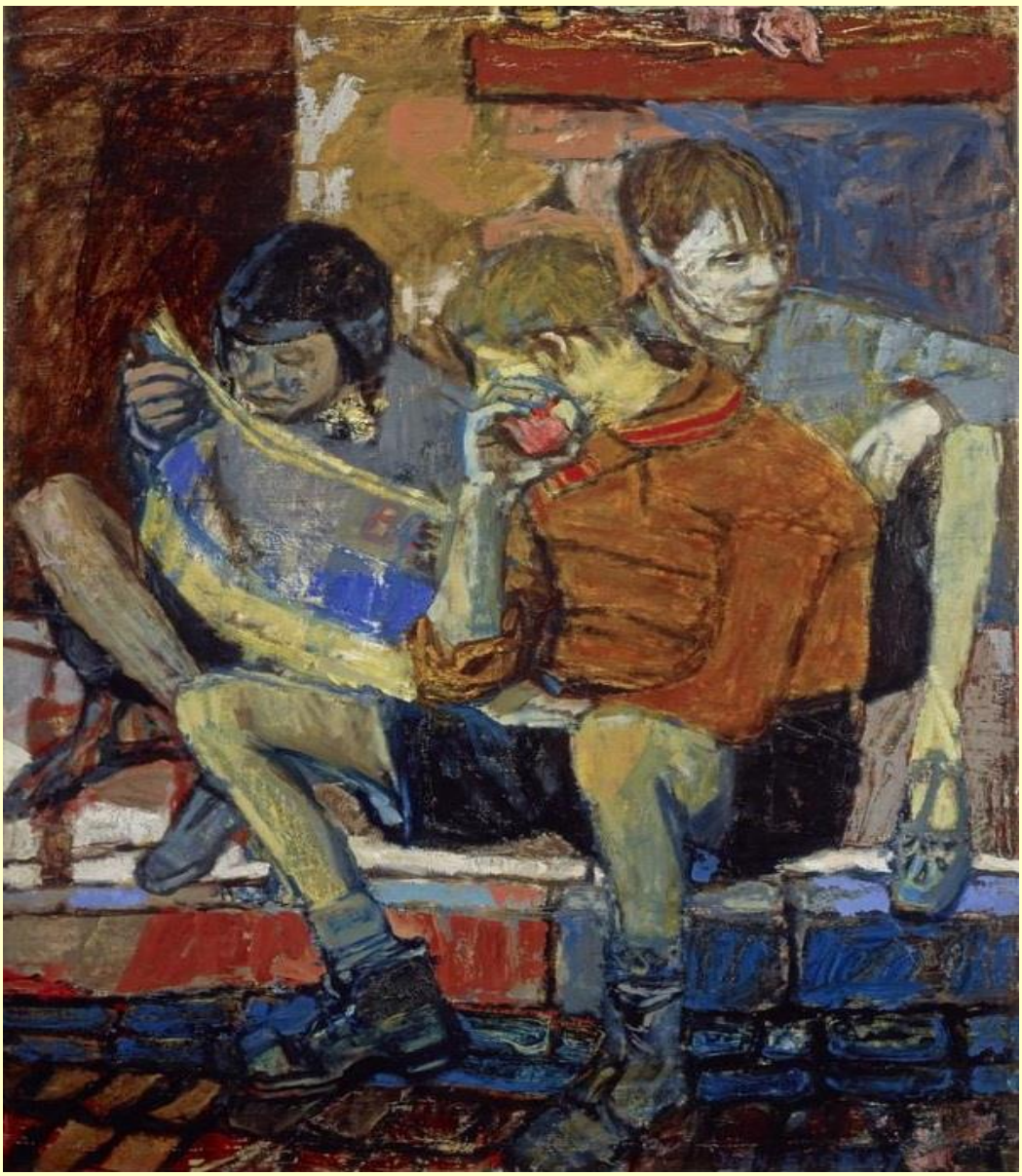
# Children in Conflict with the Law



## Mental Health, Psychosocial Care & Protection for Children & Adolescents

## Training Series 3


Developed by

Community Child & Adolescent Mental Health Service Project

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"In the little world in which children have their existence, whosoever brings them up, there is nothing so finely perceived and so finely felt as injustice."

— Charles Dickens, Great Expectations

## Contents

# 1. Understanding Children in Conflict with the Law: Applying the Vulnerability Lens

# 1.1. Identifying Pathways to Coming into Conflict with Law

## Objectives

- To begin understanding the pathways to coming into conflict with law.
- To develop frameworks of understanding children's pathways to alleged offence—namely, psychosocial and environmental factors, and mental health problems.

## Time

2 hours

## Concept

Some quick Reminders:
CICL comprise of:

- Children who have committed alleged offence
- Children who have not actually committed offence but were in the 'wrong' place/ 'wrong' time/ 'wrong' peer group.

**Basic Premises of Psychosocial Work with CICL**

Key premises of our work with CICL are:

i) The child is and certainly should be reflective and accountable for behaviours i.e. there are and must be consequences to difficult behaviours. But the method of accountability cannot be those that are used for adults, or in adult criminal justice systems, nor can the consequences be the same. This is because adult and juvenile justice systems differ in their basic objectives: the goal of the adult system is to punish; the goal of the juvenile system, on the other hand, is to rehabilitate and serve the minor's best interest.

ii) There is an innate belief that all children, and that includes children who have allegedly committed offences 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 intervention at all.

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.

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

journeys...and so, if we understand the journey, we can identify specific interventions to address the issues that caused a given child to get to the Observation Home.

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

# Activity for Identifying Pathways to Offence

**Method:** Mapping and story-building

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

**Process:**

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

**Discussion:**

- Ask each sub-group to present their child-story in plenary and explain the child's pathway to the offence—ask them to present a clear justification for the pathways to offence they have decided on.
- Invite comments and questions from all participants, enabling them to reflect on: i) various pathways to offence; ii) how these pathways differ in different children; iii) the implications therefore that this differential understanding would have for intervention (for example, if one child's pathway to sexual abuse offence was peer influence while another child's pathway to sexual abuse offence was experience of abuse/ revenge for the same, then the intervention for the former would focus on helping him/her cope with peer pressure while for the latter, it would focus on healing for sexual abuse experienced by him/her).
- Summarize: no child is born a 'criminal'; there are various life circumstances and individual factors (that cause different children to respond to their life situations in different ways) that lead children to commit alleged offences.

# 1.2. Further Analysis of CICL's Vulnerabilities

## Objectives

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

## Time

2.5 hours

## Concept

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

**Framework for Understanding CICL's Vulnerabilities**

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

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

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

| Basis of CICL's Vulnerability (4): Child Labour | Impact & Consequences/ Pathways to Alleged Offence |
|---|---|
| • Children from low socio-economic strata often sent away to work—sometimes to far off places.<br>• Poor remuneration<br>• Exploitative conditions of work.<br>• Cruel treatment by employers. | ✓ In the work place, children live with /are exposed to older adolescents & adults:<br>✓ who might engage in criminal behaviours and act as role models<br>✓ who force children to engage in such behaviours (for perverse entertainment/ pleasure or to ensure children are caught in the act and they themselves escape punishment).<br>✓ Who engage them in practices of substance abuse.<br>✓ Children may be far away from family have little connect with families—experience neglect/ loss of attachment relationships...making it easier for the antisocial adults around to influence them. |

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

| Basis of CICL's Vulnerability (6): Mental Health Disorders | Impact & Consequences/ Pathways to Alleged Offence |
|---|---|
| **A. Externalizing Disorders:**<br><br>**<u>Attention Deficit Hyperactivity Disorder (ADHD)</u>**<br>• A Neuro-Developmental Problem, requiring medication/ behaviour training (often unrecognized & untreated in CICL)<br>• Inattention/ restlessness/ difficulty sticking to & completing tasks/ haste in making decisions<br>• Uncontrolled aggressive behaviours/ poor emotional regulation<br>• Poor social skills, inadequate social judgement and impulsivity | ✓ Increased conflict with peer group .<br>✓ Poor decision-making skills.<br>✓ sensation-seeking activities such as substance abuse, inappropriate sexual behaviour and other high risk behaviours. |
| **<u>Conduct Disorder</u>**<br>• Rule-breaking behaviours, of stealing, violence/ aggression/ cruelty to people & animals<br>• Destruction of property/ use of weapons<br>• Truancy<br>• Threatening, manipulating others towards' one's own ends<br>• Engaging in sexual coercion/abuse<br>• Empathy and remorse/ guilt (?) | ✓ Most of these behaviours directly lead to conflict with the law.<br>✓ Some behaviours, especially if they are long-standing (since childhood), may lead to problems with the law later on. |
| **B. Internalizing Disorders:**<br>**<u>Anxiety & Depression</u>**<br>• Difficulty concentrating, irritability<br>• Lot of body aches and pains (no medical cause)<br>• Low energy/ tiredness/tension of muscles<br>• Sleep & appetite problems<br>• Poor self-esteem/ sense of hopelessness<br>• Difficulty doing daily tasks & activities<br>• Suicidal thoughts/ attempts | ✓ Emotional dysregulation leading to angry or violent behaviours.<br>✓ Most common risk is substance abuse...can also be high risk sexual behaviour—which in turn can lead to conflict with law. |

| Basis of CICL's Vulnerability (7): Life Skills Deficits | Impact & Consequences/ Pathways to Alleged Offence |
|---|---|
| • Due to lack of supervision and guidance by caregivers, children do not develop the requisite life skills to be able to negotiate the many situations they find themselves in, on a daily basis (such as peer pressure, substance use etc).<br>• Thus, there are deficits in the following (WHO) life skills of:<br>- Decision making<br>- Problem solving<br>- Creative thinking<br>- Critical thinking<br>- Effective communication<br>- Interpersonal relationship skills<br>- Self-awareness<br>- Empathy<br>- Coping with emotions<br>- Coping with stress<br><br>*Children with various mental health disorders and/or substance use can also be viewed as lacking critical life skills. | ✓ Limited ability to process and solve problems<br>– seen as a threat to well-being or self-esteem<br>– Thinking through a problem does not take place in the child's mind<br>– urge either to retaliate or subdue the situation by aggression<br>– aggressive (versus non-aggressive) forms of conflict resolution.<br>✓ Distorted perception regarding events<br>– Children misinterpret events.<br>– 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.<br>– 'You did that on purpose'.<br>– Where outcomes are interpreted as intended and intentions are perceived as hostile, the chances of an angry/aggressive response become that much higher.<br>✓ High risk (sexual/ substance abuse & self-harm) behaviours |

**Substance Use**

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

As children grow into adolescents, there are social and peer pressures that cause them to feel the need to use substances such as alcohol, nicotine, tobacco etc. Where there is greater access and availability of substances, and where it is 'normal' or common to use

them, adolescents are increasingly likely to use them. For ease of understanding, the stages of substance use can be broadly viewed as follows:

***Stage 1: Experimentation***
Many adolescents might initially experiment, with substance use—usually out of curiosity and/or under peer pressure. For many adolescents, their use of substances might stop right here. But for others, this may be the first step in addiction. In fact, the earlier they begin (such as when they are 12 to 15 years or below), the greater the risk of addiction.

