnerable, many who work with these children (like much of the general public) find it difficult to overcome long-held, deep-rooted notions about criminality, and traditionally-held convictions on 'disciplining children' and the need for retributive justice.

That said, we are in no way suggesting that the proposed method is flawless or fool-proof; no assessment method is fool-proof, unless it were to yield indisputable empirical evidence—such as objective medical tests can (eg. blood tests, Xrays etc). No psychological assessment can lend itself to this level of accuracy and certainty. Therefore, the methods and approaches we are proposing for preliminary assessment present one way to implement Section 15, at least to ensure that the larger rehabilitative objective of the JJ Act is adhered to, as are the principles of child rights and child's best interests.

6. Psychosocial and Mental Healthcare Assistance: Interventions for Transformation and Behaviour Change

A great deal of attention has been focused on trying to understand the background and circumstances of CICL, including the pathways that led them to offence behaviours. However, the best assessments and analyses are of little value unless all that information and understanding is used to provide children with assistance that enables behaviour change and social rehabilitation. The question is what are we doing to assist CICL? If we do not provide them with opportunities, guidance and inputs for behaviour change and social rehabilitation, how can we expect them to transform? Merely admitting them in the OH cannot bring about the requisite transformations, considering that the OH is not intended to be a detention centre.

Children in conflict with the law, like children in other care and protection institutions, come from difficult psychosocial circumstances, those which often cause them to have compromised life skills, consequently leading to commission of offences and conflicts with the law. A number of both individual and group methods can be used with children in conflict with the law, as with other children's groups, to bring about behavioural transformation and promote psychosocial well-being in them. This chapter describes some of the types of interventions that can be implemented with CICL, in the OH.

6.1. Individual Interventions

a) First Level Responses

Following the administration of the detailed psychosocial and mental health assessment (previously described), the therapist/ counselor provides what are known as first level responses to the child. First level responses include but are not limited to the following and could take about an hour after the assessment is completed:

- Initial responses that the counselor provides to address any immediate questions, doubts and anxieties the child may have (including with regard to bail and other juvenile justice board processes);
- The paraphrasing and framing of the problems that the child is faced with i.e. outlining how and why the child appears to have come into conflict with the law;
- The proffering of assistance to the child to help find ways to resolve his/her problems.
- Initiating or laying the ground for the processes of behaviour change in the child, through a conversation that 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

First level responses are provided to all children assessed (which ideally should be every child who comes to the Home). 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.

Building a Therapeutic Alliance with CICL

Therapeutic alliance refers to the relationship between a mental health professional and a (child) client, and is regarded as important for the outcome of psychological therapy. In some ways, it may be said that the JJ Act itself discriminates against these children by placing them in a category separate from 'children in care and protection'—though children in conflict with the law, given that they come from difficult circumstances similar to children in need of care and protection--have been and continue to be in need of care and protection. Given that these children already have a sense of being 'the other', it is often difficult for facilitators and counselors to engage and build a therapeutic alliance with them.

CICL are often judged by everyone; they have been frequently targeted for punishment due to their difficult behaviours (in fact, being in the observation home itself is a punishment); starting from families in which these children have been victims of parental neglect and abuse (both emotional and physical), to schools where these children have been victims of bullying and corporal punishment, to the police who are reported to engage in the most severe forms of physical violence, these children have been almost continually punished, for behaviours they were responsible for and those that they were not. Even the most sympathetic and well-intentioned people end up being judgmental and critical by giving them (moral) advice and instruction, emphasizing on them the need to improve themselves and 'be good'. As a result, CICL already have a deep mistrust of the (adult) world, which they have always experienced as being unjust, un-empathetic, hierarchical and patriarchal, powerful and dominating, violent, judgmental and critical.

However difficult it is to develop therapeutic alliance with CICL, it is imperative to build one as it is necessary, for without a relationship of trust and collaboration, it would be difficult to work with the child to provide therapeutic and other assistance. It is also considered as a best practice for improving treatment outcomes and engaging and maintaining youth in mental health treatment. Considering the imperative to develop a strong therapeutic alliance with the children in the Observation Home, the NIMHANS team used the following methods and activities to do so:

- The team spent a lot of time with children, up to 2 to 3 hours per day, for at least 4 to 5 days/week.
- The mode of engagement was casual and informal with friendly humour. Even on days there was no clear activity or agenda, the team 'hung out' with the children, using casual informal conversation and much humour to interact with them. (This also conveyed to children that there could be a respectful, yet fun interpersonal relationship even in the absence of purposeful activity).
- Some of this time was spent engaging children in leisure and recreation activities such as film screening, board games, art sessions and role play activities (group activities).
- Time was also spent discussing/ talking more about children's interests, hobbies, their likes and dislikes about various subjects such as music, dance, movies, their favourite artists, and many more.
- Acknowledging and validating their emotions and concerns, their day-to-day lives and difficulties within the observation home was also done on a continual basis, with the team making efforts to talk to the OH staff and alleviate some of the children's problems there.
- Individual assessment and the therapeutic sessions that followed also provided opportunities for the team to spend one-on-one time with children and understand and respond to their unique issues and concerns.

As a result of all these efforts, the children became more relaxed and comfortable around the NIMHANS team and a strong rapport was gradually built, indicated by the fact that children shared a great deal of their lives, including daily events and happenings at the OH with the team. The team was also able to gain a deeper understanding of the children's worries and concerns, their aspirations and worldviews.

b) Depth Therapeutic Interventions

Based on the psychosocial assessments, some children were identified for depth intervention based on the assessment. These were children with: i) (risk of) self-harm behaviours; ii) severe depression (usually with experiences of trauma and abuse), requiring pharmacotherapy and depth psychotherapy; iii) moderate to severe Attention deficit hyper active disorder (ADHD), also requiring pharmacotherapy and specific behaviour training; iv) long standing substance use and dependence (and associated withdrawal symptoms); those charged under POCSO act for offences related to child sexual abuse, requiring depth therapy on medium to long term basis for behaviour transformation.

For some children, especially those not requiring pharmacotherapy, sessions were conducted by the NIMHANS therapist in the Observation Home. However, these were often logistically difficult, resulting in irregular sessions. Thus, most children requiring depth interventions were referred, following bail, to the Dept. Child and Adolescent Psychiatry, NIMHANS. Following their in-patient admission at NIMHANS, the children received interventions from a multi-disciplinary team, comprising of inputs from the Dept. of De-addiction Medicine and of Rehabilitation (for vocational training) along with emotional and behavioural inputs from the Dept. of Child & Adolescent Psychiatry (where life skills training, to address deficits in emotional dysregulation/coping with peer pressure/ assertiveness & negotiation skills/problem-solving/ conflict-resolution/decision-making, was also implemented in great depth, using creative and cognitive behaviour therapy methods); where required, family therapy and other treatments were also made available to the child's family. Such a wide and multi-disciplinary approach was used to ensure that the child's individual as well as family and systemic vulnerabilities were addressed so as to avoid recidivism. A report on the child's treatment and the child and his family's response to the treatment is made to the JJB, along with recommendations for the child's placement and further training.

Examples of Individual Interventions

Case Vignette 1: K, aged 17 years

History and Issues for Intervention

K came into conflict with the law for alleged theft and was admitted to the Observation Home. His father had a history of alcohol addiction and the child dropped out of school early on. He then worked in various places such as construction sites, garages where he had experiences of physical/ emotional abuse. He also spent most of his time with his peer group who influenced him to engage in substance use and other rule-breaking behaviours.

Issues for Psychosocial Intervention:

i) Anxiety and Depression (due to experiences of physical abuse experiences since childhood).

ii) Conduct problems (truancy and other rule-breaking behaviours).

iii) Substance abuse (use of tobacco and alcohol; the latter led to poor emotional regulation and inappropriate social judgement as a result of which he engaged in anti-social behaviours; he also experimented with cannabis and inhalants).

*Although apprehended for stealing, the child had not actually committed this offence; hence, it was not an agenda for therapy.

Interventions

The child was seen in individual therapy during the period of his stay in the OH, as well as in the NIMHANS in-patient facility after he received bail. Individual therapeutic interventions are described below.

- Anxiety and Depression Issues:
  - Mapping the child's life experiences and times of anger, fear, happiness, and sadness, so as to acknowledge and validate his difficult experiences of abuse.
  - Using listing and story-building methods to deal with his own traumatic memories as well as to recognize the impact of traumatic events on others.
  - Mask-making and art to enable the child to identify his worries and fears and how he responds to them; guided imagery and other relaxation techniques to control anxiety.
  - Film screening and discussion of films such as Stanley Ka dabba, I am Kalam, Chain kuli ki main kuli, to reflect on trauma and difficult experiences, including how other children have coped in such situations.
- Substance Abuse:

- To facilitate and development of understanding of the substance use an activity by listing and perspective-taking on the consequences of substance use on social/interpersonal relationships, and on financial situation.
- Harm reduction- An activity where a story of a child who is currently living on the streets was built along with the child…how this child's life would play out if he continued to use substance, as part of insight facilitation and motivation for change.
- Relapse prevention- understanding of the perceived benefits and harms, understanding the process of relapse, drug refusal skills, implemented through discussion and role play.

• Life Skills Training Skills:

- Emotional regulation, stress/anger management and decision-making were worked on using story- stems and role plays on various social situations and themes that the child encounters in his daily life.

• Family Work:

- The child's father who had recently quit alcohol use, was counselled to motivate the child to be abstinent, and encouraged to spend quality time bonding with the child.

• Pharmacotherapy:

- Initially, he was on medication for depression but half way through the therapy sessions, it was withdrawn as it was no longer found to be necessary for him i.e. he had learnt to cope without it.

• Social Rehabilitation:

- As the child was not interested in continuing his education, but wished to work with his father in welding, the JJB concerned facilitated a vocational training course for him in welding.

Outcomes

- The child's anxiety and depressive symptoms decreased and he was able to cope with minor stress situations (unlike before). He was insightful and was able to acknowledge problems he had and how his actions had impacted his life and that of others. He was highly motivated and keen to take up a job to earn money and repay the loans which his father had borrowed for his release from the JJB. He was also motivated and willing to stop using substances.

Case Vignette 2: V, aged 14 years

History and Issues for Intervention

V, a 13 year old, was from a migrant labour family dropped out of school due to financial difficulties and was working in a garage. He spent most of his day with his friends in the workplace, most of whom were older than him. Under the influence of his peers, he started to smoke cigarettes and to watch pornographic videos. V's curiosity about sexual matters grew and he decided to 'try out' what he had seen in the videos. Hence, when an 8 year old girl who lived next door was alone, he engaged in sexual acts with her, and was charged for child sexual abuse, under POCSO.

Issues for Psychosocial Intervention:
Enabling the child to acquire life skills as follows:
i) Making appropriate decisions about sexuality and relationships
ii) Coping with peer pressure

Interventions

A brief intervention was done with the child while he was staying in the observation home, as detailed below. The child has been referred to Dept. Child and Adolescent Psychiatry, NIMHANS for further (consolidation of) inputs when he is released from the OH. The inputs in the OH focused on providing insight and helping the child

to reflect on events/ circumstances of coming in conflict with the law including the offence for which he committed.

A framework was provided to the child regarding where, when, how and with whom can one engage in sexual activities was done using the 'window approach'. This is an approached developed by the Project to enable children and adolescents to understand and make decisions about sexuality and relationships, including learning how to recognize sexual abuse. When one wants to talk to children about sexual abuse, it is necessary to talk about several ideas and concepts before finally talking about abuse—hence, the idea is to 'open the window' to one concept and then the next one…and so on, until we reach the last one of abuse and protection, by which time children have an understanding on all other related concepts.

Window 1: Acknowledging Needs and Pleasures
Acknowledging to the child that everyone feels sexual desire and has sexual needs; that most young people are curious about sex and sexuality and that is normal and healthy…nothing wrong with it at all. The issue is how we express this curiosity and how we decide to 'try out' sexual acts, with whom and when.

Window 2: Privacy, Consent and Boundaries
Discussing with child the issues of consent and permission—when, why and from whom we take permission in various contexts…what happens when we do things without taking permission/ how others feel when we go against their wishes; how an 8 year old child is not in a position to actually give consent because she does not know about sexuality issues…what personal boundaries mean (when we say things to people that are abusive or hurtful or offensive, then we are violating mental or emotional boundaries; when we touch people in ways that make them uncomfortable/upset i.e. without their consent, we are violating physical boundaries (as also in the case of hitting and other violent actions); how the 8 year old girl may have felt therefore when he engaged in sexual actions with her.

Explaining to the child the POCSO Act and its implications—were explained to the child as he was not aware and did know the consequences of his action/behaviour.

Window 3: Relationships
Discussion with the child on various types of family and non-family relationships, how even within the family, only parents have a sexual relationship…others such as siblings/ parent-child relationships do not entail sexuality…and if they do, then there are violations of social and family relationship boundaries; again, how the 8 year old girl may have felt therefore when he engaged in sexual actions with her…how even in the context of romantic and sexual relationships, under what circumstances/ in what contexts can one engage sexually.

Window 4: Health & Disease
Discussion with the child on sexually transmitted diseases/ risk of pregnancy to the girl, in case of unprotected sex, including what protected sex means (condom use).