***Stage 2: Regular Recreational Use***
A certain proportion of those who started to experiment or try a substance, will progress to occasional or even regular use of substances. Some risky behaviour may also begin to occur at this stage—with adolescents binge drinking, driving under the influence of substance or becoming pre-occupied with substances. Symptoms such as depression, anxiety and/or opposition/defiance may also begin to emerge.

***Stage 3: Problematic Use***
Regular use of substance tends to escalate, with increased consumption, greater frequency, and most importantly, worsening consequences: relationships with family, school and friends may be adversely impacted; problems at schools may emerge (with rule breaking, truancy etc); other antisocial activities may also lead to conflict with authorities and law.

***Stage 4: Tolerance***
In the early stages of substance use, adolescents need to consume relatively smaller amounts of the substance to obtain a 'high' or feel the pleasurable effects. But over time, they feel the need to consume increasing amounts of the substance, in order to enjoy the same pleasurable effects (or the same level of 'high') i.e. they have to use more alcohol then they used to, for instance. This is because with increasing amounts of substance, the pleasure pathways of the brain become less efficient…requiring more substance to stimulate them. But because the person needs to consume more of the drug to get high, does NOT mean that their body can safely handle that amount. In fact, it is this increasing tolerance (and the felt need for more quantity of the substance) that often leads to overdose.

***Stage 5: Dependence***
As the person's tolerance continues to grow, and they increase the quantity and frequency of substance use, they lose the ability to experience to any pleasure unless they are under the influence of intoxicants. Therefore, they also tend to lose interest in other life activities such as play, academics, hobbies etc because they no longer enjoy them. They thus become excessively and predominantly preoccupied with substance use over everything else (this is known as salience).
In fact, whenever their drug of choice isn't available, a drug-dependent person may go into withdrawal. Withdrawal is a set of harshly-unpleasant – and sometimes dangerous – mental and physical symptoms (headaches, nausea, sweating, loss of appetite…) that result when the body goes into "shock" because the accustomed substance not available. The pain and discomfort of withdrawal is often what pushes a person into relapsing.

***Stage 5: Addiction***
The final stage is addiction – a medically-diagnosable disorder that has identifiable symptoms, namely:

- Tolerance

- Loss of Control – an inability to choose the frequency or amount of consumption
- Failure to cut back or quit
- Disproportionate time spent thinking about, acquiring, using, or recovering from use – an obsession that interferes with everyday life
- Abandonment of other responsibilities and interests
- Withdrawal
- Continued usage despite negative consequences

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

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

**The Modified Social Stress Model**[1]: This model was developed in the context of substance use—to understand the risk of substance use in children but it can be applied to children in conflict with law in a broader sense...to understand the risk of committing offence. According to the model:

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

Wherein:

- **Risk** refers to how likely a child is to engage in substance use behaviour.
- **(Dis) Stress** is the way a person feels (e.g., anxious, tense, burdened) in response to real or perceived stressors. A stressor may be observable (e.g., violence, poor living conditions, a physical disability), or it may be less visible to others (e.g., emotional abuse, trauma). Thus, a stressor may be a life event (accident/ abuse/ loss experiences), an enduring life strain (psychological difficulties/ illness/ lack of educational and recreational opportunities...) or everyday problems (survival issues relating to food/ shelter...). The more stress a child is under, the more likely he or she is to use substances.
- **Normalization of behaviour and situations refers to how normal and acceptable the use of substance is in a child's environment.** According to the Modified Social Stress Model, a person is more likely to become involved with substances if using substances is considered normal in the person's environment i.e. where other children/ peers and adults in the family or neighbourhood, use or accept the use of some substances, children are more likely to use substances as well. Legality and law enforcement, availability, price, advertising/ media and community cultures influence normalization of behaviour and situations.

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

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

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

# Activity for Further Analysis of CICL's Vulnerabilities (I)

**Method:** Case study analysis and discussion

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

**Process:**

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

**Discussion:**

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

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

**Case Studies for Discussion:**

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

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

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

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

**Case 5:** B was a 17 year old boy who was one of 6 people who gang-raped a female student in a private bus in which she was travelling with a male friend. The woman died from her injuries thirteen days later while undergoing emergency treatment. The Delhi Police described the juvenile as the most brutal of the six accused. B was ten or eleven when he left home. Part of a family of seven, B was the oldest child. The father was a psychiatric patient. The daughters earn Rs.50 a day as farm labourers when there is work. B's mother saw him briefly twice or thrice in the last six-seven years after he went to the city, as a boy, to find work. His mother remembers the time he was born only vaguely. A village elder strains to remember him. B was a good boy says another villager by which he seems to mean he remembers nothing particularly bad about him. The man who owned the *dhaba* remembers him as a boy who didn't have a mobile phone, was not into girls or cricket or movies. His jobs were the jobs of a poor boy with no education – bus cleaner, dishwasher, helper to a milkman, *dhaba* assistant.

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

**Case 7:** H is a 15 year old boy from an upper middle class family. He went to an expensive private school where he was in romantic relationship with his classmate. After some months, the girl no longer wanted to be with him, told him so and started going out with another boy. H was very angry. He hacked into the girl's e-mail account wherein he found that she had some nude photographs of herself (that she was sending to her new boyfriend). The child sent those photographs to everyone in his class (including the girl). The girl's parents lodged a complaint to the school and police after which the child was charged under POCSO.

**Case 8:** M is a 17 year old boy from middle socio-economic family. He had completed 10$^{th}$ standard and started working in a garage. He was in a mutually consenting, romantic relationship with a 16 year old girl who lived in his neighbourhood. The two families however opposed the relationship and fearing that they would be separated, they ran away to another town and 'got married' in a temple and lived together for 6 months (the boy was working in someone's estate). The parents lodged a police complaint and when the boy and girl were found, the boy was charged with kidnap and rape (POCSO).

**Case 9:** N is a 16 year old boy in a mutually consenting romantic relationship with a girl in his class. They had already made long term plans of marriage. The girl told N that she was afraid that her parents may get her married to someone else later. So, she suggested to him to take nude pictures together and send them to their parents—so that 'they will have to get us married'. N was not sure this was the right thing to do. But when he refused, the girl said: 'if you love me, and you really want to marry me, you would do this...else, it means you don't...and I will commit suicide'. So, N finally gave in and took nude pictures and sent them to their parents, following which the girl's parents complained and he was charged under POCSO.

**Case 10:** Y is a 15 year old child from a single-parent family; his father (who died) was an alcoholic and there was domestic violence at home, also directed at the child. He decided to drop out of school and started to engage heavily in substance abuse—mainly alcohol and solution. He started to steal, along with his peers, in order to procure substances. He had a system with his peers, of sharing the substances they managed to procure. During one of these times, there was a conflict. The child over-heard his two peers plotting to kill him; so, when they fell asleep, he decided to hurt them really badly so that they would fear him. But in doing so, he ended up killing them. He came into conflict with the law for murder.

**Case 11:** V is from a middle class family with no significant family problems (i.e. no domestic violence/parental marital conflict/financial stress). The child has no intellectual or developmental disabilities nor does he have any emotional problems; he has had no difficult experiences of abuse and trauma either. He has a long history of behaviour problems relating to stealing, aggression, truancy and other rule breaking behaviours as well as substance abuse (namely alcohol, tobacco and cannabis). He had been bothered frequently by an older adolescent—who was known for bullying children and youth in the neighbourhood. Thus, V decided to 'finish him' and one day, under influence of alcohol (which he drank in order to have 'more courage'), killed the adolescent, following which he came into conflict with the law.

# Activity for Further Analysis of CICL's Vulnerabilities (II)

**Method:** Film screening and perspective-taking

**Materials:** 'Kaka Mutai' a Tamil film (with English sub-titles). This film is about *two children living in a slum community, and how they yearn to taste a pizza from the pizza shop that has opened near their locality; it is about how they try to get the access the money to buy pizza and what happens after…the class divides in our society and how children's aspirations are impacted by globalization and the culture of consumerism…of what desire means.*

**Process:**

- Screen the film.

**Discussion:**

- Let us reflect on the film through 3 levels of processing:

  i) Do a basic emotive and empathic sharing of impactful and unforgettable characters/images/issues/scenes in the film.

  ii) What psychosocial themes do you observe playing out in the film? What are themes particularly relevant to CICL?

  iii) How might we use the understanding of these themes to inform our work with CICL?
- What kinds of questions and themes would you discuss if you were using this film with a group of CICL? (Ask participants to develop a list of questions as they watch the film).

*<u>Note:</u> It is useful to end the day (particularly day 1 and 2) of the training with this activity; it can also be done after 5 pm as it is enjoyable and allows the participants to relax and be entertained but at the same time continuing the immersion in issues relevant to the training and work with children.*

# 2. Assessing Children in Conflict with the Law

# 2.1. Psychosocial and Mental Health Assessments for CICL

## Objectives

- To learn how to administer psychosocial assessments for children in conflict with the law.
- To be able to develop a summary and care plan based on the information obtained through assessment.

## Time

2 hours

## Concept

Why do we need to do a detailed psychosocial and mental health assessment of each CICL? What are the objectives of the assessment?

- To Identify the pathways to offence (what are the vulnerabilities of a given child, and how did he/she come into conflict with the law?).
- To check for any psychiatric/ mental health issues that the child requires to be treated for.
- To develop a care plan that will assist the child with:
    - Behaviour change
    - Social rehabilitation

**Considerations for developing the psychosocial and mental health assessment…**

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

- 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 Psychosocial-mental health proforma presented below has been developed through actual field work with several hundred children and is now being used not only at NIMHANS for CICL but also in other states].*

Remember that the positions taken by some child care workers/ service providers/ activists that no assessments should be done, is not helpful! No one was born with skills to assess and work with CICL…and so, we need to learn and develop them. Lack of so-called technical expertise cannot be the reason why we do not engage in assessments…because if we do not do systematic assessments, we will not be able to provide the much-needed assistance and interventions to these very vulnerable children.

## Activity for Psychosocial-Mental Health Assessment (I)

**Method:** Practice and discussion

**Material:** Assessment Proforma--1 copy to each participant, preferably translated into a language of their use. See Annex I for proforma. *[Detailed Guidelines on the assessment proforma are also available in Annex II—it is recommended that the facilitator reads them and also provides copies to participants].*

**Process and Discussion:**

- Help participants familiarize themselves with the assessment proforma:
  - Discuss each question in the assessment proforma i.e. go through it, ensuring that participants understand how to ask questions and record information on various items.
  - Also discuss the nature of information emerging from each question and how it is going to be used/ how it will feed into intervention plans.
- Allow participants to use the assessment proforma:
  - Divide participants into pairs, wherein 1 person assumes the role of the counsellor and the other that of a CICL.
  - The person playing the counsellor role administers the assessment proforma to the person playing the child—to allow participants to practice using the proforma.
  - Half way through, the roles may be reversed so that all participants have a chance to practice using the assessment proforma.
  - Encourage participants to check with you about questions that are hard to ask/ not clear.
  - Request participants to keep the completed proformas (they will need to use them for the preliminary assessment proforma activity).

**This proforma may be used along with the existing SIR forms.*
**Note: It is recommended that the workshop is followed by on-the-job field training wherein the participants can practice using the assessment format with children in the observation home/ any other CICL setting. Classroom role plays (a mock setting), can be very different from using it directly with the children!*

# Activity for Psychosocial-Mental Health Assessment (II)

**Method:** Film Clip Viewing and Discussion

**Material:** Training film clips on:

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

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

**Process:**

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

**Discussion:**

- Invite participants to share their observations.
- Ask them to try some of the more complex sections of the assessment proforma on the basis on the film clips they have just viewed.

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

# 2.2. Preliminary Assessments for CICL

## Objectives

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

## Time

2 hours

## Concept

The JJB magistrate may request mental health professionals to provide mental capacity assessment of all the children who 16 years old and above and are alleged to have committed a heinous crime, in accordance with section 15, under the new Juvenile Justice Act, December 2015. Thus, upon request of the Juvenile Justice Board (JJB) Magistrate, mental health professionals conduct assessments of specific children and provide a brief about the child's mental health issues, if any. [While the Act states that preliminary assessments should be conducted by the JJB, possibly due to the many ambiguities of this assessment, often refer children to mental health professionals].

As per the JJ Act 2015, the objective of the preliminary assessment, is to *'evaluate the role of the child in the alleged offence, as well as his mental condition and background'*.
As per JJ Act (Section 15), the preliminary assessment asks three questions:
i) Does the child have the mental 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.

Like many child rights' activists and child mental health professionals, the NIMHANS team (which developed this proforma), was not in favour of Section 15 in the new JJ Act that introduced preliminary assessment—because we believe that under no circumstances should children be transferred for trial to the adult systems. There are many reasons for this—from neuro-biological ones that recognize how the adolescent brain and its functioning is different, thereby rendering adolescents vulnerable to certain types of behaviour…to the importance of recognizing issues of vulnerability and proportionality[2]; world-over, both research and experience with such children has shown that retributive justice approaches are not effective as compared to reformative and restorative justice approaches. Also, there are adequate provisions under the Juvenile Justice Act to address the issues of CICL and assist them.

However, whether we agree or not, Section 15 has been introduced, and for now, the law is here to stay. If there are no systematic ways of implementing the preliminary assessments, they will be implemented in randomly, without the requisite knowledge and skills in child

[2] Proportionality refers to the balance between seriousness of the alleged offence and the seriousness of the circumstances that the child comes from. Given the fact that most CICL come from backgrounds of neglect, abuse, poverty, poor parental supervision, lack of schooling and other opportunities, they are vulnerable to mental health and psychosocial issues. This fact needs to be given valence in systemic decision-making processes.

mental health and/or on working with CICL. Even the experiences and skills of mental health professionals are extremely varied. In other words, the kind of preliminary assessment report a given psychiatrist may provide to the JJ Board would depend on a number of variables such as:

- His/her views on Section 15 of the JJ Act 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).

The question then is: how do we implement the law in such a way that we still manage to assist the child, uphold child rights and try, therefore, to influence the transfer decisions i.e. to protect children from being transferred to the adult systems of trial? The preliminary assessment designed and implemented by NIMHANS thus uses a mental health lens to assess CICL's capacities for the alleged offence—and focuses on highlighting a given child's vulnerabilities, so as to make the argument that a child requires mental health and rehabilitation interventions (not transfer).

**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. | Administered 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. |
| 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 to committing 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. |

In the absence of details in understanding or interpretation of these three questions that are required to be addressed in the preliminary assessment, the NIMHANS Project (which developed the preliminary assessment format) interpreted them as follows, i.e. that preliminary assessment should consider or be based on:

- Best interests of the child i.e. giving him/her a chance for transformation and rehabilitation.
- Child rights

- An understanding of child mental health issues, especially of children in difficult circumstances
- Consider treatment, behaviour change and rehabilitation

## Activity for Preliminary Assessment

**Method:** Practice and discussion

**Material:** Assessment Proforma--1 copy to each participant, preferably translated into a language of their use. See Annex III for proforma. *[Detailed Guidelines on the assessment proforma are also available in Annex IV—it is recommended that the facilitator reads them and also provides copies to participants].*

**Process and Discussion:**

- Help participants familiarize themselves with the assessment proforma.
- Discuss each question in the assessment proforma i.e. go through it, ensuring that participants understand how to feed information into this form, using information from the detailed psychosocial-mental health proforma.
- Ask participants to remain in the pairs in which they completed the psychosocial-mental health proforma.
- Ask them now (in their pairs) to fill out the preliminary assessment, using the information they have on the mental health-psychosocial proforma.
- Encourage participants to check with you about questions that are hard to ask/ not clear.
- Request the sharing of some preliminary assessments in plenary.

**It may be useful for the facilitator to use one example and demonstrate how to fill out the preliminary assessment, in plenary—before everyone attempts the task in pairs.*

# 3. Psychosocial & Mental Health Interventions for Children in Conflict with Law

# 3.1. First Level Responses to Psychosocial & Mental Health Concerns

## Objectives

- To learn how to provide first responses to assist CICL with reflection and behaviour change.
- To practice using these responses with various children and problem contexts.

## Time

3.5 hours

## Concept

There are many problem contexts or problem behaviours due to which children come into conflict with the law. Some of the common ones are stealing, violence and aggression, (perpetration) of sexual abuse and substance abuse. Following the administration of the detailed psychosocial assessment, the child worker/ counselor provides what are known as first level responses to the child. This could take about an hour's time and help initiate the process of behaviour change in the child. It entails discussions on:

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

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.

**A Framework for Effecting Transformation and Behaviour Change**

Just like in training workshop 1, we learnt a framework for analysis of children's emotions and behaviours (context-experience-inner voice-emotion-behaviour), we are now going to learn another framework within which to provide a response to children. Whatever the (problem) behaviour that is targeted for change, there is a framework of intervention that consists of 4 stages, namely i) acknowledgement of emotions/needs/desires, ii) insight facilitation, iii) motivation for change, and iv) behaviour change.

**The Behaviour Transformation Framework…**

- Is to be used for first level responses to children.
- The therapist may touch on all 4 stages of the framework in a single session or if timelines permit, focus on one stage at a time i.e. one stage per session.
- While the 4 stages are iterative and therefore laid out in a linear manner, and indeed they should be implemented that way, the therapist may have to move back and forth between them and repeat some of the stages. For instance, while discussion methods of behaviour change (stage 4), if you find that the child still has issues with motivation for change (does not really want to make the change as yet).

**Step 1: Acknowledgement (of Experiences and Emotions)**

***"My counselor is on my side…and understands what happened and why it happened…at least someone understands and respects my feelings and does not think I am a bad person."***

***Vs***

***"Everyone thinks I am bad…no one really understands what happened and how I felt…"***

This essentially refers to the counseling skill we learnt in workshop 1—of recognizing and acknowledging emotions (and possibly difficult experiences) of the child. For example, to empathize with the child's anger in a given situation, or desire in the context of stealing. Remember, in case of CICL, you are NOT validating the action/ behaviour (of stealing or aggression); you are validating the emotion or the experience that lies behind it.

If a child has been provoked into an anger reaction or stolen something or engaged in sexually inappropriate action, a direct criticism of the action will only serve to make the child defensive and mistrustful of the counselor (and consequently create a negative therapeutic alliance). It is therefore important to acknowledge that the child had some reason for his action i.e. that the action was a result of some emotion, need or desire, and that emotions, needs and desires are legitimate, BUT how we express them and how our expressions and actions are perceived by others is the issue we need to discuss. For instance, getting angry is natural (to everyone) but how do we express the anger? Do we walk away, shout, hit others…? Is shouting and hitting the most useful way to express it? Similarly, there is nothing wrong with desiring a mobile phone or money…we all want or like certain things but is stealing the way to obtain them? So, the idea is to acknowledge the emotion, need or desire NOT the action that ensued as a result of these i.e. you are not acknowledging the need to hit or steal.

Acknowledgement of children's needs and emotions helps them feel that the counselor sees them as reasonable persons with the capacity to think and reflect (as opposed to 'bad' or 'unreasonable' persons—which is how most of the world has perceived them so far, and which is not motivational for children to want to change their behaviour). This acknowledgement is critical for what is known as the 'therapeutic alliance' or the counselor-child relationship—which is especially important in the context of CICL. As you know, CICL are often viewed negatively and labelled as being 'bad kids', so validation and acknowledgement of emotions helps to establish a relationship of trust with the child i.e. so that the child understands that you are on his/her 'side'.

**Step 2: Insight Facilitation**

***'Now I know what I did was a problem…I understand reasons why could be a problem for myself and others around me."***

***Vs***

***'I am not really sure what is wrong with this behaviour, so why stop it? What's the problem anyway?'***

Most times, CICL know about 'right' and 'wrong' behaviours i.e. for example, they know that taking things that do not belong to oneself is 'wrong'. However, a deeper understanding of why this behaviour is 'wrong' or unacceptable is not so clear in their minds. Insight facilitation refers to helping the child reflect on a deeper level as to why a given behaviour is a problem and explore reasons why the behaviour is not acceptable.

Insight refers to what understanding children have of the offence they have committed: Are they able to recognize what their problem is? Do they see it as a problem for themselves and others? Children who have an understanding of their alleged offence and acknowledge the difficulties it has created for self and others, are said to have insight. There are two ways to understand whether a child has insight:

a) A child who has allegedly murdered someone under the influence of alcohol and he may say that murder or killing is the problem. Or he may say that murder is not a problem—that when certain people behave in ways that are difficult or make him angry, violence, including murder is a legitimate response.

Thus, at level 1, at first instance, the question is whether the child is able to recognize the key problem of his actions. If he does not or is not in agreement that murder is a problem, the therapist will need to enable him to realize what the problem is (i.e. to gain insight)—not through didactic methods of insistence and coercion (we are not the police!) but through discussion and Socratic enquiry[3] *('Does the law permit us to kill anyone we disagree with? Why not? If you were the victim of violence or a close friend/family member of your's was the victim of violence and murder, would you support the action?)*

b) You may ask a child who has murdered someone under the influence of alcohol, why you think he is now in the Observation Home or in trouble with the police. If he says that it is for murder—it is true but actually only partially insightful. If he were to also recognize that this problem was caused by his substance abuse problem and therefore substance abuse is the other and/or 'real' problem, his insight would be complete.

At level 2, the question is whether the child is able to recognize the deeper, less obvious issue of substance abuse i.e. that substance abuse caused him to be intoxicated, which in turn caused him to commit murder. And is he therefore able to recognize substance abuse as being the 'real' or underlying problem that requires to be worked on, for him to not get into trouble in the future? If not, the therapist needs to work with the child to build insight i.e. enable the child to identify and recognize how his actions (and others). This is done again through discussion on the chain of events that led to the final act that got the child into trouble, to enable him to recognize what else happened in that situation (before) that led him to his last action.

[3] The Socratic method is a form of cooperative argumentative dialogue between individuals, based on asking and answering questions to stimulate critical thinking and to draw out ideas and underlying presuppositions.