Window 5: Safety and Protection
Discussion on what safety means i.e. physical and emotional safety from hurt and harm, people's right to be safe…safe and unsafe spaces, safe and unsafe people.

Window 6: Sexual Abuse
Recognizing various forms of sexual abuse (which includes instances where safety/ boundaries/ consent issues are violated).

Outcome

Child was able to understand how to make decisions regarding sexual relationships. He was previously unaware that his acts were offensive—following interventions, he was able to understand the problem with his previous behaviours.

Experiments with Peer Counseling

A majority of children in the observation home are from dysfunctional families, have had problems with school and education and frequently been child laborers; they are also considerably vulnerable to adverse peer influences, especially as neglect and poor supervision at home had led them to developing gaps in life skills. It was observed in the Home that children tended to frequently obey many of their peers, especially those to whom (for whatever reason) they owed allegiance. Also, given that CICL often have a difficult relationship with adults (as discussed above), they are disillusioned with the adult world and so tend to rely on their peers for emotional support, affirmation and a sense of belonging.

Thus, we experimented with peer counseling/ support initiatives wherein children requiring to learn prosocial skills were assigned to take care of children who were new to the home and/or were anxious and depressed. The peer counselors were requested to play the role of a listener, and enable the other child's inclusion in group activity, and protect him from bullying and violence. The peer counselor was also taught relaxation techniques for anxiety control, and encouraged to remind the child concerned to practice these techniques through the day.

It was observed that peer counselling could have a three-fold purpose: i) provide emotional support for children who require it; ii) provide opportunities for learning pro-social skills for those children who lacked them—this would be critical in enabling them to transform some of their socially less desirable behaviours, re-create their identities and enhance self-worth and self-esteem; iii) consequently, bring about a change in the culture of the organization i.e. make the OH a place that is welcoming, supportive and nurturing, one that offers space and opportunity to children who come there versus being a place of detention, where more violence and punishment is used to respond to children who have committed offences.

c) Family Counselling

Parental involvement and cooperation are critical for children to be able to avail of mental health assistance and treatment in the first place, as well as for follow up and maintenance of behaviour change, thereafter, in the medium to long term. Thus, an important part of individual counseling and therapy was counseling of parents or family of the child. The family members of the child were provided with support and assistance in the following areas, through eliciting their participation in intervention plans for their children:

- ✓ Improved ways to communicate with children, through joint parent-child sessions.
- ✓ Inputs on how to build quality relationships with their children, such as spending time doing leisure and recreational activities i.e. being part of children's life in meaningful ways (versus merely providing for basic needs and material comforts)
- ✓ Facilitating the examination of parenting styles and attachment relations and issues—and making the necessary shifts to more appropriate parenting styles i.e. for improved parent-child attachment and relationships.
- ✓ Provision of monitoring and supervision to children (to ensure that they engage in age-appropriate activities, thereby also preventing recidivism).
- ✓ Dealing with children's emotional and behavioural issues, such as anger and aggression, demanding behaviours.
- ✓ Engaging parents and caregivers to be part of any contracting that was undertaken as part of the child's therapeutic interventions, including psychoeducating parents on how they can emotionally support their children to maintain these contracts.
- ✓ Encouraging parents and caregivers to play an active role in the process of reintegration of children i.e. ensuring that their children engage in educational and vocational training activities, after leaving the observation home.
- ✓ Referral of parents to relevant specialized departments/ treatment services within NIMHANS, to address their mental health problems, including marital conflict, substance abuse and/or mental illness.

6.2. 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. Further, while the plan was conduct life skills training sessions, it required more time and greater understanding of the children and their lives, their needs, interests and viewpoints, to be able to initiate meaningful group therapy or life skills sessions. Thus, the Project thus began to focus on the day-today activities and structuring children's time in the institution.

A largely experimental approach to group work was taken, engaging the children in more leisure and recreation activities, such as film screenings, board games, art sessions, and role play activities. The following activities were implemented and also gradually introduced into a daily time-table for the Home:

- **Art:** Rolls of paper were taken and spread out on the floor across the room to form long panels for children to draw and paint on. Children sat along these panels, demarcating spaces for themselves on the panel to work on. Many gave form to other ideas and images they wished to draw. It was interesting to observe that those children who had not committed any offence tended to draw pictures of mountains/ rivers/houses/mosques/temples and other scenes while those who had allegedly committed offence tended to draw figures of people and actions of violence and substance use, and scribble obscenities (though they were not quite sure of the meaning of many English abuse phrases!). Based on the children's interest in art, the Project team got permission from the OH superintendent to provide a wall/ room wherein children could paint and decorate the wall. The children themselves whitewashed the classroom. A wall space was allotted to each child and the painting activity continued for about 2 weeks.

- ***Indoor Games:***

The Project staff started to experiment with engaging children in indoor games, namely board games/ card games/ jigsaw puzzles/ thambola / dumb charades/ quiz games/ reading story books. The objective was two-fold: i) to enable them to engage in rule-based games so as to enhance their social skills/ team-playing abilities; ii) to facilitate activities that would increase their attention-concentration skills and sitting tolerance (especially necessary for ADHD children but useful for all).

- **Film Screening**

It was observed that children enjoyed movie screening and some well-known children's films were screened, but it was found that many children were not very interested in these and that they wanted to see commercial films often with more explicit content (violence and sex). Since screening such films was not in keeping with the OH rules, we began to screen commercial films but only those that had prosocial themes—for example, films such as *Bhajarangi Bhaijaan*, *Chak de India* also allow for discussion and learning on prosocial behaviour. [Interestingly, however, we have observed that children in the OH spend vast amounts of unstructured, unsupervised time watching television, on which they actually watch a lot of violent films].

Implementation of Indoor Games and Activities

Process:

- A session was done with the children to enquire and learn about what they would like playand they reported that they would like to read story books, play card games, board games such as snake and ladder, chess, jigsaw puzzles.
- The Project team purchased a variety of games and books accordingly.
- A plan was devised according to the numbers of players that each game/ activity would allow prior to the session (see copy of plan below).

Organization Plan for Group (Indoor) Games for Children in Observation Home

Game	Game Contents	No. of Games	No. of Children Per Group	Total No. of Children
Chess (Board Game)	1 Chess Board + 36 Pons (each)	2	2	4
Snakes & Ladders (Board Game)	1 board/ dice/ pons (each)	5	4	20
Ludo (Board Game)	Board, dice, pons	5	4	20
Cricket (Board Game)	Cards	5	4	20
Uno Cards	110 cards	1	4	4
Cricket Cards	50 cards (per pack)	2	2	4
Krish Cards	50 cards (per pack)	1	2	2
Jigsaw Puzzles (1)	40 pieces (each)	3	2	6
Jigsaw Puzzle (2)	104 pieces	1	4	4
Jigsaw Puzzles (3)	500 pieces each	2	6	12
Books (Book Corner)	Around 40 books in Kannada Hindi and English	1 book per child at a time	40	Up to 40
3 D puzzles	25 in each	3	4	12
Building blocks- wooden set	200	1	4	4
Other puzzles- forming complicated shapes	10, with 50 cards	2	4	8

- In the session, children were told what games were available and how many could play each game at a given point in time. They were then asked to select which sub-group/ game team they wanted to belong to.

- Each sub-group was then provided with one game/ activity material and following rules was explained:
- Each member in the team is responsible for all the items.
- Any breakage of the items should be rectified by the team.
- No argument/ fighting amongst each other.
- One team can engage with one game at a time.
- No one should disturb other groups.

Observations:

- Contrary to what the Observation Home staff said (that it would be very difficult to manage children when they play group games as there would be fighting and breakage of materials) children were very enthusiastic and careful in their use of games and materials; none of the games were damaged.
- They took turns and played cooperatively, without disagreement or fighting.
- Unexpectedly, one of the most popular games were the jigsaw puzzles, which require greater focus and effort than board games or card games. Clearly, children enjoyed the cognitive aspects of the activity.
- Also surprisingly, several children were keen to read books—they were observed to be engrossed in their reading corners despite the general noise around them.
- Board games had the ability to engage and occupy them for up to 2 hours.

Formation of Children's Committees

In accordance with the JJ act mandate, the Project initiated an election process for the formation of the children's committee. In preparation for committee formation, the following activities were implemented first:

- Discussion on the need for leadership and the essential qualities of leaders: All children were given opportunities to respond and they were asked to also give valid explanations for the same.
- Division of children into groups to form parties: A random selection was done and children were divided into 5 groups.
- Enabling each 'party' to come up with a name for themselves, a symbol, a slogan and a brief speech to describe what they would do for the OH committee if they were elected.
- Nominations from each party for various positions on the committee.

Following this, a process of secret ballot was used to complete the voting processes. During the course of this, election processes in a democracy were discussed with children, including the reasons for secret ballot. A president, vice president, representatives for entertainment & culture, sports & games, library, hygiene & personal care, and for welcoming & orientation of new residents, were selected. The roles and responsibilities of each member were discussed and the committee actively engaged in organizational issues in the OH in the weeks that followed.

Later, the committee were asked to prepare a timetable by considering all other children's views and ideas. It was suggested that each day there should be certain activities such as- physical exercise, television time, library time, Indoor games, outdoor games, learning, dance/music and so on. The children had prepared a fairly good timetable which was then presented to the superintended of the observation home. However, the timetable was not implemented completely, as few of the children were not willing to participate as well as the observation home staff did not support the children to implement the same as they used to involve children in other chores in the home such as cleaning, helping in the kitchen, helping the staff in other official work.

Observation:

- The children were very enthusiastic and they actively participated in the process of election.
- The children had a sense of pride and they had a sense of belonging as they were given opportunities to decide and make choices about their own daily life in the observation home. The process of election enabled them to feel important.
- There was a change in the observation home's environment children were more responsible, they said 'this is our observation home, we will take care of it, until we are here all of us want to be happy so we will make sure no one fights'.
- The elected leaders were enthusiastic that they have the power and at the same time they were also responsible. They had all been following all their duties and responsibilities. They had themselves initiated many activities in the observation home such as every day after the tea time the president had allotted time wherein he and other leaders used to talk to other children who were upset or sad and help them to relax. Every day in the night few of the children used to be sad as they remembered their family, hence the leaders decided to play anthakshari before going to bed, so that everybody could go to bed in a cheerful mood.
- When the leaders were asked to make a list of their needs, each committee member based on their roles and duties prepared a list and presented it in front of all the children and obtained their views. This list was submitted to the staff of the observation home and requested them to do the needful.
- Usually when new children were admitted to the observation home, they were bullied and physically abused by other children in the home. However, after the committee was formed new children reported that no one bullies us, as the leaders won't allow it.
- There was a certain culture in the observation home which was relaxed and all the children were usually seen in a happy mood which was contrary to earlier environment which was tense and hostile.

During our work with the children in the observation home, many of them wanted to read books and requested for books to read, as they had no access to books. The staffs were not willing to give children any books which were available in the observation home stating that the children would destroy it. Hence, the project team collected around 200 books from NIMHANS staff and provided books to the children and ensured that these books would be available freely to all children. There were English, Kannada as well as Hindi story books, magazines. After the books were collected they were brought to observation home and children sorted the books and prepared a list so that they could maintain a register to note who had borrowed a book and all the children were requested to follow this procedure.

Contrary to the staff's fears that children were not interested in reading and that they would tear up books, children were very responsible and they all followed the rules and each child borrowed books every day. Even children who could not read were borrowing books and looked at the pictures. Many children, who could read, read out the stories to other children who could not read.

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 counseling, several children were selected to be part of life skills sessions. Ideally, life skills sessions should be conducted for all children.

Life Skills Education and Training

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

Most mental child health problems (except for those such as psychosis and those caused by organic factors or physiological problems) may also be viewed as life skill deficits. For instance, violent and abusive behaviours result from children's inability to regulate emotions, negotiate inter-personal relationships and/or resolve conflicts in alternative or creative ways; thus, the objective of any therapeutic work with such children will be to enable them to acquire the life skills to manage anger and aggression—in other words, to manage emotions, develop creative thinking, problem-solving and conflict resolution (life) skills. Children in difficult circumstances (including CICL), who are exposed to experiences of deprivation and abuse from early childhood, develop emotional and behaviour problems which may also be viewed as being created by life skill deficits i.e. due to their difficult circumstances, children have not learnt certain life skills, and that results in emotional and behaviour problems. These life skill deficits, if not addressed, then exacerbate emotional and behaviour problems, increasing the risk for more serious behaviour problems and chronic mental health disorders.

The Adolescent Life Skills Series developed by the NIMHANS Project, focuses on socio-emotional development, gender, sexuality and relationship issues and substance abuse. In accordance with life skills education pedagogies, the activities use a range of creative, participatory methods such as art, games, drama and film, to enable children to reflect on life situations and decisions, as opposed to didactic, top-down methods of instruction typically used in most education systems.

[28] 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.

However, given the large numbers in the OH, there is a need to prioritize children for participation. This is done based on the following criteria: i) Children who have been in the OH for more than a month and are likely to stay for a longer time (due to the nature of the offence/case); ii) those involved in more serious or 'heinous' offences; iii) those who are reported to bully others; iv) those who volunteered to be part of the group (due to their motivation for change).