Insight into/acknowledgement of the problem by the child are the first steps for transformation to occur i.e. only if the child views his/her actions as being problematic can interventions for change be discussed/provided, else the therapeutic process cannot move further. If children lack insight, then they are unlikely to see the need to change their behaviours, let alone to practice the methods that you may give them to change. The child's insight is thus used to frame the target for behavior change i.e. in the above example, the behavior change issues for therapeutic work would be to enable the child to: i) use non-violent ways to express anger or resolve conflict; ii) address the substance abuse/ addiction issues

**Step 3: Motivation for Change**

***"If I change some of the ways in which I behave or respond to people and situations, there are several benefits and gains…to me and to my family, my future…so, I would like to make some changes in my life."***

***Vs***

***"I don't see any point in changing my behaviour or way of life…what difference would it make to myself or anyone? I will not do things differently—as there is no use in that."***

Even when children have developed deeper insights into their behaviours and understand why such behaviours are problematic, it does not guarantee that they will change these behaviours. Any change or adaptation of a new behaviour requires motivation—a will to change that is strong enough to help a person practice different behaviours. In this stage, the counselor therefore builds on the previous steps to help children perceive gains and benefits to making changes in behaviour. For example, what might be the benefits of stopping substance abuse? Might there be financial gains? Perhaps some interpersonal gains, wherein others may trust in the child, therefore enabling the child to build stronger relationships with family and significant others? Are there benefits for the child in the short and long term/ in the future as well? Such questions need to be discussed with the child to help motivate him/her to making behaviour or life style changes.

Acknowledging that an action he/she has committed is problematic is a good start but still not adequate for behavior change to take place. Thus, the next stage in the counseling process, after insight facilitation, is to work on children's motivations for change. What this means is, 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 stage 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. If children are able to reflect on these issues, they form the basis for them to want to change behaviours.

For instance, if a child says that he wants to stop stealing and gives reasons for it (such as how bad the other person would feel or that he/she may not have friends as people will not trust him/her and call him/her a 'thief'), it indicates that the child has motivation for change

i.e. he/she sees reasons to change his/her behaviour. Thus, motivation for change means having the ability to think more deeply about the action in terms of what benefits would accrue to the child if he/she chose to change them.

Were a child to say 'I want to stop stealing because it is wrong', it means essentially the child has some general knowledge that is a wrong/ socially unaccepted behavior but he does not have a deeper understanding of why it is wrong or socially unacceptable—so, in such an instance, the child has not clear reasons to change his behaviour and consequently, the therapist needs to initiate discussions to build his/her motivation for change.
*Note: The ability to see that stealing is wrong because it gets one punished is not counted as a deeper level thought—true as it might be, this is a very simplistic way of thinking appropriate to young children (not older children and adolescents) who are at the initial stages of their moral reasoning and development.*

Similar to insight facilitation techniques, motivation for change is also done through discussions and Socratic methods—essentially, by enabling the child to examine the consequences of committing versus not committing the concerned action, and enumerating the gains/benefits of refraining from committing the action. (*What have been the consequences of killing someone? What are the consequences for your education, your family/ inter-personal relationships today? Should you continue to kill people when you are angry, what would be the consequences in the future—for your job, your family life, friendships/ social life? If you were to deal with your substance abuse issue/ stop drinking, what might some of the benefits be?)*

**Step 4: Strategies for Behaviour Change**

***"I know many different things that what I can do to help me make better decisions or responds more appropriately to people and situations…so that I can feel relaxed, confident and happy."***

***Vs***

***"I want to change how I behave because I don't want to continue to get into trouble and be unhappy…but I don't know what to do or how to do it."***

Following the previous steps, once the child has deeper understanding and insights about his/her behaviours, and feels motivated to change (problem) behaviours), he/she is ready to receive some guidance on how to actually practice new or changed behaviours. This is the time to provide anger control methods, relaxation techniques, scripts on how to resist peer pressure etc. in accordance with the issue. Thus, merely providing these methods without engaging in the previous steps is not likely to be effective as the child requires to be prepared for behaviour change, before strategies for changes are actually suggested; also, if children mechanically practice behaviour change strategies without a basis to doing to (i.e. without insight and motivation), it is less likely to make for successful or enduring change.

Thus, the last stage in the intervention process is behaviour change—which involves ideas, strategies and techniques that the child is assisted to learn so that when implemented, he/she does not engage in the undesirable behaviour any longer. Essentially, these strategies and techniques are to enable children to manage difficult situations and emotions, be able to make decisions on how to respond in such a way that they come to no personal harm and what they do does not harm or hurt others either. Different problems may entail different techniques as discussed below ***(these strategies may be shared/ explained during the course of the activity that is part of this module)***.

**Behaviour Change (A): Anger & Aggression**

**a) Appropriate Expression of Anger:**

- Verbal confrontation of the person who provoked or aggressed against the child ('Why did you do that? I didn't like what you did…I found it hurtful. Perhaps you would like to tell me what the problem is?'
- Reporting or complaining to parents/teachers/police/ adult authorities and allowing them to take the necessary measures against the person child is upset with (instead of taking matters into their own hands and reacting to a situation)
- Encourage children to talk to a friend/ trusted person about the anger-provoking frustrating experience—another way to give vent to anger and express it without it creating problems for self and others.

**b) Anger Control**

These are techniques children can employ when they are in a provocative situation and they need to try to control their anger:

- Walking away from the situation of provocation.
- Using various relaxation techniques to calm down: drinking some water, sitting in a quiet place and counting from 100 to 0 (backwards), deep breathing (as taught in Yoga, wherein child focuses only on breathing)—explain to the child that such techniques will prevent the child from hasty verbal and physical reactions that may get him/her into trouble.
- If the anger continues despite trying to walk away and relax, child can punch a pillow and give vent to frustration and upset (note: warn children that the surface they punch must be a soft object such as a pillow and not a hard object such as a wall, which children are often apt to do—explain that the purpose is to vent frustration/ anger, not to hurt oneself!)

**Monitoring Anger: Anger Diary**

Children who are literate can be asked to maintain an anger diary. This is a diary that they make a simple entry into daily, as follows:

Date:

Reasons/ situations that made me angry today:

How angry did I get? On a scale of 0 to 10, my level of anger was….

What did I do when I was angry?

Did I try to use any of the anger control methods I learnt? Did they work?

This record helps the child (and therapist) to monitor, over time, the causes of child's anger and track his responses, including those that work best for him.

**c) Self-Identity and Future Impact**

- Discuss the child's personal identity—'*who are you? Who do you want to be? Do you want to be the sort of person whom everyone is afraid of—have people say X is a violent, unpredictable person and it is best not to engage with him or be friends with him…you never know when he will lose it and hit you…? Or do you want to be the sort of person to whom everyone comes for help knowing you are patient, will listen calmly and will solve problems in a way that no one will get into trouble …?'*
- Ask child to list all his good qualities, talents and skills—this can even be represented diagrammatically in a circle. Ask child whether he wants anger to be bigger than and therefore overwhelm all his good qualities and talents? Or should anger be a smaller part of his identity with his good qualities/talents being the major part of who he is.
- Discuss the future impact of his anger/ violent behaviours (were they to continue) on… (i) His job: *'What do you want to be when you grow up? (Let us say child says he wants to work in an office). So you are working in an office and your boss gets*

*upset with you over something, you don't like what he says and you get very angry…if you get up, bang the table, shout and throw something at your boss, what would happen? …Would they still keep you on? …And if you try and look for another job, they will ask what happened at the previous place…they may ask for a recommendation…?'*

His family life: *'Suppose some day you grow up and decide you want to be with someone…may be you even decide to get married…and have children. Suppose your anger is out of control and you are in the habit of hitting your family when you get upset, what will happen to your relationship with you husband/wife and children? What kind of a family will your's be?'*

**d) Opinions and Position-Taking on Violence**

This entails engaging children on their opinions and positions on violence by presenting and discussing everyday situations—such as incidents that occur at home, road rage, pushing and shoving in queues, playground fights, communal violence, war (who is affected? how?)…so that children reflect upon violence and take positions on engagement in violent acts in different situations, thereby developing an ideology on (non)violence.

**e) Response to Bullying**

Explain to the child that there are 2 types of responses to difficult people (some of whom may be bigger in size, older, coercing us or taunting and teasing us):

***Internal Responses:*** Things we think inside our heads, so that others cannot see or know what these are—for example: 'I know that this guy is cruel and mean, not just to me but to everyone, so why bother with him'; 'I don't care because I know he is wrong…just because he calls my sister names, that does not make her those things'; 'I can just ignore stupid, senseless people such as him'. Enable the child to think of a set of internal responses and statements for his specific situation.

***External Responses:*** Things we say or do that others can see and know because they show outside—for example, laugh at what the other person says (at least pretend that you didn't take it seriously), give a clever response back, complain to a trusted adult, move away and not associate with the concerned person, Tell the people who are teasing you that you don't like what they are doing to you (this is only if you are sure that they will not retaliate to really violently hurt you; if you think they will hurt you, avoid this response), be friends with people who care about you and will not hurt you.

All of the above are alternative ways of responding to the anger and upset we feel when people treat us badly sometimes.

**g) Practicing Conflict Resolution and Problem Solving**

In addition to the above strategies, it would be useful to give children a range of difficult situations for reflection and discussion. While this is best done in groups as it brings forth multiple viewpoints for children to think about and choose from, it can also be done with individual children. What this entails is giving children what could potentially be a real life situation—*'There is a well-known neighbourhood bully whom you also fear. One day, he interrupts your game of cricket with your friends and snatches your bat. When you start to get upset, he laughs at you and says rude things about your family.'* Ask the child i) all the possible ways in which one could respond to such a situation (list them); ii) ask him to examine the consequences of each of these responses; iii) based on the consequence, ask him to select the best response—what would he therefore do eventually? (Encourage him to apply the above-discussed techniques to the situation). The more children practice such

responses, the more they develop critical life skills such as conflict resolution and problem solving.

**f) Positive Conversion of Anger**

The idea of channelizing and converting anger energies into prosocial actions that are useful to the self and others is a more advanced level of anger interventions, usually done in the last stages of therapeutic work on anger. This perspective-taking method lends itself well to children who intrinsically have a sense of fairness and are often prompted into anger responses by experiences of injustice (being provoked when they feel that they or others around them have been treated unfairly).

- Discuss with the child: As already mentioned, everyone gets angry and like other emotions we feel (sadness, disappointment, anxiety, excitement, happiness…), anger is also one…it is but natural to get angry in certain situations. Different people express and manage anger differently, also depending on the legitimacy of the anger.
- **When Anger is Justified:** *'Anger is not bad always; in fact it is a valid and good emotion in certain situations…for example, you go to a big shop, so you know that the chop keeper is quite well-off. You see a poor person come to buy 2 Kg rice and you notice that the shop keeper cheats him by wrongly weighing the rice and giving him only 1.5 Kg of it. Would you be angry? Why? (Presumably the child would say he would be angry with the shop keeper for cheating someone, that too a poor person). So, when you see injustice, you do get angry…that is legitimate isn't it? Suppose you didn't get angry at such injustice, what kind of person would that make you? An apathetic indifferent person who doesn't care about justice…? So people who get angry are also people who care about others and about justice'*. Ask the child to provide more examples of situations he has perceived injustice and been angry.
- Explain to the child how some people use this anger that arises from experiences of injustice (either in themselves or others) to do something good and useful. Discuss with the child famous social activists such as Mahatma Gandhi and Ambedkar--who were angry about the injustices done to the so-called 'untouchables' and therefore started social movements fighting for their justice and rights; Mother Teresa who felt the injustice suffered by homeless and disabled children and started a worldwide organization (Missionaries of Charity) to take care of such children. Discuss how it is the anger of injustice that has propelled these people into action to benefit others…what would the child do to convert his anger into something positive and beneficial? It does not have to be a large social movement…but at his level, for instance, how might he convert his anger of being bullied/ physically abused…?