The objectives of these life skill[28] sessions were explained to the group at the start i.e. that these sessions were intended to prepare them to live their lives in ways that were productive and happy, without getting into trouble or by learning how to manage problems that arose. Codes of conduct (listening/ participation/ zero tolerance policy about violence) in the group were also laid out. The Project team rolls out these sessions 2-3 times per week.

Life skills sessions addressing issues on emotional issues, sex and sexuality, motivation, gender and violence are implemented. 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.
More specifically, socio-emotional work includes issues of loss, grief and trauma, managing feelings such as anxiety and anger, empathy and inter-personal relationships, problem solving and conflict- resolution methods. Sexuality and relationships work includes themes such as acknowledging attraction and love, understanding issues of consent and permission, health, safety and protection, to enable children to be assertive and make decisions in sexuality and relationship contexts.

From the Field Worker's Diary…Life Skills for Socio-Emotional Development

Institution: Observation Home
No. of Children: 16 (boys)
Age group: 16 to 18 years

Session 1: Getting to Know Each Other

Objectives:

- Establishing rapport with children.
- Getting them to be comfortable with each other.
- Setting group norms.
- Creating a space for children to begin engaging in emotional expression.
- Enabling children to share their life stories and experiences.

Methods: Card Game

Materials:

'Getting to Know You' stack of cards (A set of cards comprising of questions on children's interests, abilities, talents, likes and dislikes).

Process:

- Children were asked to sit in a circle.
- Introduction- As all of you know me, and that I come to the observation home many days a week. I have been working with most of you here individually to understand why you're here, what were your difficulties, and also to assist you to ensure that you will not be back to the observation home. We have also together watched movies; have done drawing and painting and so on. Today I called you people because as most of you have been in the observation home from past several months, and have been charged with a case and you are here because of it. While you are here, we want you to consider your stay in the observation home as a learning opportunity and as a time when you could plan your future. I will spend some time with you all so that we can all work together can plan for your future.
- Facilitator informed the group- 'From today I will be conducting 2- 3 group sessions in a week with you all, so that we could learn more about each other, and then to learn few techniques and skills which will ensure that you will not be back in the Observation home again'
- It was suggested that as we are all a group now- let's name our group, and each one of you will get a chance to suggest a name and later we will all vote for one and the name which gets the maximum number of votes will be our groups name. Children were excited about it and started suggesting a few names such as :
  - Free Boys- We all are free from problems and free from the world ,
  - Cool guys- we all our always cool and happy,
  - Fun Boys- we all like to have fun and be happy always.
  - Big Boss group - We all our bosses of ourselves
  - Madivala Boys – We all are from the Madivala Home
- After the voting they all choose Big Boss Group as the group name. All the children were appreciated for their suggestions.
- Children were asked to repeat the group name together few times. Later I suggested lets have few rules to enable us to enjoy better and to learn together as a group:
  - We all are here together and we all should respect each other.
  - When anyone of us are sharing anything about themselves we should listen to them and not make faces or jokes about it even after the session.
  - We all will help each other and trust each other.
  - We will not share others secrets which they share in this group outside the group.
  - We will all come in time to the sessions.
- Facilitator: 'we will now play a game to get to know each other better'.
- Facilitator explained the game by placing the stack of cards at the centre of the circle and told them that each one of you will be picking a card from this stack and will have to read the instruction on it and respond accordingly.

- Each child was given one turn to pick the card and asked them to respond. After each child finished responding to the card the same questions was opened to other children who wanted to respond and it was not made compulsory for them to respond.
- Some of the children's responses to the cards are below:
- How would you dress if you were to look really fashionable?
  - Wear jeans with white shirt, wear black shirt and jeans, wear a shervani, formal dress.
- How would you like girls to be dressed?
  - Most of the boys were shy initially but later were excited to give their responses.
- Your greatest wish or desire?
  - To get out the observation home'.
  - To be able to go back home and be with the family.
  - To work and have a life with no problems.
  - To be happy, buy a bike, build a home.
- What does friendship mean to you?
  - One who helps us when we are in need
  - Who will be with us in good and bad.
  - One who is helping caring and always available to you.
  - Who accepts us how we are, who wouldn't judge us.
  - A friend is one who will never break our trust.
  - A person who shares our happiness and sorrows.
  - A person who will always help us to be a good person, correct us when we are wrong.
- What is one quality you like in yourself?
  - I help other when they are sick.
  - I always help other who are in need.
  - I like to make jokes and make other laugh.
  - I talk to other who are sad and help them to feel better.
  - I don't like violence, when other people are fighting I stop them.
  - I share my things with others.
- If you had a Rs. 1 lakh, what would you buy with it first?
  - I will buy a new car, bike, a house and party.
  - I want to help others who are in need.
  - I want to give it to my parents.
  - I will use some money to buy new clothes, party and rest I will use it to start a business.
- Children who wanted to share one or more thing were encouraged.
- The children were thanked and appreciated for their responses.
- All of us knew each other from so many days, all of you have been living in the same place from so many days but did you know what everybody's answer would be? No right… So we will all be spending time just like today to understand each other much better and learn from other's experiences.

Observations and Analysis:

- Most of children were excited and happy to be part of a group.
- They were few children who were hesitant and shy to respond in the beginning but with slight encouragement and reassurance they were able to respond.
- Few children were very comfortable and encouraged others to respond and they themselves took initiatives to share their views and thoughts.
- They wanted to continue the session even after the lunch time- this shows that children are waiting for opportunities to interact and to be part of a group where they are not judged or criticised. A more non-judgmental and unprejudiced approach will enable a facilitator to build a good therapeutic alliance with children in conflict with the law.
- At the end they were excited to know when I will be coming next and told me that they had lots of fun.

Session 2: My Journey, My Story

Objective: To provide a platform for children to narrate their life stories.

Methods: Mapping and narrative

Materials: Picture of: i) mother holding a baby (1); ii) train (1); iii) children's institution (1); iv) train station (6 per child) (see below); chalk, coloured pens/ pencils for writing; a large space for children to move about.

Process:

- Introduction: As we all know each other's likes dislikes and we are comfortable with each other; today let's share few of our memories and life events.
- Rules of the groups such as respect, confidentiality and trust were reiterated.
- We can compare our life to a a train journey- it begins when we are born and it moves through different train stations i.e. our different life events. So today let's share our life journey from our birth till now.
- The Mother and baby card was placed in one corner of the room and explained to the children that this is where their life journey begins, and place the children's institution card at the farthest corner of the room, and explained to the children that this is where you are now'.
- It was also explained that- our lives are like a train journey—we start at a specific point and travel through many places, meeting different people, with various events happening to us during the course of the journey...as we move to our destination.
- Then using chalk railway track was drawn and connected the stations.
- Then facilitator also explained- between where we started and where we are now, we have stopped at various stations—few of them might be small ones, big ones, important ones, happy ones, sad ones. What we will do now is to tell stories about our journeys and the stations we were at one the way...starting from when we were born or whatever you remember as your earliest memory, until now.
- Later facilitator said- As we are still travelling on the train of life and may not yet know what our ultimate destination is or what we want it to be, we still our at a certain place with certain people now—like being at a station.
- Each child was asked to think of the first/oldest memory they have about their life (the starting station) and later share when was it what was their age (if they know it), what happened at the time, why they remember it/ why it was an important station for them.
- They were asked to narrate their story one by one.
- Most of the children shared their happy memories 'first day when my mother took me to the anganwadi', 'the time when I had climbed a tree and took all the mangoes from the neighbour's farm', 'the time I spent with my brother and sisters', and few of them shared their sad/difficult memories such as: 'the time when I was ill and how my family looked after me', ' my grandfather passed away, I was very close to him'. Facilitator provided acknowledgement and validation for the child's responses.
- After the first round of sharing the children were asked to share the next memory they had about their childhood.. Few of the children shared their happy memories and most of them shared Death of their parent, death of their brother, running away from home, their mother's illness, the day when I was so angry with my father and was about to hurt him very badly, as he had beaten up my mother'. few of the children while sharing were upset they were asked to relax; their emotions were acknowledged and validated.
- As the children started to share more of their difficult feelings and much later stages of their life, the children were asked to next share one of their life event when they felt proud about themselves. Few children found it easy to share their experience such as 'the day when I passed my 10 the exam', 'when I had won a prize in the school for dancing', 'when I had joined a job and was cooking very good food', 'when I got my first salary'. However, other children who had no memory to share they were reassured and helped them to remember the time when they have helped other and felt good about themselves, or the day when they were appreciated in the observation home for good behaviour etc.
- Then the children were asked to share one memory/ life event when they were very angry/ upset- most of the children shared the time when they were in the police station and how they were severely beaten up and punished physically and emotionally, the time when they were punished even when they have not committed any mistakes. The children's anger towards the police and the people who punished them without reason was validated and they were reassured 'of course you would be angry, if there is injustice then everybody will be angry'.
- As the children had raised the issue about physical violence a discussion about 'how people feel when they are physically abused' was done and they were asked – whether they have ever physically abused others without any reason, many of them said yes. Then they were asked to think and take a perspective about how people feel, and they were asked to remember the time when they were physically abused.

- Later, children were asked to think about the event which caused them to come to the observation home/ the event that happened before they were taken into custody by the police. After which all the children shared their experiences.
- They were also reassured, by telling them —every one of us would have experienced a traumatic event but yet we learn to move on and cope in the hope of being happy/finding joy. And this is made possible by remembering happy memories.
- All the children were thanked for sharing their most traumatic experiences and each of the children's experiences and their emotions were acknowledged and validated.

Observation and Analysis:

- As each child needs more than 5 to 8 mins to share one memory it was difficult to conduct session as planed- i.e. each memory of the child could not be discussed. Hence, it was decided each child will be sharing 4 most important memory of their life- one happy, one sad/difficult and one proud moment of their life, the event which caused them to come to the observation home.
- It was observed that all the children were very companionate to each other and were very sensitive while others were sharing their difficult memories.
- They also helped to lighten the mood by making few jokes and telling them a funny incident.
- The children were very thoughtful and were processing issues such as physical violence, in fact one child even said that 'from now on I will remember the time when I was in police station before hitting others'. This shows that children are processing and trying to relate their experiences before taking any further decision.
- When children were sharing the experience/ event which caused them to come in conflict with the law, many of the children were insightful and even said if I had not taken that step I would have been at home and finished my college by now. This shows that many children when they are with people who are non judgemental and do not giving advice/ criticizing them, they tend to be more open about their experiences and insightful about the decision they took which were not appropriate.

Session 3: Why do we get angry…?

Objectives: Examining various anger situations and ways of handling (inter-personal) conflict.

Methods: Listing,

Materials: Paper and pens

Process:

- The children were asked to sit in a circle. I asked if anybody will be able to tell all of us what we did in our last sessions; all the children were given opportunities to respond. Most of the children were able to recall.
- Introduction: In the last session we talked about our various life events and our life journey. We also spoke about the time when you were very angry and upset. Today let us talk more about it. All of us have a various types of emotions. There are feelings that make us feel good—like happiness and peace. And then there are some uncomfortable feelings such as fears, sadness and anger. Anger is a feeling that most of us experience at some time or the other. We feel angry for many reasons, such as people not behaving properly with us, when we do not get what we want or when we feel unfairly treated. We also show our anger in very many different ways, either verbally or with actions or with aggression. Anger affects has physically and emotionally. It affects our relationships. If we learn better ways to deal with our anger, we would not only feel calm and in control of the situations, we would also feel healthy. In this session, we are going to examine the reasons/ situations in which we get angry, how we respond, the consequences of our anger and ways to manage our anger better.
- Then children were asked to think of one situation which made them very angry and as the children enjoy drawing they were asked to draw that situation which made them angry.
- Children who did not want to draw were given option to write or narrate the incident.
- Children's responses:
- I was very angry the day when my mother was beaten up by my father and I really wanted to hurt him bad, for many days I did not speak to him.
- When I came to know that the people who have logged a case against me have destroyed our home put all our things and caused trouble to my parents.
- When another child in the observation home complained falsely against me even when I had helped him and supported him when others had caused trouble.
- When the guards here just scold us and use foul language against our family.

- When someone hits me or uses foul language.
- When I saw him (other child in the group) hitting other smaller children I was very angry.
- When I came to know that my mother's friend is teaching her to consume tobacco and also drink, I was angry with my mother's friend and fought with her. After which her friends and relatives came to take revenge, when I hurt them badly with a knife.
- I get angry when other accuses me of things which I haven't done.
- When I was riding with my friend near my neighbourhood, without reason 2 boys shouted at us and tried to bully us, as we were very angry, me and my friend later went and hit them with a rod and a sharp knife.
- After each child had shared their experience of anger their emotions were recognised and validated
- Later, the children were asked to think of their experience and share what they did when it happened and what else they could have done instead/ alternative way that they could have handled that situation.
- Children's responses for the above situation:
- I should have sat with him tried to understand why he was angry and then may be scold him than hitting him.
- I am still angry that I was not able to do anything; I want them to be punished.
- I felt like hitting him, but I did not as he was released. When the magistrate asked me, I did not speak in my defence, I wanted to.
- I feel like scolding back but I am afraid.
- Feel like hitting them and sometimes I do hit them.
- I hit him back and made sure that he asked sorry.
- I fought with that lady and slapped her, because of which her friends and relatives tried to hurt me.
- I sometimes fight and sometimes just keep it to myself.
- I should have just neglected it, or complained against them.
- During this facilitator pointed out strategies that some of the children had taken such as complaining and trying to talk and sort out the problem was appreciated.
- So, during the next session we will be discussing more about different strategies that we could follow in order to control anger and to ensure that we do not get in to trouble. How to manage anger.