**Behaviour Change (B): Stealing**

**Alternative Ways of Obtaining Needs**

Discuss with child ways to obtain their needs (other than stealing)—such as a financial plan to save money over time to buy what they want, a plan towards working for/ earning the money. At times, children may not be able to work right away as they may have to complete their education. In such cases, you could discuss the types of jobs that one could get without education and those that one could get with an education (some paper qualification) and the difference between the salaries and remunerations thereof. This would help the child see the value of long term planning, including make decisions to delay gratification of needs i.e. help children understand that some things we do (or have to do) today may not yield instant

results and get you the mobile phone you want but it could get you a lot more (relatively much higher gains) if it is done in a planned way, with a long term focus and perspective.

**Note: Where severe deprivation is the basis of stealing behaviours, children do not require counselling! They need practical assistance and support—in terms of institutionalization so that their basic needs are met, or, financial support to their families.*

**Behaviour Change (C): Substance Abuse**

**a) Coping with Peer Pressure**

This entails the following discussions on friendship and assertiveness:

- Acknowledging that friends are fun and everyone must have friends, that they are an integral part of one's life.
- How do we select our friends? What kind of people do we want as friends? What qualities do we look for in a friend? If a person gets you to do things that make you uncomfortable or that get you into trouble, can he/she be considered a 'real' friend? So, what is a real friend?
- Even if someone is a friend, if he/she coerces us to do things that are uncomfortable or that may lead to trouble, how do we say 'no'? Is it ok to refuse to do things that you know may hurt you/ get you into trouble?

**b) Addressing Underlying Issues of Anxiety & Depression**

This entails validation of emotions such as of sadness, anxiety and depression, and acknowledgement of the child's difficult and traumatic experiences. If these are severe (for instance, if the child is unable to function properly on a daily basis/ having trouble engaging in daily activities and/or has thoughts of self-harm, the child would require referral to a tertiary centre for psychiatric treatment.

**c) Medication-Assisted Therapies**

Substance use disorder has been recognized as a chronic relapsing medical illness with relapses and remissions and a strong genetic component similar to illnesses such as diabetes and hypertension[4]. Also, individuals who have used substances intensively and/or over a long time are at greater risk of relapse due to certain irreversible neurobiological changes in brain pathways. While psychotherapeutic and behavioural interventions can alleviate substance use problems in adolescents, the use of medications can also play a major role in preventing relapse and facilitating longer periods of abstinence[5]. For instance, Nicotine replacement therapies are most effective for tobacco cessation; effective medications have also been developed for alcohol dependence and other types of substance use.

However, it is important to remember that the choice is never between psychosocial therapy interventions/ therapy and medications; rather it is psychosocial therapy interventions/ therapy only or psychosocial therapy interventions/ therapy and medications. Thus, medications are used as aides to psychosocial treatments and the role of pharmacotherapy in treatment depends on the specific type of substance use disorder.

[4] McLellan AT, Lewis DC, O'Brien CP, Kleber HD(2000).Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA.284(13):1689-95.

[5] Barber WS, O'Brien CP. (1999). Pharmacotherapies. In: McCrady BS, Epstein EE, editors. Addictions: A comprehensive guidebook. New York, NY: Oxford University Press. pp. 347–369

Pharmacological or medication interventions have three broad objectives: management of acute withdrawal syndromes through detoxification, reduction of cravings and urges to use illicit drugs (in the initial recovery stage), and prevention of relapse to compulsive drug use[6].

As indicated by the substance abuse tool embedded in the assessment proforma, where a child appears to require intensive treatment, pharmacotherapy will almost certainly be necessary in addition to psychosocial interventions. Systems and service providers working with children in conflict with the law are often hesitant about the use of psychiatric and de-addiction medications as they believe that there may be side-effects that they cannot control and/or that may affect legal decisions to be made regarding the child's offence and actions. However, systems and staff need to be educated about their concerns and reservations – that these cannot be used as justifications to withhold medication that could potentially improve children's mental health and well-being. In fact, not allowing for use of pharmacological treatments for mental health issues is a violation of children's right to health and treatment (also mentioned in the JJ Act). As long as the medications are recommended following detailed assessments by recognized/ accredited mental health hospitals and institutes, using formal written prescriptions with details on the method and course of treatment, there should be no problem for the child or the child care service system/ staff.

**Behaviour Change (D): Sexual Abuse & Sexual Decision-Making**
This entails a discussion of the window approach, to help a child to understand and reflect upon each factor that is relevant to the decisions they make in sexual behaviour-- as outlined below in the activity.

## Activity for First Level Responses to Psychosocial & Mental Health Concerns

**Method:** Role play and discussion

**Materials:** Case studies & frameworks and content for first level response--as shown in the boxes/ pages below) (case studies contributed by the participants may also be used).

**Process & Discussion:**

- Explain the framework and content for a given area of response (for example, anger and aggression).
- Divide participants into pairs-- One person assumes the role of the child and the other that of the counselor.
- Explain the framework and content of response for each area/theme, as presented in the boxes below (refer also to the notes on behaviour change strategies as discussed above under 'Concept'):
- Response (A): Anger and Aggression
- Response (B): Stealing
- Response (C): Substance Abuse
- Response (D):Sexual Abuse & Sexual Decision-Making (POCSO Cases)
- Give the pairs the suggested cases (in the boxes below) asking them to apply the frameworks in practice-- to practice how each stage of the session would proceed.
- Ask pairs to volunteer to role play in plenary and demonstrate how they could conduct the session with the child. In case of larger groups or time limitations, you could ask pair to demonstrate stage 1 of acknowledgement of feelings, another pair to demonstrate stage 2/ insight facilitation…and so on, enabling the group to understand how a an intervention is structured.
- Encourage groups to comment, ask questions and share ideas they may have experimented with in different situations.

**Explain only one area/theme at a time (not all together)--for instance, 'Intervention A: Anger and Aggression', to be followed by activity & discussion before proceeding to the next area/theme.*

## First Level Response (A): Anger and Aggression

- **Acknowledgement of Anger:**
  - Legitimate feeling...everyone gets angry...not wrong
  - Issue is how to express it in ways that don't hurt us/others + manage and control it.
- **Insight Facilitation:**
  - When do you get angry? (List reasons)
  - How often do you get angry? (Anger thermometer)
  - What do you do at the time?
- **Motivation for Change:**
  - Examine consequences of anger—what happens when anger is not controlled?
  - Future Orientation—If your anger is not managed, what will happen 5 to 10 years later when i) you are working/in a job; ii) you have a family?
  - How do you think it would be beneficial to you if you do control your anger?
  - What is your ideology or position on aggression?
- **Strategies for Behaviour Change**
  - How to control anger...techniques to manage it.
  - Walking away from provocative situation;
  - Confronting the person - Why did he/she behave with you like that? And telling them that their behaviour made you angry.
  - Reporting/Complaining**:** Telling or complaining to teacher/parents/superintendent…
  - Relaxation Techniques - Deep breathing, counting slowly from 100 to 0, Drinking a glass of water.
  - If anger continues, to vent it by punching a pillow.
  - Responding to bullies (internal/ external response).
  - Writing a letter to person you are angry with.
  - Maintaining anger dairy to monitor anger/ behaviour change

  **[Refer to Behaviour Change Strategies section under 'Concept'—to provide more ideas on how to respond].**

**Case Study A.1:**

R is a 16 year old boy who comes from low socio-economic background, a loving and somewhat over-protective family. He is a school drop-out and now works in a garage. He has a large group of friends in his neighbourhood with whom he plays sport. He does not engage in any anti-social behaviours or substance abuse. One day, while R was hanging out with his friends, an older adolescent (19 years old), a well-known neighbourhood bully came and started calling R's sister and mother abusive names. R got angry and hit him. The fight escalated and the bully brought out a knife and try to hurt R. At some point, R got hold of the knife and it injured the bully. R is now in the OH for attempted murder.

**Case A.2:**

P is a 17 year old boy goes to a large international school. He is apprehended by the police for the alleged murder of a grade2/ 7 year old boy in the same school. The younger child was found dead in a toilet of the school with his throat slit. P later confessed that he had killed the 8-year-old child to get the exams postponed and avoid a parents-teacher meeting. The accused was a below average student who did poorly in his exams and excelled at only music.

## Intervention B: Stealing

*No labelling- 'taking other people's things without permission' (not 'stealing')

- **Acknowledgement of Need**
  - Let us first examine the legitimacy of your need (what you took from someone)...
  - Everyone has needs and desires—not wrong to want things.
  - Issue is what methods we use to get them without getting into trouble/ hurting others.
- **Insight Facilitation**
  - Why is it wrong to take others' things without permission...to whom does the stuff belong to? How did they acquire it? (By working/ earning to buy it...)
  - Can we then take what does not belong to us? (Sense of Entitlement)
  - How do you think the other person felt when he knew that his stuff was taken/ lost? How would you feel if someone did this to you? (Empathy building)
- **Motivation for Change:**
  - Examine consequences of taking things without others' permission—what happens when we do this?
  - Future Orientation—If this behaviour continues (becomes a habit), what will happen 5 to 10 years later when i) you are working/in a job; ii) your friendships?; iii) what will people say about you/ your trustworthiness?
  - How do you think it would be beneficial to you if you change your behaviour?
- **Behaviour Change**
  - Are there ways in which you can get what you want in a planned manner? (Working, saving money...)

**[Refer to Behaviour Change Strategies section under 'Concept'—to provide more ideas on how to respond].**

**Case Study B.1:**

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

**Case Study B.2:**

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

## Intervention C: Substance Abuse

- **Acknowledgement of Emotions/ Pleasures**
  - Many people use substances—to varying extents... some use it occasionally/ socially, others use it very frequently until it becomes a habit and they cannot do without it/ it starts affecting their health/life /work.
  - That there are benefits to using substance is also true...it may give pleasure, help forget about difficult and sad events in life...
  - Issue is not whether it is good or bad/ you are bad for using substance...it is about a decision you may want to make—whether to use it or now...based on the impact it may have on your life...and how are you going to decide between the pleasure substance use may give (momentarily perhaps) vs the impact it may have on your life?
- **Insight Facilitation**
  - Explore the financial impact of substance use i.e. get child to calculate how much he spends each day/week on substance + how else he could use that money if it was saved.
  - Explain/ show videos about health impact of substance use
- **Motivation for Change**
  - Future orientation —If substance use continues, what will happen 5 to 10 years later when i) you are working/in a job; ii) your family relationships?
  - Benefits of not using substances?
- **Behaviour Change**
  - Develop assertive skills—saying 'no' to substance when offered by friends/peers.
  - Explore ideas of friendship & peer relationships—who is a friend? One who tells you to do things that are beneficial to you or harmful to you? If someone asks you to do harmful things, is he/she really your friend? And so, should we be considering their opinion?
  - Role plays on assertiveness/ saying 'no' to peers.
  - Help child address anxiety/ depression through medication and therapy methods (if that is basis of substance use)
  - Consider medication for withdrawal symptoms/ prevention of substance abuse (when craving is very high/ withdrawal symptoms are hard to cope with).
  - Environmental modification: place child in closed institution/ protective environment (away from adverse peer group influences/ gangs), where there is a structured daily schedule (education, vocational training).

**[Refer to Behaviour Change Strategies section under 'Concept'—to provide more ideas on how to respond].**

**Case Study C.1:**

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

**Case Study C.2:**

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

| **Intervention D:Sexual Abuse & Sexual Decision-Making (POCSO Cases)** | | |
|---|---|---|
| | **Sexual Abuse** | **Inappropriate Sexual Decision-Making** |
| | • Harmful/ hurtful to another person wherein violence and abuse occurs.<br>• Behaviour problem<br>• Not mutual, non-consenting.<br>• Therefore, a serious offence. | • Adolescents who run away to 'get married'/ live in together...<br>• Life skill issue (decision-making)<br>• Often mutually decided, consenting based on an existing romantic relationship<br>• Actually not an offence- if adolescent sexual rights are respected. |
| **Acknowledgement of Emotions** | • Acknowledge that everyone has sexual needs and desires...sexual acts can be pleasurable.<br>• But there is a context to them...where, when, how and with whom we do them...have to be thought through before we act on our needs/ desires. | • Acknowledge seriousness of relationship...plans for marriage, may be even commitment...adolescent's attraction/ love...not to be undermined...<br>• But could there have been ways of doing things in a more planned manner so as to be comfortable and successful in doing so? |
| **Insight Facilitation/ Motivation for Change** | • How would the other person have felt when you did that? Could they have been hurt, angry, scared...? (Empathy building)<br>• In case victim was a child—at what age are people usually ready for sexual engagement i.e. physically and in terms of feeling desire/ attraction? Do young children have the physical/ mental capacity to engage sexually? So then can we...?<br>• Did you know that there is a law called POCSO? It says...<br>• Even if the person is same age as you, can you still go ahead and act on your desires? What about the other person's permission/ consent?<br>• New JJ amendment/ December 2015 after Nirbhaya case...transfer system for heinous crimes | • What might have your parents' concerns been about your living together/ marrying? (Discuss financial stability, education completion)<br>• Engagement in a physical/live-in relationship can result in girl getting pregnant...your readiness for parenting/children?<br>• Law about marriage—have to be 18+ years...why did that law come into being? (women's health/ pregnancy/ baby's well-being...) |

| | |
|---|---|
| **Behaviour Change** | So, how do we help adolescents make decisions about sexual engagement? The window approach...(also in Training Manual 2 on 'Working on Abuse & Trauma).<br>• Window 1: Acknowledgement of Love and Attraction/ Needs and Pleasures<br>*"There is nothing wrong with feeling love and attraction for someone…everyone does and love and physical intimacy are wonderful…they are important aspects of human life. We cannot deny the need for love and sexual intimacy—and must make space in our lives for them. The question is can we set aside everything else (such as education, everyday activities and life plans) and only focus on love and sex?"*<br>• Window 2: Privacy<br>*"What does privacy mean? Why do windows have curtains? Why do we close the door and take a bath? Where can we engage in sexual activity? There are public spaces such as parks, market places…can you think of some private spaces? Are facebook and other social media public or private spaces? It is not that it is wrong to put certain type of (intimate) pictures there…but once you put a picture out there, do you have any control over who sees it i.e. your privacy? Can we control what some people may think and act if they see a certain kind of picture? For instance, if a girl puts a picture of herself in a sexual position with her boyfriend, some of us may think it is her right to do so and think no more of it; however, some of her male classmates may see it and think...? That if she can do that with that guy, then why not me? What if they then approach her and coerce her to do the same…? While many of us are supportive of women's rights and women's safety, and believe that women should be able to wear what they please and go out at any time, in the confidence that they won't be harassed, what are the realities of the world we live in?"*<br>• Window 3: Consent and Boundaries<br>*"What does permission and consent mean? In what situations do we ask for permission? For instance, if I want to enter your room, how do I do so? If I do not knock or ask, and I walk right in, how would that make you feel? What happens when consent is refused and we still go ahead and do something…whether we take someone's belongings or enter their space…? It is likely that there will not be much trust or respect or liking left in a relationship where people feel coerced. Violence is an extreme form of force or coercion…what are others? Suppose you asked someone out for a movie and he says 'no' and you buy tickets and tell him that he must come…? When he continues to refuse, if you say (in a sweet tone of voice)—'please, please…aren't you my friend? Don't you love me? If you really loved me, then you would come…' would this be a form of coercion? So, not all use of force is angry or violent; it can be done in ways that are softer, but it still means coercion—when one pushes a person to do what he/she does not want to do. And when we coerce someone we are breaking boundaries..."*<br>• Window 4: Health & Safety<br>*"Risks of unprotected sex? Unwanted pregnancy…HIV and other sexually transmitted diseases. What is protected sex? How to use a condom?"*<br>• Window 4: Relationships<br>*"Who is the person that one is considering having sexual intimacy with? Is it a young child—in which case it may be problematic because it is not possible for a young child to give consent…since she does not understand sexuality issues. (There are also laws against sexual engagement with children). Is it someone within the family… like an uncle—and that may also be difficult, considering boundary issues/ family relationships? Is it a friend—if so, how long have and how well have you known him/her? How do we get to know people and establish trust…? What are your plans/ expectations of the relationship and what are his/hre plans and expectations?"*<br>• Window 5: Abuse and Protection<br>*"When a person engages with another person, without taking into consideration the issues discussed above i.e. he/she does not take into account issues of privacy, goes against consent, uses coercion and breaks boundaries, disregards relationships…there are also laws about abuse—separate ones for abuse of children and adults…" [Briefly discuss POCSO and other criminal laws on abuse/rape…and explain the new JJ Act/2015 amendment so that children understand the legal implications of abuse).* |

**Sexual Abuse Case Studies**

**Case Study D.1:**

P is a 14 year old child from a single parent family. He never went to school and was a child labourer.

He usually spent time with his neighbourhood friends who were mostly older than him. One time, they had shown him pornographic videos after which the child was curious about sexual relationships. The next day, the child took one of the young boys in his neighbourhood, an 8 year old, to an abandoned building nearby and touched the young child inappropriately in his genitals, following which he came into conflict with the law when the young child complained to his parents.

**Case Study D.2:**

B was a 17 year old boy who was one of 6 people who gang-raped a female student in a private bus in which she was travelling with a male friend. The woman died from her injuries thirteen days later while undergoing emergency treatment. The police described the juvenile as the most brutal of the six accused. B was ten or eleven when he left. It's a family of seven, with B being the oldest child. The father is a psychiatric patient. The daughters earn Rs.50 a day as farm labourers when there is work. B's mother saw him briefly twice or thrice in the last six-seven years after he went to the city, as a boy, to find work. His mother remembers the time he was born only vaguely. A village elder strains to remember him. was a good boy says another villager by which he seems to mean he remembers nothing particularly bad about him. The man who owned the *dhaba* remembers him as a boy who didn't have a mobile phone, was not into girls or cricket or movies. His jobs were the jobs of a poor boy with no education – bus cleaner, dishwasher, helper to a milkman, *dhab*a assistant.

**Sexual Decision-Making Case Studies**

**Case Study D.4:**

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

**Case Study D.3:**

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

**Case Study D.5:**

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

# Activity for First Level Responses to Psychosocial & Mental Health Concerns (II)

**Method:** Film Clip Viewing and Discussion

**Material:** Training film clips on:

- 'First Level Response to Peer Influence Issues'
- 'First Level Response to Sexuality Issues'

**Process:**

- Screen each clip (and follow it with the discussion).
- Ask participants to observe how the 4-step framework (acknowledgement of emotions/experiences, insight facilitation, motivation for change, strategies for behaviour change) are followed by the counsellor, in each clip.

**Discussion:**

- Invite participants to share their observations.
- Ask them to pick out specific things said by the counsellor (in the clip) that reflect that she was following the 4-step framework we have discussed and practised using.

*<u>Note:</u> *This film clip viewing and discussion activity may also be done before the case studies-role play activity, particularly if the participants find it difficult to understand the first level response framework and the steps involved; seeing how it is done and then attempting it themselves might work better for some groups.*

# 3.2. Depth Interventions for Psychosocial & Mental Health Issues

## Objectives

- To use life skills training methodologies.
- To learn methods to enable adolescents to cope with trauma as it pertains to loss and grief or sexual abuse.

## Time

2 hours (could be longer if facilitator and participants wish to try out more activities—in which case, it can even extend to a day).

## Concept

The basic concepts of life skills training methodologies have been introduced and discussed in the previous workshop (Training Series 2 on 'Working with the Trauma of Loss & Abuse'). Activities from the Adolescent Life Skills Series I on *'Social and Emotional Development'* as well as Adolescent Life Skills Series II on *'Gender, Sexuality & Relationships'* (developed by the NIMHANS Community Child & Adolescent Mental Health Service Project) may be used for depth interventions.

As discussed, one of the key problems that CICL have is deficits in life skills—mainly those pertaining to emotional regulation (such as anger, anxiety and other impulses), problem-solving, conflict resolution and assertiveness. Activities in the Life Skills Series that focus on conduct, anger and anxiety management, substance abuse, and coping with peer pressure would be useful to do with CICL; as also previously discussed, the Life Skills Series on Gender, Sexuality and Relationships and the activities that are designed in accordance with the 'Window Approach' are for use not only with child victims of sexual abuse but also children and adolescents who violate boundaries and engage in high risk sexual behaviours and/or sexual abuse behaviours.

However, this does not mean that activities that focus on trauma and coping with difficult issues should not be done with CICL. A common error in understanding CICL is made when we view them only in terms of their negative behaviours. You now know that the basis of many of these externalizing behaviours (such as aggression, stealing, substance abuse…) can often be emotional problems, arising from abuse, difficult and traumatic experiences within the family and outside. Furthermore, just because a child has socially inappropriate behaviours, that does not preclude him/her from also having internalizing disorders or emotional problems—and he/she has the right to assistance for coping with trauma, abuse and other difficult issues that are causing him/her emotional distress.

It would therefore be useful to start with the life skills activities that focus on emotional issues (such as coping with difficult experiences and managing worries and anxieties) and then move on to activities that focus on socially inappropriate/ 'problem' behaviours (such as conduct and substance abuse). In fact, if you look at how the Life Skills Series on Social and Emotional Development is laid out, it begins with activities that help children work on their emotional issues and then moves on to helping them to reflect upon and address behaviours. (Remember the Context-Experience-Inner Voice-Emotion-Behaviour Analysis Framework!)

## Activity for Introducing the Practice of Life Skills Methodologies

**Method:** Practice and demonstration

**Material:** Life Skills Series (Printed along with the materials required)

**Process:**

- Divide participants into sub-groups (of 6 per group depending on the number).
- Select any 1 life skills series on socio-emotional development—either the one for children or adolescents.
- Allot one thematic area from the series (such as conduct, substance use, peer relations…) to each sub-group, asking them to do the following:
    - Read the activities one by one (pertaining to the theme allotted to them).
    - Discuss how they would execute it with a group of children.
- Request each sub-group to come forward in plenary and briefly do the activities allotted to them—they may use the larger group as the child group.
  [The idea is just to familiarize themselves with the methodologies and the practice].

**Discussion:**

- Invite participants to ask questions about the activities and methods, and to anticipate challenges they may face while working with children—so that these may be discussed.

*Similarly, the other life skills series pertaining to adolescents (on gender, sexuality and relationships) may also be demonstrated and discussed—this one has several film clips, which could be played, either in full or selectively, depending on the time.
*Alternatively, the facilitator may also demonstrate some activities.
*Assuming that some life skills activities have already been discussed in the previous training workshop, the activities for this session could focus on CICL issues.