Observation and analysis:

- It was observed on the contrary of other people's notion about children in conflict with the law, that they are children with behavioural problem/ spoilt brats they do not care for others. These children do not lack empathy they do have an understanding about how other people feel. But the issue of emotional regulation and managing one's own emotions is what they lack and they need to be thought how to do it using various techniques.
- Everyone in the home or other people in the society treat these children as the 'child who went to the jail' or 'trouble maker' 'children with behavioural problem' they never consider to even check whether the child has really done something wrong or he was falsely accused and thus they treat them with no respect and criticize/ judge them based on the case they are charged with.
- Most of the situations that they shared were related to physical violence and the injustice that they have experienced. This gives us an understanding about the children's experiences of abuse and trauma, which has great implications on the children's current behavioural issues.

Session 4: Managing and Controlling Anger

Objectives:

- Generating awareness of emotional regulation
- To help children develop an awareness of situations of provocation and the ways in they respond or express their anger.
- To enable children to examine the usefulness of their responses and discuss alternative ways of expressing anger and responding to conflict or problem situations.

Method: Listing, discussion.

Process:

- The children were asked to sit in a circle and were asked to do a recap about the previous session. All children were able to recall and they were able to recall most of the sessions.
- Introduction: as I had said in the last class that today we will be discussing various methods in which we could control anger and alternative methods that we could follow or use in order to ensure that our anger has not caused harm to us or others.

- Further reiteration was done to emphasise 'Feeling angry is not wrong'. The important thing is what we do with our anger and how we respond. If we respond in ways that do not hurt others or us, it is alright; but if we respond in ways that hurt others or us, then it becomes difficult we get into trouble.
- Further, 'At the same time we don't say that you should just keep quite if your angry, because it is unfair and you need to express it. If we do not get it out or we do not express then all the anger will accumulate and keep on building up… one fine day it burst out just like a balloon which has too much of air'. And also when we are angry because we have been treated badly/ unfairly then we have to be angry… we need to defend ourselves. If we don't then people start taking advantage of us. So, it is very important to manage our anger in ways that are effective and do not hurt others or us.
- Children were asked to list few techniques that they know / tried which might help to reduce anger. Together a list was created as follows:
- Tell the person 'I am angry with you because…'
- Complain to the police/ elders.
- Ignore & Walk Away
- Punch a pillow or tear some newspaper
- Slow breathing/ counting from 10 to 1.
- Washing your face, exercise.
- Play a game/ watch TV.
- Write it out or draw it out!
- Tell the person 'Stop it…I don't like it because…'
- Go to your cool down place and take deep breaths.
- Walk away, after some time when other person is calm try to talk/negotiate.
- The children wanted to further discuss situations where in they are angry and they are in great danger, for example- what if 4-5 people are armed and want to hurt us if we don't hit back or defend ourselves we will be killed'. The children's views were validated; of course when you are in danger we don't ask you to try to negotiate or to be calm which is impractical. We should then try to think of ways in which we could handle the situation in the best way where no one is hurt like- calling up the local people/ screaming for help/ calling the police etc.
- The children were also asked to think why/ how they would have come into that situation, is it because they have fought with them previously/ they are trying to hurt to take revenge, or are it a onetime situation where in they are trying to rob from you. When it is due to revenge then there is always a way in which you could avoid such a situation or to negotiate even before coming to this situation. However, sometimes you might have to defend yourself to save yourself.
- Children were thanked for their active participation and also asked to try to practice some of the techniques when they are angry net time and to share it with us in the next session.
- Later, children were given two situations and asked to prepare a small skit during the next session where they need to enact what was the initial response and what would they do differently now after learning few anger management techniques to ensure that no one will be hurt.
- When I came to know that my mother's friend is teaching her to consume tobacco and also drink, I was angry with my mother's friend and fought with her. After which her friends and relatives came to take revenge, when I hurt them badly with a knife.
- When I was riding with my friend near my neighbourhood, without reason 2 boys shouted at us and tried to bully us, as we were very angry, me and my friend later went and hit them with a rod and a sharp knife.

Observation and Analysis:

- The children were very thoughtful and insightful.
- When children were doing a recap -there responses showed that they were thinking and were processing the sessions. They had thought about the discussion which was done.
- Children were excited to prepare and enact a skit- the enthusiasm showed that the children are keen to spend time and participate in these life skills sessions. Using different methods such as art/ narration/ listing / discussion/ theatre techniques to develop life skills is effective with children especially adolescents.

Session 5: Further Exploration of Alternative Ways to Manage Difficult and Provocative Situations

Objectives:

- To enable children to examine the usefulness of their responses and discuss alternative ways of expressing anger and responding to conflict or problem situations.

Method: Role play

Process:

- All the children were greeted and asked whether they have prepared for the skit. Children shad prepared with one situation
- The children were excited and had even practiced to enact. Children were asked to enact the situation first and then to enact what would be the best way in which they could have responded.

Situation: 1:

Scene 1

Two boys Nikhil and Shahid riding a bike (speeding) and honking loudly. Two other boys standing nearby started verbally abusing and trying to hit them. They try to fight back but as many people gathered around they rode away.

Scene 2

Nikhil and Shahid go back home and discuss that we have to teach them a lesson. They decide to take a large metal rod and a knife to threaten them.

Scene 3

Nikhil and Shahid armed with a metal road and a knife, go in search of the two boys who tried to hurt them. They see one of the boys and hit him and Nikhil threatened him with a knife. During this the boys is hurt badly and falls down. People from that area noticed and came to help him. Then Shahid realising that they had hurt the boy badly stayed and took him to the hospital, where as Nikhil ran away. Shahid was arrested by the police.

Alternatives for Situation 1:

Scene 1

Two boys Nikhil and Shahid riding a bike (speeding) and honking loudly. Two other boys standing nearby started verbally abusing and trying to hit them. They try to fight back but as many people gathered around they rode away.

Scene 2

Nikhil and Shahid go back home and discuss that we have to teach them a lesson. Nikhil suggest that they hit those two boys so that they would not trouble them in future. Shahid refuses and says 'they tried to hurt us, but if we hit them back then we are doing the same thing as them, let us think properly and decide what to do, let's talk to my elder brother so that he will suggest what best we could do. If we hit them and they complain then we might get caught by the police.

- The children were thanked and appreciated for their excellent depiction of the situation. The children were appreciated for their thoughtful alternative which they suggested.
- Discussions on how both the responses were different, which was better and why? Was done with the children. This was done to generate an insight among the children regarding how few decisions/actions will have greater impact/implications on interpersonal relationships, socially and legally.
- Discussions were had to reiterate that getting angry is not the problem/ wrong the way in which we respond to it might create problems.
- When we are very angry/ sad our mind will be completely occupied by it, during which we won't be able to make appropriate decision. Hence, it is always best to relax/ walk away to bring down the anger a little bit and then think when we are relaxed. An example was given to ensure that the children understand the concept well, 'when we a window glass is dirty you cannot see through it, once you have cleaned it you will be able to see similarly when we are angry or upset we won't be able to think clearly just like a dirty window, but once we are calm (the window is clean) we will be able to think better.
- The session ended by congratulating the actors and all other children applauded.

7. Systemic Issues & Implications for Juvenile Justice System Policy and Practice

7.1. Assistance to CICL: A Systems Issue

Thus far, the document has described the CICL's vulnerabilities and pathways of offence, methods and proformas for assessment, including preliminary assessment, and psychosocial and mental health interventions that require to be made available for CICL. However, for care, protection and assistance to be provided to CICL, there needs to be a consolidated systematic approach to actually make things happen on the ground for children. There are several stakeholders who work within the Juvenile Justice System to provide assistance to CICL:

- Police (specifically the Special Juvenile Police Unit, where available) are the first contact of the child who comes to the juvenile justice system.
- Superintendent and staff/ counselors of the observation home are responsible for provision of food, shelter, healthcare, protection and rehabilitative facilities and opportunities for CICL on an immediate and continuous, day-to-day basis.
- Juvenile Justice Board (including the magistrate and other members) execute socio-legal rehabilitation and reformation functions in accordance with the JJ Act.
- Health and mental health services/ teams assess and provide assistance to CICL on medical and psychiatric issues.
- Non-governmental organizations and other individuals, depending on their mandate, assist the staff with provision of sports, leisure and recreation, vocational training and life skills activities.

Additionally, of course there are larger systems within which the above-mentioned stakeholders work: the staff of the observation home work within the Dept. of Women and Child Development (or the Dept. of Juvenile Welfare in some states) and within the department several staff are appointed under the central government Integrated Child Protection Scheme (ICPS), whose function is care and protection of children in difficult circumstances; under ICPS, the District Child Protection Unit (DCPU) in each district as a fundamental unit for the implementation of the scheme i.e. it coordinates and implements all child rights and protection activities at district level. Other than the JJB magistrate, other members of the JJB (usually with social work/ psychology or legal backgrounds), are appointed by the Dept. of Women and Child Development.

The police are stakeholders as they are the first people who apprehend a child alleged to be in conflict with law. They are then responsible for making inquiries about the case and submitting a charge sheet, which goes into the child's file and is used by the legal authorities, including the JJB. The police also have the authority to immediately release a child on bail (at the police station).

The JJB magistrate is a member of the judiciary, as a metropolitan magistrate or a judicial magistrate of the first class. JJB magistrates' terms vary, so every year, or sometimes even within a few months, new members from the judiciary are appointed to the position. The magistrate is often the person who plays the most critical role in the socio-legal rehabilitation of CICL because ultimately, it is it is she/he who makes decisions and passes orders for the CICL's future, in terms of placement and care.

The health and mental health teams may be drawn from facilities available in the district—usually, government medical hospitals at district level, provide medical and health assistance. When it comes to mental health and psychiatric concerns, the issue is less clear. Some JJBs have reported that they seek the assistance of government medical hospitals having departments of psychiatry (although almost none of them have specialized child psychiatry personnel); some report approaching private psychiatrists in the district; many JJBs have reported that they are at a complete loss as to where to obtain preliminary assessments or to send CICL for assistance. Remote rural districts find it especially difficult to organize parents or teams to send

children to larger cities where mental health assistance may be available. (Incidentally, Child Welfare Committees also face the same challenges).

Ultimately all the assessments and interventions that have been proposed and discussed in this document can only happen on the ground if the relevant stakeholders function, individually and collectively, to assist CICL. This final chapter of the document thus raises various systemic concerns and challenges that have been observed during the course of the NIMHANS team's work. While we recognize that observation homes in various Indian states may work differently and may have different challenges and concerns, our attempt is to flag up at least some of the gaps and systemic challenges we have experienced, along with recommendations to address them.

7.2. Concerns & Challenges: Related Recommendations for Policy & Practice

A. Institutional Issues

A.1. Engagement of children through structured daily activities

The Project team's observations show that children in the observation home are not really engaged productively all day. The existing schedule is neither one that is concrete with activities that keep children busy all day, nor are the activities rehabilitative in any way i.e. there are no sessions to enable children to reflect on their offences, life skills sessions to equip them to do things differently in the future (and thereby prevent them from coming in conflict with the law again), vocational training programs aimed at increasing the rate of successful reintegration of children into society.

Consequently, children are expected to transform, without any skilled inputs, to change their behaviours. Transformation is expected to occur merely based on the fact that they are in the Observation Home—which then implies that being in the Home is a punishment, thereby suggesting that the JJ system follows a retributive system of justice rather than a rehabilitative one at least, let alone a restorative justice system. It is indeed unjust to expect that without any reflection or guided processing children are expected to transform, even with their vulnerable background and life skill deficits. The lack of opportunities for transformation will also only serve to increase rates of recidivism.

Despite providing materials for indoor games, demonstration and the pleas of the Project team, the OH staff did not conduct activity sessions and all the games, puzzles which was provided was just locked up and not used. The justification of the OH staff is that the children will 'break and destroy' all the games and materials. These prejudices and lack of proactive actions towards the children are harmful because:

i) they do not allow the OH then to serve as a rehabilitative centre, one that provides children with opportunities to change or enhance their (social) behaviours—consequently, the OH gets reduced to a detention centre, which it is not intended to be;
ii) they do not enable children to be gainfully occupied, thus actually resulting in more fights and unnecessary chaos in the Home;
iii) they contribute to an institutional culture that is hierarchical and oppressive, thus increasing vulnerable children's anger and mistrust of the world, in particular of the adult world—thus leading them to continue their defiant or anti-social behaviours.

A.2. Institutional Culture in Observation Homes

The difference between an observation home as a place of detention versus a place of reformation and opportunity is critical. The hierarchy of authority in observation homes, whether it concerns the administration staff or other support/ security staff is such that the functioning of the institution is run along the lines of jail culture. Inducting children in the maintenance and cleanliness of a home, when presented as a joyous and collective responsibility of the family as an institution, is a positive culture. The use of 'menial' chores as a means of punishment for apparent infractions is a negative institutional culture practice—it leads to more resentment and alienation, thus compromising the very spirit of juvenile justice.

A.3. Child Safety

In continuation with the above discussion on institutional culture, the induction of children into work that is otherwise to be carried out by the institutional staff creates both a level of familiarity and access to materials and implements, which then come into use during times of resentment and retaliation. There are serious safety issues involved in getting children to engage in institution chores as they then have access to knives and objects/ substances they could hurt themselves and each other with—given that many CICL have difficulty with emotional regulation and impulse control, engagement in certain chores can result in injury and hurt. They also have access then to institution keys and electrical systems, and children have tended to use this access and knowledge of the institution working to run away from the home at opportune times.

Recommendations for Policy & Practice (I): Institutional Issues

(i) The importance of a daily schedule and engagement of children throughout the day, in a variety of activities, cannot be emphasized enough. Daily routines and activities are important because they give such children opportunities to be gainfully occupied and regulate themselves; certain types of activities such as indoor games help enhance their sitting tolerance and attention spans, as well as their social skills.
Children will learn and behave as they are treated—if treated with respect and given responsibility, they respond in the same ways, if they are not respected and trusted, children will have no motivation to behave better or differently. It is imperative therefore for Observation Homes to create a culture of respect and nurturance i.e. for caregivers to change their orientations towards children in ways that allow them to show empathy and respect. Such orientations are only possible when institution staff are put through intensive training programs wherein, through their learning on the difficulties of CICL, they are able to adopt a vulnerability (versus a criminal) lens to these children, and see them as requiring assistance.

(ii) We are not suggesting that children should not help with institution chores. But this depends on whether this is presented to them, and experienced by them as a formal institutional culture, of affiliation and belonging. There has to be a healthy balance between monitoring the use of various tools and implements used for various chores, and the maintenance of the institution.

Furthermore, careful choices may require to be made about which children (based on psychosocial and mental health assessments) may be engaged in certain types of chores i.e. those who have less prominent impulse control and emotional regulation issues, for instance, may be selected to help in the kitchen—even so, there needs to be close supervision and monitoring, ensuring that all tools and implements are returned and no longer accessible to children, after they have been used for work purposes.

B. Mental Health & Child Rights Concerns

B.1. Lack of Vetting and Training of NGOs Assisting CICL

Public-private partnerships are to be encouraged, and the challenges of staffing shortages could be plugged through the engagement of non-governmental agencies (NGOs) to provide recreational, rehabilitation and counseling services to the children. However, it has been observed that many a time, NGOs and volunteers are engaged by the authorities to work with the children in various capacities, without adequate and appropriate vetting and training. Given the challenges of working with CICL, and their specific vulnerabilities, it is essential to vet NGOs and volunteers, in terms of their orientations to CICL, their skills and experience in working with such children, before permitting them engage with them.

For instance, we have known some religious agencies, whose good intentions towards the children are not in doubt, to engage in ways that have been damaging to the children i.e. approaching such children from solely moralistic point of view, without a deep understanding of their vulnerabilities, tends to result in moralizing to them to 'be good' or 'behave better' in ways that are hollow; such ways of engagement are therefore judgmental and have tended to make children feel increased anger and/or extreme guilt—both of which are likely to translate into further high risk behaviours.

Another trend that has been observed is of counselors with limited or no experience, who are permitted access to the children; they often have no training or orientation in working with CICL, and so tend to administer assessments and provide inputs that are technically incorrect, thereby doing more harm.

B.2. Mental Health Objectives in Conflict with Legal Agendas

When children who have committed an offence come to the Observation Home, as per the rules of the Juvenile Justice System, they usually have a lawyer appointed for them. Children are almost immediately told ('brain-washed') by their lawyers not to admit to the crime they have committed, 'no matter who asks, no matter for what purpose' according to the OH staff reports. This is in the interests of them getting bail soon or going free, and so from a legal perspective, such methods may be perfectly legitimate. Child rights activists and legal professionals have also raised , in this context, the issue of self-incrimination i.e. that if children were to admit to the alleged offence, this would not be in keeping with the constitutional right of a person to refuse to answer questions or otherwise give testimony against himself or herself, which will subject him or her to an incrimination.

However, from a mental health perspective, the child's not admitting to the offence is counter-productive—unless the child admits to the offence, it is not possible to work on transformation through provision of psychotherapy. This has made providing therapeutic inputs in certain cases very difficult as children deny that they have committed an offence. Psychotherapy and restorative justice processes rely on acknowledgement of the problem or insight into one's problem as a first step towards transformation—if acknowledgement of and insight into the problem are not there, there is no basis for behaviour change.

B.3. Barriers to Treatment of Mental Health Disorders

Mental health services face yet another challenge in the Observation Homes, namely the use of medication to treat neuro-developmental disorders such as ADHD, and any other psychiatric disorder that might require pharmacological interventions. This is so even with provisions made by the JJ Act, 2015 and the United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990)[29] that the juveniles are not to be denied of mental health assistance or any prescribed medical interventions.

During the course of individual mental health assessment of children in the Home, the project experienced difficulties in obtaining permission even with legitimate NIMHANS medical processes and prescriptions. There are several problems with denying children in conflict with the law psychiatric medications when they require it:

- Allowing for children in care and protection to receive psychiatric medications but not for children in conflict with the law is clearly discriminatory and very much against the spirit of the JJ system.
- It is a violation of children's rights to health and to treatment when they are ill.
- Not allowing for treatment for mental health disorders such as ADHD will result in children's inability to make the necessary behaviour changes and to prevent recidivism.

When the Project approached the JJB magistrate concerned and the Dept. of Women and Child Development for permission to prescribe psychiatric medications, with due documentation and hospital prescriptions, the

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[29] The United Nations Rules for the Protection of Juveniles Deprived of their Liberty—On Issues of Medical Care, states that "A juvenile who is suffering from mental illness should be treated in a specialized institution under independent medical management. Steps should be taken, by arrangement with appropriate agencies, to ensure any necessary continuation of mental health care after release.

Section 53- Juvenile detention facilities should adopt specialized drug abuse prevention and rehabilitation programmes administered by qualified personnel. These programmes should be adapted to the age, sex and other requirements of the juveniles concerned, and detoxification facilities and services staffed by trained personnel should be available to drug- or alcohol-dependent juveniles. Section 54- Medicines should be administered only for necessary treatment on medical grounds and, when possible, after having obtained the informed consent of the juvenile concerned. In particular, they must not be administered with a view to eliciting information or a confession, as a punishment or as a means of restraint. Juveniles shall never be tested in the experimental use of drugs and treatment. The administration of any drug should always be authorized and carried out by qualified medical personnel.

DWCD was willing but the JJB magistrate at the time was not—and disallowed the NIMHANS team from working in the OH from then on. The NIMHANS team was only able to return to the Home about three months later to provide psychosocial services to CICL when that JJB magistrate left and a new one came in place of her, following which permissions were obtained once again to re-start work. This incident is also indicative of how despite the existence of the JJ Act and protocols regarding the health/ medical treatment of children in state custody, individual magistrates and service providers may or may not adhere to these or act in the best interests of children, thereby depriving children of their right to health and treatment.

B.4. Children's Rights to Growth and Development Hindered by Unnecessary Legal Bureaucracy

It was observed that the Home also housed some younger children (13 to 14-year olds) who had been convicted for mild offence (theft). These children came from backgrounds of severe emotional abuse and neglect, with parents who were alcohol dependent and did not come to bail the children out. However, in many cases, the legal bureaucracy persists, stating that it is 'unable to close the case' since the parents of the children do not show up in court; when asked what would happen if the parents never came and how long these children will continue to remain in the observation home, the answer is 'until the case is closed', with no definite timelines on how soon this can happen.

As a result, these children were in the observation home for months on end, denied education and other opportunities that they could avail of if they are shifted to a care and protection home—which is where they should be considering their difficult family circumstances/ the inability of their parents to care for them. Furthermore, when younger children and adolescents are housed with older adolescents engaging in offences (and mere separation of sleeping spaces is not enough), the former group is at risk of being influenced by the latter—we have, for instance, observed younger adolescents in the observation home acquire new habits of aggression and substance use due to the influence of their older peers.

In fact, there are many children in care and protection institutions, who have committed far more serious offences than some of these children in the observation home; however, they are not in the observation home only because schools/ families/ communities have not (yet) complained about them. This also goes to show that the categories created by the JJ Act i.e. children in care and protection and children in conflict with the law are artificial—in reality, they come from similar backgrounds and circumstances, which result in the same risks and vulnerabilities. Every child in conflict with the law, thus was and continues to be a child in need of care and protection.

Recommendations for Policy & Practice (II): Mental Health & Child Rights Concerns

(i) Need for Vetting & Orientation of NGOs and Volunteers

As a matter of general principle, in all child care institutions, not just in observation homes, all NGOs and volunteers should be vetted before allowing them to engage with children. Since the institution superintendent and authorities may not always have the requisite technical expertise to vet these agencies and individuals, it may be preferable for them to contact recognized government institutions and personnel, with technical expertise in child mental health, to help them with these vetting processes. Following the vetting and selection process, there should be basic orientations with 'Dos and Don'ts' for persons who will be visiting the Home and engaging with the children. For instance, if the persons concerned are to be doing art or other recreational activities with children, they should not engage children in discussions about their offence or try to provide advice and inputs—as they are unlikely to be aware of many other issues pertaining to the child. Given the somewhat vague definitions of a 'professional counselor' in India and the lack of licensing and regulation, thereof, infinite caution needs to be exercised in who is permitted to administer psychosocial and mental health assessments to individual children and develop preliminary assessment reports for them. As it has sometimes proven to be difficult to monitor and streamline counsellors from NGOs and private agencies, it is recommended that the children are assisted in mental health matters by government personnel, namely,

Departments of Psychiatry in Government Medical Colleges or the District Mental Health program (so that there is at least a minimum level of accountability within the system). However, these mental personnel would also require training and capacity building as many of them do not have the requisite knowledge and skills in child mental health and in the specific area of CICL. Where government personnel are not accessible, NGOs may be called upon to provide counselling services, but never without appropriate training and supervision by technically competent child mental health personnel.

(ii) Differential Role of Lawyers in the Juvenile Justice System

Legal processes and methods that are counter to mental health and transformation are not beneficial to the child or his/her future nor to society as a whole. Therefore, the concept of self-incrimination should not be applied within the juvenile justice system—and legal personnel should be trained to take a different perspective when defending child clients. Where children have allegedly committed an offence, and children acknowledge their offence, the lawyers purpose should not be to obfuscate the offence and prove the child innocent; it should be instead, to argue that the child is a victim of his/her vulnerabilities, that in turn placed him at risk of coming into conflict with the law…and that in the light of his/her vulnerabilities, and in keeping with the legal principles of proportionality and mitigation, the child should be accountable but in ways that are developmentally appropriate; the lawyer's argument could be against transfer to the adult criminal justice system (where section 15 is applicable) and advocate for psychosocial care and rehabilitation of the child. Thus, the role of legal personnel in the juvenile justice system is (and must be) different from that of legal personnel in the adult criminal justice system. If legal personnel were to assume the suggested role, then there would be no conflict between legal and mental health agendas.

Thus, only legal processes that allow children to tell the 'truth' without fearing the consequences can be supportive of the mental health processes that need to take place for children to transform—and indeed, the essence of the Juvenile Justice System is to allow children a chance at life, to support them to change and be socially responsible well-adjusted citizens. After all, the main premise of placing juvenile offenders under the JJ system instead of within the adult criminal system is the belief that children cannot be put in the same category as adults under the Criminal Justice system of the country and given their physical and mental immaturity and dependence on others, require special provisions.

(iii) Facilitating Access to Treatment of Mental Health Disorders & Developmental Disabilities

No child can be denied the right to mental health treatment—and all institution staff and legal personnel must be oriented to this way of thinking. Logically speaking, if a child has the right to be treated for typhoid or an injury or fracture, the child equally has the right to receive treatment and assistance for mental health problems, whether it is for a developmental problem such as intellectual disability or attention deficit hyperactive disorder (ADHD), mental illnesses, emotional disorders such as anxiety and depression, substance use disorders, and life skills deficits. Indeed, if behaviour transformation is the goal, as it must be for successful rehabilitation, and prevention of recidivism, providing access to mental health services is critical for CICL.

(iv) Prioritizing Child Development & Protection over Bureaucracy & Legalities

JJ processes should recognize the vulnerability of younger children and adolescents, the hopelessness of some of their families coming in to bail them out or indeed to take care of them, and see them as children in need of care and protection. They must, without delay, transfer such children to care and protection homes, where they can avail of education and other developmental opportunities, as such measures are most likely to protect children from coming into conflict with the law. Lengthy bureaucratic and legal procedures cannot be prioritized over children's rights, development and welfare.

Suggested Roles for Child Mental Health Professionals in Assisting Children in Conflict with the Law

In other parts of the world, based on their understanding and experience evaluating children and adolescents, their knowledge of child psychopathology, normal child/adolescent development, and risk factors for future antisocial behaviours, are involved with juvenile offenders in many different ways. They may be involved in forensic evaluations, which pertain to risks assessments, child's competency or capacity to commit offence, damages caused by the harm. Assessments may also entail risk is for recidivism; whether the adolescent can be rehabilitated and should remain under juvenile court jurisdiction; whether the charges should be waived or transferred to adult criminal court; whether there were mitigating factors involved; and whether the adolescent had a diminished capacity or was not guilty by reason of insanity, based on the child's age, development, and maturity play a significant factor when evaluating a child.