# 4. Field Practice

# 4.1. Supervised Field Practice

## Objectives

- To enable participants to apply the knowledge and skills gained in the workshop.
- To enable them to translate theoretical knowledge into practice and action.

## Concept

As done in earlier workshops, there is no substitute for field practice! Thus, this workshop also concludes with a demonstration of work with CICL in the field (under direct guidance and supervision of the facilitator), and a field practice assignment that requires to be completed by participants later on.

## Activity for Supervised Field Practice

*To be done by all participants on the last day of the training workshop.

**Material:** Psychosocial & Mental Health Assessment proformas for CICL

**Method:** Practical implementation of individual assessments in an Observation home (or in a care and protection home where there are children identified with behaviour/conduct problems)

**Process:**

- Select (with the support of the organizing agency) an Observation Home or a care and protection home where there are children identified with behaviour/conduct problems.
- Ask the institution staff to provide a list of children that you can work with individually—it could be children whom they have observed to have emotional and behaviour problems.
- Ask participants to get into pairs.
    - Each participant-pair must work with one child, over a period of about an hour to do the following:
    - Administer the individual assessment proforma
    - Provide some basic inputs through use of the first level responses taught in the workshop
    - Feed back to the institution staff/superintendent on the institution on what the child's issues and requirements are (i.e. the individual care plan).
- The work with individual children is done by the participants under supervision of the facilitator—so ensure that you provide on-going assistance i.e. as the participants work with children and have questions or doubts.

**Discussion:**

- Re-assemble (in a separate space) and discuss in plenary the experience of the participants—what went well? What did they feel confident doing? What part of their interaction and interview with the child was challenging? Provide suggestions accordingly—encourage participants to also assist each other with solutions.

# 4.2. Homework Assignment

## Objectives

- To enable participants to continue to apply the knowledge and skills gained in the workshop.
- To enable them to translate theoretical knowledge into practice and action on a sustained basis.

## Concept

Practice, practice, practice in your daily field work…try out all you learnt!

## Activity for Homework Assignment

*To be completed by all participants who attended the training workshop, in the weeks following the workshop.

**Material:** (Relevant) Assessment proformas

**Method:** Practical implementation of individual CICL assessments in a child care institution/ Observation Home/School

**Process:**

- Ask participants to do the following:
    - Select any child in your institution (age 13+) who has a behavior problem relating to aggression/violence, substance abuse, stealing, sexual offence or romance/sexuality.
    - Use the assessment format discussed in the workshop to conduct a detailed assessment of the child.
    - In case the child is between 16 and 18 years, and if he/she has been charged with a heinous offence, as per the JJ Act 2015 amendment, also fill out a preliminary assessment report (according to the format discussed in the workshop).
    - Conduct first level responses with the child—briefly document how you responded to the child immediately after the assessment (using the acknowledgement of emotions/insight facilitation/motivation for change/strategies for behavior change framework).
    - Select and use at least 2 to 3 intervention methods learnt/ contained in the life skills module to address the child's problem—briefly document how you went about this part of the intervention.
    - Briefly describe the child's responses after your interventions—was there any change?
    - List some of the challenges you faced during your work.

*Note: This is the last level/ final workshop—however, a review workshop, spanning 2 days, may be organized. During this time, the CICL assignment as well as any other work/ concerns/ learning that have emerged over time, during the course of the training and field practice may be reviewed; additional and more advanced inputs may also be provided. This is a more effective way to evaluate learning and retention than what are popularly known as 'refresher training workshops', a favourite with many agencies, but in reality, can be repetitive and boring for participants!*

# Annex I

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

**Community Child & Adolescent Mental Health Service Project**
**Dept. of Child & Adolescent Psychiatry, NIMHANS**
**In Collaboration with Dept. of Women & Child Development, Govt. Of Karnataka**

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

### Section 1: Basic Information (including alleged offence)

**Assessment done by (Name of Individual & Agency):**

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

**Age:** **Sex:**

**Location/ Place of Origin:**

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

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

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

**2.2. Institutional History**

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

**2.3. Schooling History**

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

**2.4. Work Experiences**

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

**2.4. Peer Influence**

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

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

**i. School/ Classmates**
**ii. Family members- cousins etc.**
**iii. Friends in your neighborhood**
**iv. Others**

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

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

**d) Age of friends?**

"Most of them are…."

i. Older than you
ii. Younger than you
iii. Same age as you

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

**f) Extent of influence of peers**

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

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

**g) Consequences of peer influences**

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

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

### 3.1. Loss, Death & Grief

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

### 3.2. Physical, Emotional & Sexual Abuse

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

a) Physically hurt you and caused you injury?

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

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

## Section 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.**<br>**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.**<br>**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)**<br>Have you felt sad or depressed, or felt down or empty, or felt grouchy or annoyed, most of the time, for the past year? | No | Yes |

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

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

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

**Depression Issues: Yes/ No**

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

- Have you ever felt like you do not want to live? Yes/ No

- If yes, have you ever acted upon this thought to not live? Yes/ No

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

**5.3. Attention Deficit Hyperactive Disorder (ADHD)**

| O2. | **In the past 6 months...** | No | Yes |
|---|---|---|---|
| a) | Have you often not paid enough attention to details? Made careless mistakes in school? | No | Yes |
| b) | Have you often had trouble keeping your attention focused when playing or doing schoolwork? | No | Yes |
| c) | Have you often been told that you do not listen when others talk directly to you? | No | Yes |
| d) | Have you often had trouble following through with what you were told to do (Like not following through on schoolwork or chores)? | No | Yes |
| e) | Did this happen even though you understood what you were supposed to do? | No | Yes |
| f) | Did this happen even though you weren't trying to be difficult? | No | Yes |
| g) | Have you often had a hard time getting organized? | No | Yes |
| **h)** | Have you often tried to avoid things that make you concentrate or think hard (like schoolwork)? Do you hate or dislike things that make you concentrate or think hard? | No | Yes |
| **i)** | Have you often lost or forgotten things you needed? Like homework assignments, pencils, or toys? | No | Yes |
| **j)** | Do you often get distracted easily by little things (Like sounds or things outside the room)? | No | Yes |
| **k)** | Do you often forget to do things you need to do every day(Like forget to comb your hair or brush your teeth)? | No | Yes |

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

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

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

**Attention Deficit Hyperactivity Disorder (ADHD): Yes/ No**

**5.4. Conduct Disorder**

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

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

**Conduct Disorder: Yes/ No**

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

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

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

**Question 2:**

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

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

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

**Question 3:**

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

**Question 4:**

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

**Question 5:**

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

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

**Question 6:**

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

**Question 7:**

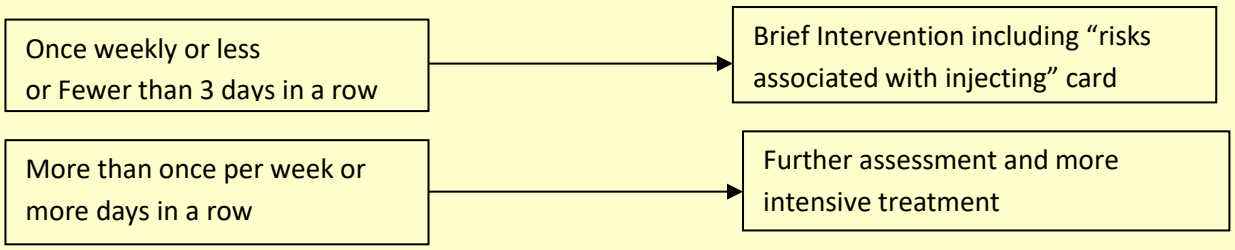
| Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)? | Never | Once or Twice | Weekly | Monthly | Daily or Almost Daily |
|---|---|---|---|---|---|
| Tobacco products (cigarettes, chewing tobacco, cigars, etc.) | 0 | 2 | 3 | 4 | 6 |
| Alcoholic beverages (beer, wine, spirits, etc.) | 0 | 2 | 3 | 4 | 6 |
| Cannabis (marijuana, pot, grass, hash, etc.) | 0 | 2 | 3 | 4 | 6 |
| Cocaine (coke, crack, etc.) | 0 | 2 | 3 | 4 | 6 |

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

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

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

PATTERN OF INJECTING INTERVENTION GUIDELINES




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 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)**

**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?

**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[7], Pathology[8] and Consequence[9].** 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).

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

[8] 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.

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

# Annex II

## Guidance Notes on
## Psychosocial & Mental Health Assessment 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, Government of Karnataka**

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

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

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

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

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

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

## 2. Guidance Notes

### Section 1: Basic Information

**Assessment done by (Name of Individual & Agency):**

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

**Age:** **Sex:**

**Location/ Place of Origin:**

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

**Guidance Notes**

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

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

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

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

**Guidance Notes**

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

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

Socio-economic status explains the kind of deprivation that a child comes from—and in some cases, unmet needs and deprivation form the pathway to offence. The lack of emotional attachment to parents due to rejection and/or harsh and punitive parenting leads to children developing antisocial behaviours in the following ways: i) poor attachment and parent-child relationships from an early age lead to emotional dysregulation i.e. difficulty in children controlling difficult emotions such as anger

and anxiety; ii) parents who are violent/ alcohol dependent/ engage in criminal behaviours serve as role models to their children who then also learn and practice these behaviours; iii) neglect and poor supervision by parents (whether due to lack of time, illness or disability) due to which children do not develop appropriate life skills.

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

**2.2. Institutional History**

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

**Guidance Notes**

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

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

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

**2.3. Schooling History**

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

**Guidance Notes**

This sub-section elicits information on the child's schooling and educational history. It is important to understand why children who were in school dropped out i.e. whether it was due to financial problems or motivational issues. The latter refer to children refusing to go to school because of bullying experiences or learning difficulties and/or pressure/abuse by teachers due to which they may have been afraid to go to school. This information must be elicited in a gentle, non-judgemental manner as

children are often criticized for not going to school but their reasons for this decision are often ill-understood. Reasons such as being expelled or suspended also throw light on behaviour problems (such as truancy and Attention Deficit Hyperactive Disorder) which then need to be addressed in the intervention plan.

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

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

**2.4. Work Experiences**

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

**Guidance Notes**

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

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

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

**2.4. Peer Influence**

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

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

**v. School/ Classmates**
**vi. Family members- cousins etc.**
**vii. Friends in your neighborhood**
**viii. Others**

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

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

**k) Age of friends?**

"Most of them are…."

iv. Older than you
v. Younger than you
vi. Same age as you

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

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

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

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

**n) Consequences of peer influences**

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

**Guidance Notes**

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

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

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

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

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

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

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

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

### 3.1. Loss, Death & Grief

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

### 3.2. Physical, Emotional & Sexual Abuse

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

c) Physically hurt you and caused you injury?

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

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

**Guidance Notes**

This section elicits information on children's experiences of trauma, mainly on loss and grief and abuse. Childhood trauma, whether due to death/loss/grief experiences or physical/emotional/sexual experiences result in emotional dysregulation leading children to then develop behaviour problems too; anxiety and depression that occur in contexts of trauma lead children to high risk behaviours such

as substance use. When children are physically abused at home or in school, they learn that these are legitimate methods of coping with problems and in turn, use the same methods to deal with various life situations and problems they are confronted with. Similarly, children who are sexually abused and have received no assistance thereafter, develop a loose sense of personal boundaries and may be more likely, in some cases, to sexually abuse others. Thus, trauma experiences form part of CICL's circumstances and can be one of the pathways to offence.