In the context of the Indian juvenile justice system, the role of mental health professionals, whether they are child psychiatrists/ psychologists or social workers, vis-à-vis children in conflict with the law, can broadly be as follows:

i) Provision of Psychosocial & Mental Healthcare Assessments and Treatment-Rehabilitation Services to CICL

Child mental health professionals may be involved in psychosocial care and mental health assessments which seek to identify the degree of impairment in children with emotional, behavioural, neuro-developmental disability and substance abuse symptoms and disorders with a view to providing treatment for these psychiatric and developmental problems. The objective here (as against to forensic evaluation) is treatment and rehabilitation of the child, and not to highlight or emphasize the child's so-called criminal activities or capacities. CICL often come from exceedingly difficult family contexts, with experiences of trauma and abuse, thereby overwhelming their capacities to cope, and making them vulnerable to various mental health issues.

As discussed elsewhere in this document, some of the common child and adolescent mental health disorders seen in CICL are behaviour problems such as Oppositional Defiant Disorder (ODD), Conduct Disorder (CD), substance abuse and Attention Deficit Hyperactivity Disorder (ADHD—which is also a neuro-developmental disorder). However, children may also have emotional problems such as post-traumatic stress disorder (PTSD), anxiety and depression which, in turn, manifest as behaviour problems i.e. such difficult emotions may result in substance abuse behaviours or anger/ aggression behaviours. Consequently, the role of the mental health professional is to use pharmacological and other (psycho)therapeutic methods to treat these children's disorder—corrective measures and treatment of emotional and behaviour problems, along with other rehabilitative interventions (social/ educational/ vocational) will ensure the larger objective of preventing recidivism.

Child mental health professionals must also therefore, based on their assessment and interventions with CICL, make requisite recommendations to the juvenile justice board, for placement, education and vocational training, and related rehabilitation and social reintegration actions. This will ensure continued care and protection of these vulnerable children by the JJ system.

iii) Development of the Preliminary Assessment Report

Although the JJ Act states (under Section 15) that preliminary assessments should be implemented by the JJB, the provision also states that *'the Board may take the assistance of experienced psychologists or psycho-social workers or other experts'*. Also, there is the risk of a conflict of interest when the JJB implements the preliminary assessment and then subsequently makes the decision regarding transfer to the adult system.

In order to avoid such problems, and to ensure that the child receives justice, it is recommended that the JJB asks for assistance from child mental health professionals in developing the preliminary report (such as the Karnataka JJBs do when they refer 16 to 18 year olds who have allegedly committed heinous offences, to the Dept. of Child & Adolescent Psychiatry, NIMHANS, for preliminary assessment report). This ensures greater scientific accuracy in responding to the questions of the 'child's mental capacity' and the 'circumstances' as mental health professionals would have the technical knowledge and skills to provide details on a given child's intellectual capacity, mental health problems and life skills as well as a detailed history of the child's circumstances, thereby providing the JJB with a clear picture on the child's background and vulnerabilities. Such a detailed but unbiased report, would be useful in assisting the JJB in making decisions regarding transfer of the child.

It is to be noted that we are in no way suggesting that mental health professionals make the decisions under Section 15—the decision to transfer (or not) is exclusively within the purview of the JJB. Considering that Section 15 of the JJ Act also goes on to clarify that the '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', the preliminary assessment report developed by mental health professionals would be akin to the testimony provided by expert witnesses in child sexual abuse cases, under the POCSO 2012 Act—wherein mental health professionals, who have first-hand knowledge of the child because they have examined (interviewed) and treated the child (including developed reports based on this work), and so are able to provide expert opinion on the developmental abilities of the child and the psychological effects of sexual abuse on the child. We are proposing a similar role for child mental health professionals in the context of preliminary assessment—wherein the mental health professional has the clinical skills and expertise to provide what is known about the child with what is called a reasonable clinical certainty.

(iv) Training of Institution Staff, Caregivers and Legal and Judicial Personnel on CICL Issues

Finally, as recommended in various ways already, we suggest that child mental health professionals participate actively in training and capacity building the various stakeholders in the juvenile justice system, namely Institution Staff and Caregivers, the police and SJPU, lawyers and judicial personnel, and the mental health fraternity at large, in issues pertaining to CICL. As mentioned, training needs to focus on understanding the vulnerabilities of these children, including their pathways to offence, administering psychosocial care and mental health assessments, developing preliminary reports and providing essential treatment and rehabilitation interventions to CICL. The training may vary slightly in content, based on the role of the concerned stakeholder—for instance, orientation and sensitization sessions for legal and judicial personnel but skill and capacity building for counselors.

C. Legal and Judicial Considerations

C.1. Police Interactions with CICL

Given the generally disempowered situation of children, power dynamics tend to play out in situations where one party, by virtue of age is younger, weaker, defenseless and allegedly in the wrong. Violent expressions of authority and its coercive forms tend to play out more against people who are hierarchically weaker—and such is the case with CICL. There is also the issue of a strange and perverse moral legitimization of violence against so-called/ alleged offenders—and much of this stems from moralistic and retributory forms of justice. Such positions, and their resulting actions therefore completely excludes a rights-based approach to CICL, also overlooking their vulnerabilities, and their needs for reformatory and rehabilitative interventions. In the light of this, while it would be unfair to generalize the view to all police and SJPU, it would not be incorrect to say that police brutalities towards CICL are quite common, across the country.

According to the JJ Act 2015, children alleged to have engaged in offence by the police, should be placed under the charge of the special juvenile police unit (SJPU) or the designated child welfare police officer. The concerned police officers should produce the child before the Juvenile Justice Board without any loss of time, within a period of twenty-four hours of apprehending the child. In reality, however, CICL report that they are often detained in the police station for a few days; many police stations do not appear to be staffed with SJPU or child welfare police officers. During the time CICL spend in the police station, they report facing physical violence by the police. Police brutalities, especially in instances of juvenile justice, constitute serious medico-legal concerns as well human rights violations.

When police come into contact with children and adolescents who have allegedly committed offence, they have a fair amount of discretionary power in terms of what actions and decisions to take. One reason why this power is often exercised arbitrarily is because police are not always conversant with the provisions of the juvenile justice law and child rights issues and because children and their families are not aware of their rights either.

Children's Experience of the Law & Order Systems

- Many children who were admitted in the observation home for the second time were charged in various cases on the basis of suspicion by police i.e. being involved in offence once has made them susceptible to being apprehended repeatedly even without real evidence. Anecdotal information also has it that when the police are not able to find the offenders in a particular situation, they tend to put charges on the children who have a history of being in conflict with the law, even if they have not committed an offence. All this is extremely worrying from a child rights perspective and there is a great need to sensitize the law and order systems to children's rights and issues, particularly those of CICL.
- Many children reported that they were detained in the police station for more than 24 hrs before being produced before JJB/SJPU. They also reported that they were physically as well as emotionally abused by the police officers.
- Many children also reported that police officers, after taking (offending) children into custody, use physical violence to threaten and coerce them into accept that they have committed the offence. The reasons for this are not clear, except perhaps to conclude that this is another form in which power and hierarchy, in combination with and the culture of violence and marginalization, plays out in adult-child relationships.
- Almost all the children are not aware of the protocol/procedures of the JJ systems.
- It was also noted that many police officers provided names of lawyers known to them, insisting that children use these persons to assist them. Anecdotal information suggests that the police benefit when the children use lawyers recommended by them, and that this gain leads police to 'unnecessarily' apprehend even those children who have not committed any offence.

C.2. Legal Awareness Programs for Children

Given that CICL's primary preoccupations are with issues of bail, release and case closure, and that these create enormous anxiety and other emotional problems for them while in the observation home, one of the most important inputs from CICL's perspective is legal awareness sessions or programs. Unfortunately, few legal awareness programs have been developed in a manner that is even remotely comprehensible to children. Given how difficult the law in general, including the JJ Act is, for a lay person to comprehend, for children, that too those from vulnerable backgrounds, of little education, it is nigh impossible to understand. In our experience, the institution authorities call upon personnel from relevant legal service agencies, to conduct such programs. These personnel, who appear to have no child orientation, read from their law books in formal, pedantic ways, stopping every now and then to loudly ask the children 'did you understand'…to which a silent, bored, restless, bemused adolescent audience is startled into replying 'yes, Sir'! Such scenes almost parody the Victorian world of the Dickensian era and form the script for a tragicomedy, albeit a depressing one! Such sessions last for a few hours, at the end of which children are none the wiser about their legal situations, let alone being aware of their rights. Their one benefit is that the session warrants a special lunch—at least a sweet! Everyone is simply relieved that the session is over and the institution authorities are content to have done their duty i.e. to organize a legal awareness session for the children, and to have ticked the boxes, as mandated by laws and procedures. Furthermore, we are uncertain whether legal awareness programs are conducted at all in some observation homes, based on our experiences in other parts of the country.

C.3. Inadequate Skills & Capacities of Juvenile Justice Board Members

Perhaps one of the most challenging (and time-consuming) tasks of the Dept. of Women and Child Development, and agencies assisting the department, has been the selection and training of the JJB members. Experience with assisting the department in these processes has yielded much food for thought on the selection, training and functioning of the JJB. (Again, while the NIMHANS Project's experience has been in Karnataka, having worked with other states, and conducted training for their child care service providers, we are given to understand that the issues are similar there).

To begin with, selection of JJB members is a difficult task because while there are many applications, very few of them are actually suitable for child work. This is not because they do not have the requisite educational qualifications, whether in social work or law, but because they do not have the skills for interactions, assessment and interventions with children; even those who claim experience in children's organizations, have very little idea about methodologies to communicate or work with children. Basically, they lack the 'right' orientations for child work. What this means is that many applicants (and members) are well-intentioned, and may have or express deep concern for children. however, the ways in which these intentions and concerns translate into practice are often not helpful to children, in particular to CICL. When adult responses are predicated on strong personal viewpoints, moral considerations and the legal rule-book, children are unlikely to be responsive or cooperative; they simply feel judged and that the JJB member is 'one more adult who thinks that I am a bad person'. In such adult-child interactions, CICL are particularly unlikely to acknowledge offences and cooperate with treatment and rehabilitation recommendations. Our experience shows that most JJB members view children through a morality lens rather than a vulnerability lens, so the orientation is problematic to begin with, and does not bode well for future work with these children.

Arguably, then, the aim of training and capacity building is to provide the selected JJB members with the so-called 'right' orientations to child work, as well as methodologies and skills to be able to interact and work with CICL. There is usually no lack of willingness on the part of government departments to organize and provide for such training programs. Indeed, innumerable training programs, of varying types, content and quality have been organized: some are more legal in nature and focus on the technicalities of the JJ Act and its implementation, while others are about psychosocial care of CICL; many of these training programs are also conducted by individuals and agencies who do not interact with CICL i.e. with individual children, on a day-to-day basis, and consequently, have no understanding of who these children really are or what their lives are about. Thus, when training is conducted by individuals or agencies who either have purely theoretical knowledge (whether in law or in mental health), or who have had some intermittent engagement with policies and systems, the quality of training for JJB members (or indeed any cadre of child care service providers) is adversely impacted. Such trainers and facilitators have no idea about practical skill training or about how to enable participants to address the challenges and realities of the field.

Further, when training programs are organized as a tokenism rather than a serious teaching and learning initiative, which calls for investment of time and (public tax payers') money, and organizers, trainers and participants see the attendance of these programs as 'ticking the boxes', then there can be no impact on learning, and consequently on practice of child work. Such training programs, it is observed, do not use creative pedagogical methods, tending to resort to powerpoint presentations and lectures, according to cut-paste agendas i.e. one trainer following the next, and lecturing, with little idea on what the previous person taught.

Coming to the participants' issues with regard to training and capacity programs, our experience in organizing and facilitating innumerable such workshops across the country, for government and non-governmental agencies and varying child care service providers, including JJB members has been somewhat checkered. While, undeniably, there are a few individuals who are deeply committed to learning and practice, and are observed to ask pertinent questions, take notes and presumably carry new ideas and learning to the field, a large number of them, alas, do not. Others have tended to arrive late for the training, be passive and disengaged or said 'we don't need to be told on how to deal with children' either because they have apparently worked for years in children's agencies or worse still, because they have children of their own and therefore 'simply know'.

Interestingly, when such JJB members have been asked, as part of the training workshop, in order to develop orientations and sensitivities to children, to recall their own childhood experiences, many of them found it very difficult to do so. This is reflective of how they have such a limited concept of children and childhood; and how hard it is for them to transcend their adult perceptions and experiences and make the shift to child-centric thinking—which is essential for development of truly empathic and helpful responses to children. Consequently, such individuals also struggle then to make distinctions between children as people, with

identities and vulnerabilities, not just entities representing (bad) behaviour. In other words, they find it hard to see that CICL are children first, not a case or 'a POCSO or robbery charge' (as unfortunately, CICL tend to be labelled as or referred to).