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

## Section 5: Mental Health Concerns *(Ask Child)

### 5.1. Anxiety

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

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

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

| | | |
|---|---|---|
| **U2.**<br>**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.**<br>**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)**<br>**Have you felt sad or depressed, or felt down or empty, or felt grouchy or annoyed, most of the time, for the past year?** | **No** | **Yes** |

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

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

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

**Depression Issues: Yes/ No**

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

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

**Suicidal Thoughts: Yes/ No**

**Suicidal Attempts: Yes/ No**

**5.3. Attention Deficit Hyperactive Disorder (ADHD)**

| **O2.** | **In the past 6 months...** | **No** | **Yes** |
|---|---|---|---|
| **a)** | **Have you often not paid enough attention to details? Made careless mistakes in school?** | **No** | **Yes** |
| **b)** | **Have you often had trouble keeping your attention focused when playing or doing schoolwork?** | **No** | **Yes** |
| **c)** | **Have you often been told that you do not listen when others talk directly to you?** | **No** | **Yes** |
| **d)** | **Have you often had trouble following through with what you were told to do (Like not following through on schoolwork or chores)?** | **No** | **Yes** |
| **e)** | **Did this happen even though you understood what you were supposed to do?** | **No** | **Yes** |
| **f)** | **Did this happen even though you weren't trying to be difficult?** | **No** | **Yes** |
| **g)** | **Have you often had a hard time getting organized?** | **No** | **Yes** |
| **h)** | **Have you often tried to avoid things that make you concentrate or think hard (like schoolwork)? Do you hate or dislike things that make you concentrate or think hard?** | **No** | **Yes** |
| **i)** | **Have you often lost or forgotten things you needed? Like homework assignments, pencils, or toys?** | **No** | **Yes** |
| **j)** | **Do you often get distracted easily by little things (Like sounds or things outside the room)?** | **No** | **Yes** |
| **k)** | **Do you often forget to do things you need to do every day(Like forget to comb your hair or brush your teeth)?** | **No** | **Yes** |

| **03.** | **In the past 6 months...** | **No** | **Yes** |
|---|---|---|---|
| **a)** | **Did you often fidget with your hands or feet? Or did you squirm in your seat?** | **No** | **Yes** |
| **b)** | **Did you often get out of your seat in class when you were not supposed to?** | **No** | **Yes** |
| **c)** | **Have you often run around or climbed on things when you weren't supposed to? Did you want to run around or climb on things even though you didn't?** | **No** | **Yes** |
| **d)** | **Have you often had a hard time playing quietly?** | **No** | **Yes** |

| | | | |
|---|---|---|---|
| **e)** | **Were you always "on the go"?** | **No** | **Yes** |
| **f)** | **Have you often talked too much?** | **No** | **Yes** |
| **g)** | **Have you often blurted out answers before the person or teacher has finished the question?** | **No** | **Yes** |
| **h)** | **Have you often had trouble waiting your turn?** | **No** | **Yes** |
| **i)** | **Have you often interrupted other people? Like butting in when other people are talking or busy or when they are on the phone?** | **No** | **Yes** |

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

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

**Attention Deficit Hyperactivity Disorder (ADHD): Yes/ No**

**5.4. Conduct Disorder**

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

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

**Guidance Notes**

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

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

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

Anxiety and depression are internalizing disorders, which refer to negative behaviors that are focused inward or problems that people keep within themselves. They include fearfulness, social withdrawal, and somatic complaints[10]. 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).

[10] 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.

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

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

**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, | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **morphine)** | | | | | | | | |
| **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)[11] 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

[11] 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).

made. However, for a child who does not drink alcohol, we consider the total score by removing this question i.e. the total score is reduced from 37 to 35 for a child who does not use alcohol. The higher the score, the more intensive the problem. Scores above 35 (for children who do not use alcohol) and scores above 37 (for children who use alcohol) mean that children need to be referred for further assessment and treatment—in all probably they require intensive interventions.

## Section 4: Potential for transformation*(Ask Child)

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

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

**c) Motivation for change**

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

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

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

**Guidance Notes**

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

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

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

How to analyse or enter data on a child's response to insight:

- Low extent: if the child is not able to give any reasons on why he/she feels his actions are a problem.

- To some extent: if the child is able to state at least one reason on why he/she feels his actions are a problem.
- To high extent- If the child is able to provide more than 1 reason on why he/she feels his actions are a problem.
Example: I think I got into this problem because I listened to my friends and did what they told me to…and that is how I got drunk…and did what I did.

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

d) Skills to Avoid Offence—this refers to life skills such as emotional regulation, empathetic response, problem solving and conflict resolution. Children who have some of these skills are likely to have higher potential for behaviour change.
How to analyse or enter data on a child's response to skills to avoid re-offence:
- Low extent - if the child is not able to give any ways to stay out of trouble.
- To some extent- if the child is able to state at least one step he/she would take to ensure that he/she would stay out of trouble.
- To high extent- if the child is able to provide more than 2 steps or strategies to stay out of trouble.
Example: "May be I could spend time with a different set of friends so that I do not get into trouble."

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

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

### 6.1. Life Skills Needs & Deficits

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

**Guidance Notes**

The World Health Organization (WHO) defines Life Skills as "*'adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life.'* Core life skills for the promotion of child and adolescent mental health include: decisions-making, problem-solving, creative thinking, critical thinking, effective communication, inter-personal relationship skills, self-awareness, empathy, coping with stress and emotions[12].

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

[12] 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.

evaluating the various options available to them and thinking through the consequences of each option—children who pick the option of theft when in financial difficulties or children who have committed murder as they has not thought of social and legal consequences of such acts.
Decision-making in contexts of romance/ relationships/ sexuality (making decisions about sexual/ relational issues with due consideration to health, safety, consent, emotional contexts of relationships) children who have sexually abused other/younger, failing to make a decision on the basis on empathy and/or of social and legal consequences that would follow; older children who have run away with their peers or with older adolescents/ adults to get married or have physical intimacy and have not thought through the implications of a marriage or (unprotected) sexual engagement.

### 6.2. Other Observations

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

**Guidance Notes**

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

## Section 7: Summary and Intervention Plan

### 7.1. Summary

Based on the above assessment, summarize the main problems and concerns of the child, including **Vulnerability**[13]**, Pathology**[14] **and Consequence**[15]**.** Highlight areas for immediate assistance/ response.

### 7.2. Care Plan

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

**Guidance Notes**

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

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

Care Plan refers to the counselor's response to the child's problem, both in terms of initial inputs provided to the child at the end of the assessment, with regard to his/her problem as well as those planned for implementation in the immediate/near future. It includes:
(a) First level responses[16] which help initiate the process of behaviour change in the child. It entails dialogue and discussion with the child for:

[13] Vulnerability: abuse/ neglect/ family pathology/ school drop-out issues that make children vulnerable to emotional & behaviour problems
[14] 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.
[15] Consequences—Pathways to institutionalization & 'criminality'

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

(b) Referral to tertiary care mental health facilities for further evaluation including psychological testing (in case more information is required for diagnostic and intervention purposes; pharmacotherapy may also be necessary for children depending on the type and severity of the mental health problems).
(c) Recommendations and/or referral for depth therapeutic work with the child (which can be undertaken either in the Home or at a tertiary care facility, depending on the skills and resources of the counsellor).

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

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

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

# Annex III

**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<br>(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 IV

## Guidance Notes on
## Preliminary Assessment Report 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, Government of Karnataka**

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

**A. Mental & Physical Capacity to Commit Offence**
The child's ability to make social decisions and judgments are compromised due to:

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

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

(iii) Experiences of abuse and trauma

(iv) Substance abuse problems

(v) Intellectual disability

(vi) Mental health disorder/ developmental disability

(vii)Treatment/ interventions provided so far

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

For item (i) on life skills deficits, refer to Section 6, 'Life Skills Deficits and Other Observations of the Child' and sub-section 6.1. on 'Life Skills Deficits'.
For item (ii), refer to Section 2, sub-section 2.1. on 'Family Issues Identified'.
For item (iii) on experiences of abuse and trauma, refer to Section 3, 'Trauma Experiences: Physical, Sexual and Emotional Abuse Experiences'.
For items (iv) and (vi) on substance abuse problems and mental health disorders/ developmental disability, refer to Section 5, 'Mental Health Concerns'.
For item (v) on intellectual disability, you may rely on your judgement based on your interaction with the child during the entire process of administering the psychosocial and mental health proforma—if the child was unable to respond to most questions or responded

in an age-appropriate manner (like a younger child would, demonstrating little understanding of many things asked or discussed), then you may suspect that he/she has intellectual disability. (Following this, it would be useful and necessary to confirm this through relevant IQ testing conducted by psychologists located in mental health facilities).
For item (vii), you may have enquired from the child, during the assessment, about whether he/she has received any professional assistance or treatment for any mental health issues/ family problems or life skills deficits that he/she has. (Generally, children in the Observation Home have never received any treatment or interventions for their problems).

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

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

**B. Circumstances of Offence**

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

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

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

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

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

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

**Guidance Notes**

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

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

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

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

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

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

**Guidance Notes**

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

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

**D. Other Observations & Issues**

**Guidance Notes**

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

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

**E. Recommendations**

**Guidance Notes**

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

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

# Annex V

## Suggested Training Schedule

| | | |
|---|---|---|
| **Day 1** | | |
| 9:00-9:30 | Introduction | |
| 9:30—11:30 am | **Children in Conflict with the Law:**<br><br>**Applying the Vulnerability Lens** | Identifying Pathways to Coming into Conflict with Law |
| 11:30—11:45 am | | Coffee Break |
| 11:45 am—1:00 pm | | Further Analysis of CICL's Vulnerabilities |
| 1:00—2:00 pm | | Lunch |
| 2:00—4:00 pm | | Further Analysis of CICL's Vulnerabilities (Cont…) |
| 4:00—4:15 | | Coffee Break |
| 4:15—6:15 | | Film Screening & Discussion |
| **Day 2** | | |
| 9:00—11:00 am | **Assessing Children in Conflict with the Law** | Psychosocial and Mental Health Assessments for CICL |
| 11:00—11:15 am | | Coffee Break |
| 11:15 am—1:15 pm | | Preliminary Assessments for CICL |
| 1:15—2:15 pm | | Lunch |
| 2:15—5:00 pm | **Psychosocial & Mental Health Interventions for Children in Conflict with Law** | First Level Responses to Psychosocial & Mental Health Concerns |
| **Day 3** | | |
| 9:00 am—11:30 pm | **Psychosocial & Mental Health Interventions for Children in Conflict with Law** | First Level Responses to Psychosocial & Mental Health Concerns (Cont…) |
| 11:30—11:45 am | | Coffee Break |
| 11:45 am—1:00 pm | | Depth Interventions for Psychosocial & Mental Health Issues |
| 1:00—2:00 pm | | Lunch |
| 2:00—4:00 pm | | Depth Interventions for Psychosocial & Mental Health Issues (Cont…) |
| **Day 4** | | |
| 9:00 am—3:30 pm | **Field Practice** | Supervised Field Practice |
| | | Homework Assignment |