We have observed that the internal noises about JJB members' own notions of children and children's experiences and behaviour are often so overwhelmingly strong that they do not then allow them to then process children's unique thoughts, experiences and emotions. There tends also to be an over-confidence that stems from the notion that 'O yes, runaway child? I know...I have heard this story many times' i.e. when one thinks one already knows, then a child does not stand a chance for his/her own unique story to be heard and understood.

Another issue that we have noticed during the course of our engagement with JJB members pertains to Board members having legal qualifications. A law background is, of course, a definite advantage for a JJB member, because his/her role is to implement the JJ Act. But we have found there to be a direct conflict of interest in appointing lawyers or advocates as JJB members, because such members have a tendency to bring a purely legal perspective to the understanding of a case, thus frequently able to think only in terms of punishment, transfer to adult criminal justice systems and justice purely from a judgement perspective. However, the role of the JJB is to approach judgement from child-centric and rehabilitative perspectives, including consideration of a child's vulnerabilities, safety and best interest—and the current constituency of the JJB does not seem to make for the desired balance between law and child rights and mental health.

Of course, one may also argue that if having a JJB member who is an advocate or lawyer does not serve the best interests of CICL, then one may argue that by the same token, having a magistrate as part of JJB is equally problematic. But perhaps the difference between lawyers and judges is that lawyers represent one party or the other, whereas judges listen to the arguments presented by all parties, to then come to an adjudication that is based on sound principles of justice and fairness. This is even more so when it comes to special positions that judges serve in, such as in juvenile justice boards.

C.4. Arbitrary Implementation of Psychosocial and Mental Health Assessments and of the Preliminary Assessment Reports

The mental health and psychosocial assessment proforma (erstwhile described in Chapter 4) is for use by counsellors and mental health professionals working in observation homes and/or facilities and services that provide care, protection, mental health and rehabilitation services to children in conflict with the law. The aim is to equip them to understand the needs of each CICL and develop interventions and care plans in keeping with behaviour transformation and rehabilitation objectives. However, given the inadequate knowledge and skills in mental health and psychosocial care, in institution staff and counsellors (generally recruited under the State Integrated Child Protection Scheme of the Ministry of Women and Child Development, Government of India), it has been challenging for accurate assessments to be conducted. Consequently, it has resulted in a system that is slow, and in some states non-existent, when it comes to providing treatment and rehabilitation interventions for CICL.

Although it has been nearly five years since the passing of the Juvenile Justice Act 2015, which incorporated Section 15 and the preliminary assessment report for CICL, its implementation has been problematic, resulting many times in even exacerbating the vulnerabilities of CICL. The preliminary assessment, as per the JJ Act is to be implemented by the JJB, who 'may' take the assistance of mental health personnel to do so. We have already detailed (above) the limitations in the skills and capacities of JJB members, particularly with regard to understanding children's vulnerabilities. So, while they may undertake to administer the mental health and psychosocial care proforma, and then develop the preliminary assessment report, they might find it difficult to do so, given that most of them do not have an advanced qualification in mental health or vast experience in working with CICL.

No research studies have been conducted to examine how Section 15 is being implemented in various states across the country, but from initial assessments and experiences with JJBs in some northern states, for

instance, every child between 16 and 18 years, who as per the JJ Act has allegedly committed a heinous offence, is transferred to the Special Court—without exception, irrespective of the result of the preliminary assessment. JJB magistrates execute the preliminary assessment in one of two ways:

i) The magistrates administer it themselves, usually by asking 'general questions' to the child (for example, they may ask the child what his father's occupation is, what the child's interests are etc). Based on the child's responses, a decision is made on whether he has the mental/physical capacity to commit a crime—unless the child has intellectual disability and is unable to respond, it is therefore generally determined that he has the capacity for offence and is transferred to the adult system. JJB magistrates feel that *'it is necessary to be strict'* and that in trial court, punishments are more intensive. They also feel that if a child is not transferred, then *'his mentality becomes is that he can do anything'.* Their view tends to be *'all children must be transferred, without exception…if we are too liberal, we will be encouraging children to commit crime'.* Such positions do not make for rehabilitative approaches to juvenile justice.

ii) The magistrate may refer the child to a psychiatrist, asking for the preliminary assessment to be done by mental health professionals, who again, not knowing how to do a mental health assessment that is in accordance with the law, almost always provide reports (often of a few lines) stating the child has the physical and mental capacity to commit offences. The kind of preliminary assessment report a given psychiatrist may provide to the JJ Board depends on a number of variables such as:
- His/her views on the JJ amendment and its implications (there are those who are ideologically against the new amendment 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).

Given the variance in knowledge, skill and approach therefore, and the nature of the mental health and psychosocial care assessment proforma, and the preliminary assessment proforma, it would be essential for all mental health professionals who use it to receive training. In other words, without training, the use of this proforma would become arbitrary resulting in varied and random opinions by professionals. This would then be unhelpful to the JJB magistrate in decision-making and most importantly, unhelpful and unjust to the child concerned.

As a result of the above factors that influence how preliminary reports are developed and how Section 15 is implemented, greater injustice to CICL, as in either situation, whether the preliminary assessment is administered by the magistrate or by a mental health professional there is not much hope for children to receive an informed, skilled and just report that would be in their best interests (except in relatively fewer cases, where mental health and legal professionals are trained and have a child rights perspective and an understanding of CICL's vulnerabilities so as to make decisions in favour of rehabilitation rather than transfer).

C.5. Challenges of the Judicial System vis-à-vis CICL

This last concern has been voiced by the JJB magistrates during the course of our engagement with them, including in training workshops organized by state judicial academies. They discuss two challenges that they have:
i) There is frequent transfer of judges, so the JJB frequently has a new magistrate who then has to acquaint himself/herself with the juvenile justice processes—and indeed, the institution staff and other JJB members also have to continually re-orient themselves to a new person assuming the position of the magistrate.
ii) The JJB magistrates state that when they spend most days of the week in the adult criminal justice system where the approaches to dispensation of justice are very different from the juvenile justice system i.e. in the adult system, the orientations are more towards punishment and other retributive methods. For the one to

two days they spend per week in the JJ system, the magistrates then feel that they have to make a huge shift in their thinking and orientation as the paradigms for dispensation of justice in the JJB entail consideration of vulnerability and rehabilitation. This shift, they say, is not an easy one and that as more time, actually most of their time, is spent in the adult system, there is a tendency to continue to use the same approaches and methods even within the JJ system, which they are aware is not how it should be.

The first concern is perhaps a more difficult one to address transfer of personnel in state systems is a reality, an inconvenient one for the most part, but an inevitable one. It does however impact children in the observation home adversely, as they experience more delays with administrative and judicial processes when magistrates keep changing.

The second issue, however, of magistrates' difficulty in constantly having to recalibrate their thinking and orientation, is more concerning. Higher officials in the judiciary feel that magistrates 'should have the caliber' to function in this manner. But the magistrates' position is a challenging one and the failure of a magistrate, even on any given day, to be unable to make the shift from the adult criminal justice system to the juvenile justice system could prove to be costly for a given child.

Recommendations for Policy & Practice (III): Legal & Judicial Considerations

(i) A great deal more focus needs to be on eliciting children's accounts and experiences of the police, following their apprehension for alleged offences, in order to hold the law and order system accountable for their actions towards children. Also, it is critical that CICL be examined for physical injuries when they are admitted in the observation home, so that signs of violence or abuse can be identified. This examination must be done by doctors (preferably). It is imperative for this to be conducted as soon as a child enters the observation home because these injuries tend to be less visible with time, making documentation challenging. Given that not all health professionals may have the requisite expertise to examine individuals for physical trauma, those who work with children's healthcare in the observation home need to be trained in this area by forensic experts and a trauma surgeons (or by Orthopedics and General Surgery professionals).

(ii) Training & Capacity Building of Police, including SJPU
SJPU and the police force in general requires not just orientation and sensitization (which are useful but not sufficient interventions) but depth training on dealing with children and youth in the context of the criminal justice system. Like lawyers and judicial personnel, they need to be trained to understand that their role vis-à-vis child offenders is very different from their dealings with adult offenders. Thus, their perspectives on children and child offenders, their positions on the use of violence as a tool for apparent justice and their understanding of the vulnerabilities of CICL, as well as procedures to be followed as per the JJ Act all urgently need clarification.

(iii) Developing Child-Friendly Legal Awareness Programs
There is a serious need for conducting quality, child-friendly legal awareness programs in the country. It would be useful if legal personnel could partner with child mental health professionals to design and conduct such programs, so that legal know-how can be presented through games and activities, and discussions that are conducive to children's developmental stage and ways of learning. We recommend that rather than theoretical readings on child rights, which are meaningless in any case to CICL, who are one of the child most rights-deprived sub-groups, a practical approach is adopted to educating children on issues that are of real concern to them.
The suggested list (below) of issues that legal awareness programs should address is based on our experiences with CICL, and the confusions and anxieties they have frequently expressed to us, during the course of our assistance to them:
- How does an FIR work? What happens after it is lodged?
- What is a charge sheet and how does it work?

- What are different types of crimes, as per the law, that children tend to be apprehended for? (Children are often told 'you are charged under 307' and they do not understand what these numbers mean).
- Why does a child have to be taken to meet the magistrate within 24 hours, before placement in the observation home?
- How to obtain free legal aid and/or appoint a private lawyer?
-What are the various administrative and legal procedures that need to occur (in chronological order), once the child is in the observation home?
- What are the various types of reports (from whom) that are required to move the case along? (Probation Officer report, counselor report, social investigation report…)
- How is bail obtained or given?
- Who comprises the juvenile justice board? What is their role and function?
- When and how often can parents visit the home?
- When and how is a case closed? And what happens to the child's records after?

All of the above information needs to be in simple language (not 'legalese'), and given to the children over a period of time i.e. over 2 to 3 sessions, in an interactive manner, so that they are able to absorb the information and ask for further clarifications.

(iv) Enhancing the Skills & Capacities of Juvenile Justice Board Members

The challenge of skills and capacities of JJB members are not easy to address. To begin with, the selection process needs to be extremely rigorous, to help confirm that desirable candidates have a stronger children and child rights orientation than legal knowledge—after all, the provisions of the JJ Act can be learnt but orientations and sensitivities to children are hard to teach and can only be worked upon if they exist in some basic capacity. In Karnataka, for instance, an attempt to assess applicants' orientations to children and child rights has been made by including case studies in the written examination—to test whether candidates are able to select more empathic and compassionate responses, that reflect some understanding of CICL's vulnerability. Child mental health professionals should also be included on the selection panel, as Karnataka has done, to be able to participate in the design and evaluation of the written tests and interviews.

Furthermore, where selection processes are concerned, we may want to re-consider appointing JJB members with law qualifications i.e. other than the magistrate. Given that the magistrate is likely to have the most superior knowledge of the law, and given his/her position in the judicial system, and within the hierarchy of the JJB, the final legal decisions are most often taken by him/her i.e. not by the other JJB members, who can weigh in but not make the ultimate decision. Given these technical knowledge issues, hierarchies and dynamics, a JJB member with a law qualification is less likely to be able to use it on the JJB; and consequently, it might be preferable, more useful to have other JJB members with social work/psychology/child development/mental health qualifications—so that they can weigh in on a given case by highlighting child development, mental health and vulnerability issues. Such a JJB is likely to have a better balance of the law and the child's vulnerabilities and best interests, thereby resulting in more just decisions for CICL.

Next, the design and implementation of training workshops is critical—not as exercises of tokenisms, for we owe it to our most vulnerable children to learn and hone our skills in ways that can be meaningful and transformational to their lives. A serious training workshop should ideally, not have the drone of adult voices and perceptions, but reverberate with the voices, stories and experiences of children—for, this is what reflects that both trainer and trainees are truly engaged. Such a workshop then entails the use of creative participatory methodologies, by facilitators who work extensively in the field, with CICL and are able to bring to the classroom the daily life realities of CICL versus use of lengthy power point presentations by persons who do limited direct (mental health and protection) work with CICL in the field, on a regular basis. Training workshops also cannot be one-off sessions, for, acquiring knowledge and skills to work with children is a process—one that requires guidance and supervision, timely follow-up and constant addition of new knowledge and skills, as people work in the field, and new issues and challenges emerge.

The NIMHANS Community Child and Adolescent Mental Health Service Project, through its extensive work with CICL, and capacity building experiences across the country, has developed training manuals and materials for child care service providers and judicial personnel who work with CICL. (Refer to www.nimhanschildproject.in). These training materials are designed to provide various stakeholders with methods for training as well as tools, activity materials and skills for direct work with children, using practical examples from the field, including addressing dilemmas and challenges that fieldworkers frequently encounter in their work with this vulnerable sub-group. The training materials are also designed in such a way that they ensure that conceptual classroom training is implemented hand-in-hand with field work, over a period of several months—to allow for the learning to be consolidated at field level, and to be iterative in nature.

All that said, training is not the panacea to all the problems that all the juvenile justice system. A training is only as good as its implementation or translation into practice. Close monitoring and supervision of institution staff engaged with providing care to CICL, and of JJB members, by appropriate government and judicial authorities will ensure that the learning from the training is put into practice. Where governments have the political will to commit time and resources to ensuring the welfare of their most vulnerable populations, such as CICL, systems surely reflect change, over time. We have observed that in states where the concerned government department has put in place strong rules and frameworks for delivering services to children, including disciplinary actions for work not done and rewards for work well done, there has been considerable, even dramatic change in the skills and service delivery of child care workers, to CICL.

(v) Use of Standardized Protocols and Methods in Implementing Psychosocial & Mental Healthcare Assessment and Developing Preliminary Assessment Reports

If we adopt the vulnerability lens to viewing CICL and their alleged offences, and dispense justice based on this, the need for psychosocial and mental health interventions and rehabilitation will become self-evident. Consequently, when justice entails every child in conflict with the law as also being seen as being a child in need of care and protection, and it becomes imperative to provide assistance to all of them, more so in fact in case of alleged 'heinous' offences, there will be no necessity to conduct preliminary assessments and transfer of children to adult systems, irrespective of their age or offence. Thus, ideally Section 15 of the JJ Act should be amended—and we should revert to the the more reformation-rehabilitation oriented approaches of the previous Juvenile Justice Act 2000.

In the interim, or until such time as the law is amended, given that neurobiological, psychosocial and mental health issues underlie adolescent offence behavior, a standardized protocol and methodology for preliminary assessments must be used, drawing from relevant disciplines, namely, neuropsychology, psychiatry, child development and law. The preliminary assessment report as developed by the Community Child & Adolescent Service Project, Dept. of Child & Adolescent Psychiatry, as described in Chapter 5 of this document is an example of the kind of preliminary assessment report that may be used for now. This will help avoid arbitrary administration of incorrect 'tests and tasks' in the name of preliminary assessments, and result in a more uniform way of implementing Section 15 across the country, thus ensuring equal opportunities to all CICL between 16 and 18 years, to obtain justice and rehabilitation. Furthermore, and more importantly, the protocol and methodology enable the juvenile justice system, including psychosocial and 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.
- Access to assistance to juveniles, by way of treatment, rehabilitation, transformation and (social) reintegration.

In short, if the protocol ensures that the above four conditions are met, the chances of children being transferred to the adult justice system will be relatively lower; they will then remain within the juvenile justice system, which has sufficient provisions to ensure that they are assisted appropriately.

However, the development of a standardized protocol and methodology, though necessary, would not in itself, be sufficient in ensuring a more fair and child-centric system for dispensation of juvenile justice. Orientation and training of the main stakeholders in the administration of the preliminary assessment, namely legal personnel, such as the juvenile justice board members, and mental health professionals is critical to the development of the preliminary assessment report such that it points the system in the direction of the child's need for reformation and rehabilitation (rather than transfer). Training on mental health assessments and preliminary assessment reports should be embedded in a larger knowledge and skill base pertaining to CICL, namely:

o Knowledge of child development theories, in particular of the adolescent life stage and the basis of its emotional and behavioural challenges

o An understanding of CICL's pathways to vulnerability (including their difficult family backgrounds, experiences of abuse and trauma in various contexts such as home/family, school, at the work place, challenges in coping with peer influences and how each of these factors place a given child at risk of coming into conflict with the law)

o Administering/ understanding psychosocial care and mental health assessments that help identify the vulnerabilities and needs of CICL

o Developing the preliminary assessment report (through use of the standardized protocol)

o Essential psychosocial care, mental health and rehabilitation interventions and services that are available or may be accessed to assist CICL.

Thus, training cannot focus merely on the administration of psychosocial care and mental health assessments and/or on development of the preliminary assessment report—these need to be a part of a broader and deeper initiative that helps legal and mental health professionals understand issues pertaining to CICLs as well as equips them with the skills to respond to these children in accordance with the scope of their roles and professions. This will ensure that the legal, child welfare and mental health systems use the preliminary assessment reports to provide children with opportunities for transformation and rehabilitation rather than solely for legal purposes of transfer. Such an approach would be in keeping with the care and protection objectives as envisaged by the Juvenile Justice Act.

(vi) The Ideal Justice System for Children?

The need and challenges experienced by JJB magistrates, to completely recalibrate and shift paradigms when move from their work in the adult criminal justice system to the juvenile justice system on certain days of the week is a very real one. There are no easy or quick solutions to addressing this issue. One solution that magistrates provided in one of our training workshops is to have a separate cadre of judges to work on issues pertaining to the child and law—including to dispense justice in contexts of children in conflict with the law and sexually abused children (under the POCSO Act 2012). In an ideal world, this is perhaps the best way forward as the judiciary could then have a highly skilled, specialized cadre or group of magistrates/judges to address the justice needs of vulnerable children. However, this is a long-term reform that the judiciary would need to consider and work towards in terms of the (re)structuring and development of their systems. Until such a time when our country is able to prioritize the justice needs of our children, and in the interim, the orientation and training of JJB magistrates (and other relevant judicial personnel) is perhaps the best we can do to ensure that CICL have access to rehabilitative and reformative justice.

*

All the actors need to be on the same page in their understanding of issues around CICL. If a police official operating in the SJPU is sensitized to adolescent brain development and the vulnerable background that CICL come from, it would make a difference in the way the child is treated and handled. If observation home staff members, including the cook and the security guards, are convinced about the potential for

transformation, their approach to the children who reside in the institution would be very different. These are but a few examples of attitudes and approaches that make a difference in systemic issues. Just as the critical word in Child Welfare Committee is WELFARE, the critical word in Juvenile Justice Board is JUSTICE. The essence of justice is in recognizing the unique universe and vulnerabilities of CICL with the attendant push and pull factors. It should then proceed to collaborate on creating the basis for transformation so that the principles of rehabilitation are upheld. Policy and practice require to be organized around these processes.

Finally, in the words of Harsh Mander, *'true justice is always tempered with compassion'*[30]. With regard to CICL, it is this compassion that needs to permeate, not only through policy and practice, but also throughout civil society; for, in the absence of such compassion, we become completely indifferent to human suffering, and the vulnerabilities that afflict children in conflict with the law.

[30] Harsh Mander: article in the Indian Express, November 25, 2019

Annex 1
Definitions of Offences as in the Indian Penal Code (IPC) & Other Laws as Applicable to CICL

Note: The list below includes some of the common alleged offences that CICL in the observation home were charged with; we have only included some key definitions or provisions of the relevant laws on these offences.

1. IPC section 378 - Theft

'Whoever, intending to take dishonestly any moveable property out of the possession of any person without that person's consent, moves that property in order to such taking, is said to commit theft'.

2. IPC Section 390 - Robbery

'In all robbery there is either theft or extortion. When theft is robbery.—Theft is "robbery" if, in order to the committing of the theft, or in committing the theft, or in carrying away or attempting to carry away property obtained by the theft, the offender, for that end, voluntarily causes or attempts to cause to any person death or hurt or wrongful restraint, or fear of instant death or of instant hurt, or of instant wrongful restraint. When extortion is robbery.—Extortion is "robbery" if the offend¬er, at the time of committing the extortion, is in the presence of the person put in fear, and commits the extortion by putting that person in fear of instant death, of instant hurt, or of instant wrongful restraint to that person or to some other person, and, by so putting in fear, induces the person so put in fear then and there to deliver up the thing extorted. Explanation.—The offender is said to be present if he is sufficiently near to put the other person in fear of instant death, of instant hurt, or of instant wrongful restraint'.

3. IPC Section 393 - Attempt to commit robbery

'Whoever attempts to commit robbery shall be punished with rigorous imprisonment for a term which may extend to seven years, and shall also be liable to fine'.

4. IPC section 391- Dacoity

'When five or more persons conjointly commit or attempt to commit a robbery, or where the whole number of persons conjointly committing or attempting to commit a robbery, and persons present and aiding such commission or attempt, amount to five or more, every person so committing, attempting or aiding, is said to commit "dacoity"'.

5. IPC Section 402 - Assembling for purpose of committing dacoity

'Whoever, at any time after the passing of this Act, shall be one of five or more persons assembled for the purpose of committing dacoity shall be punished with rigorous imprisonment for a term which may extend to seven years, and shall also be liable to fine'.

6. IPC Section 300- Murder

'Except in the cases hereinafter excepted, culpable homicide is murder, if the act by which the death is caused is done with the intention of causing death, or—
(Secondly) —If it is done with the intention of causing such bodily injury as the offender knows to be likely to cause the death of the person to whom the harm is caused, or—
(Thirdly) —If it is done with the intention of causing bodily injury to any person and the bodily injury intended to be inflicted is sufficient in the ordinary course of nature to cause death, or—

(Fourthly) —If the person committing the act knows that it is so imminently dangerous that it must, in all probability, cause death or such bodily injury as is likely to cause death, and commits such act without any excuse for incurring the risk of causing death or such injury as aforesaid'.

7. IPC Section 307 - Attempt to murder

'Whoever does any act with such intention or knowledge, and under such circumstances that, if he by that act caused death, he would be guilty of murder, shall be punished with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine; and if hurt is caused to any person by such act, the offender shall be liable either to 1[imprisonment for life], or to such punishment as is hereinbefore mentioned'.

8. IPC Section 359 – Kidnapping

'Kidnapping is of two kinds: kidnapping from 1[India], and kidnapping from lawful guardianship'.

9. IPC Section 375 - Rape.

A man is said to commit "rape" if he—

a. penetrates his penis, to any extent, into the vagina, mouth, urethra or anus of a woman or makes her to do so with him or any other person; or

b. inserts, to any extent, any object or a part of the body, not being the penis, into the vagina, the urethra or anus of a woman or makes her to do so with him or any other person; or

c. manipulates any part of the body of a woman so as to cause penetration into the vagina, urethra, anus or any ~ of body of such woman or makes her to do so with him or any other person; or

d. applies his mouth to the vagina, anus, urethra of a woman or makes her to do so with him or any other person, under the circumstances falling under any of the following seven descriptions: — First—Against her will. Secondly —Without her consent.

Third/y—With her consent, when her consent has been obtained by putting her or any person in whom she is interested, in fear of death or of hurt.

Fourth/y—With her consent, when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married.

Fifth/y—With her consent when, at the time of giving such consent, by reason of unsoundness of mind or intoxication or the administration by him personally or through another of any stupefying or unwholesome Substance, she is unable to understand the nature and consequences of that to which she gives consent.

Sixthly—With or without her consent, when she is under eighteen years of age.

10. Protection of Children against Child Sexual Offences (POCSO) Act 2012 which is *'to protect children from offences of sexual assault, sexual harassment and pornography, and provide for establishment of Special Courts for trial of such offences, and for matters connected therewith or incidental thereto.'*

11. Narcotics, Drugs and Psychotropic Substances (NDPS) Act 1985 that *'prohibits a person to produce/manufacture/cultivate, possess, sell, purchase, transport, store, and/or consume any narcotic drug or psychotropic substance'.*

Annex 2
Psychosocial & Mental Health 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

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

l) 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 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.			

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).

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:

b) 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?

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 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

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:

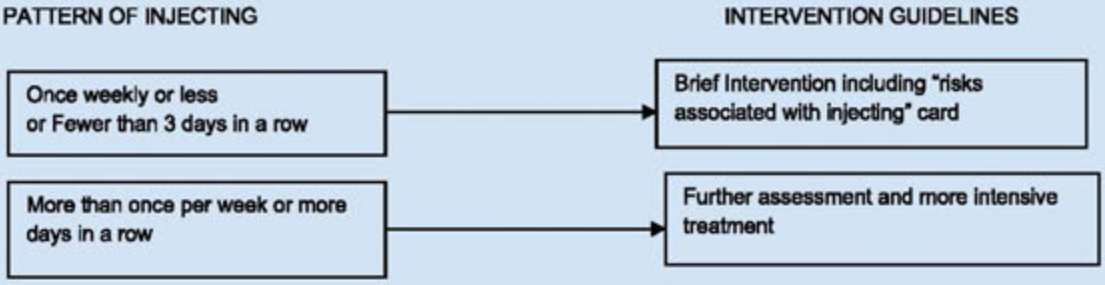
Has a friend or relative or anyone else ever expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?	Never	Once or Twice	Weekly	Monthly	Daily or Almost Daily
Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
Cannabis (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.



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**[31], **Pathology**[32] **and Consequence**[33]. 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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[31] Vulnerability: abuse/ neglect/ family pathology/ school drop-out issues that make children vulnerable to emotional & behaviour problems

[32] 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.

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

Annex 3
An Example of a Completed Psychosocial & Mental Health Proforma for Children in Conflict with the Law

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

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

iii) Work place

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.	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

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?**

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.

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.	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	

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).

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:

a) 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 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...		
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)

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

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)
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, mushrooms)	(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 oplates (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

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

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

0. NO

(1. YES)

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	-
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).	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)	-

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[1], Pathology[2] and Consequence[3]. Highlight areas for immediate assistance/ response.

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.

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1. Vulnerability: abuse/ neglect/ family pathology/ school drop-out issues that make children vulnerable to emotional & behaviour problems
2. 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.
3. Consequences—Pathways to institutionalization & 'criminality'

Annex 4
Preliminary Assessment Proforma for Children in Conflict with the Law

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 5
Examples of Completed Preliminary Assessment Reports for Children in Conflict with the Law

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,

xxxxxxxxxxxxxxx
[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,

xxxxxxxxxxxxxxx

[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,

xxxxxxxxxxxxxxx

[Name & Designation of Mental Health Professional]

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