A Rapid Assessment of Child & Adolescent Mental Health and Protection Needs and Services in Arunachal Pradesh

For Department of Women & Child Development,
Government of Arunachal Pradesh
April--June 2023

SAMVAD

(Support, Advocacy & Mental health interventions for children in Vulnerable circumstances And Distress)
(A National Initiative & Integrated Resource for Child Protection, Mental Health, & Psychosocial Care
Established by Ministry of Women & Child Development, Government of India
Located in Dept. of Child and Adolescent Psychiatry at National Institute of Mental Health & Neurosciences (NIMHANS), Bangalore

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At the outset, we would like to express our gratitude to the Hon. Minister of Women and Child Development, Ms. Smriti Zubin Irani, for her vision and steadfast support, which has culminated in this collaborative effort between SAMVAD and the Government of Arunachal Pradesh. Indeed, it is this vision and support from the Ministry of Women and Child Development, Government of India, that has enabled SAMVAD to engage in learning collaborations that facilitate knowledge creation and dissemination on critical aspects of child mental health, protection and psychosocial care.

We are deeply grateful to the Department of Women & Child Development, Government of Arunachal Pradesh for permitting the SAMVAD Team to conduct this rapid assessment and so as to provide key recommendations for the promotion of child protection and mental health agendas in the state.

We would also like to acknowledge the support extended to the SAMVAD Team by the various State Departments of Health and Family Welfare, Education, Rural Development & Panchayati Raj, Department of Labour & Employment, and Social Justice, Empowerment and Tribal Affairs, to legal and judicial personnel and non-governmental agencies. They were truly generous with their time and inputs, participation in the exercise.

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We hope that this rapid assessment will serve as a strong foundation for the state's work on child protection and mental health—and that SAMVAD will continue to have the privilege of supporting Arunachal Pradesh in its endeavours to assist vulnerable children and adolescents.

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Glossary

AA – Alcoholics Anonymous

ANM – Auxiliary Nurse Midwife

ASHA – Accredited Social Health Activist

CBO – Community-Based Organisations

CCI – Child Care Institution

CHC – Community Health Care/Community Health Centre

CICL – Children in Conflict with the Law

CNCP – Children in Need of Care and Protection

CSA – Child Sexual Abuse

CWC – Child Welfare Committee

DCPO – District Child Protection Officer

DEIC – District Early Intervention Centre

DMHP – District Mental Health Programme

DRC – District Resource Centre

ECCD – Early Childhood Care and Development

ICDS – Integrated Child Development Scheme

ICPS – Integrated Child Protection Scheme

IEC – Information Education Communication

JJB – Juvenile Justice Board

NGO – Non-governmental Organization

NIMHANS – National Institute of Mental Health and Neuro Sciences

NMHP – National Mental Health Programme

PHC – Primary Health Care/Primary Health Centre

POCSO – Protection of Children from Sexual Offences Act, 2012

PTSD – Post-Traumatic Stress Disorder

RBSK – Rashtriya Bal Swasthya Karyakram

RKSK – Rashtriya Kishor Swasthya Karyakram

Contents

I. Background and Rationale

Background and Rationale

Arunachal Pradesh, or the land of the dawn-lit mountains, as it is known, is the state in the furthest north eastern part of India. It was formerly part of the state of Assam, and known as the North Eastern Frontier Agency (NEFA); thus, it was administered by the Ministry of Home Affairs, along with the Governor of Assam acting as agent to the president of India. Later, it became a Union Territory, with Itanagar as its capital, and subsequently, in 1987 attained statehood. The state, comprising of 13 districts, is inhabited by 52 major tribes and many sub-tribes[1].

There is little research literature on child and adolescent protection and mental health issues, thus far, in Arunachal Pradesh. A recent paper exploring types and causes of violence against children in eastern zone of Arunachal Pradesh i.e., Anjaw, Dibang Valley, Lohit, Lower Dibang Valley, and Namsai districts, interviewed professionals dealing with child-related issues, and found that physical and sexual violence, emotional abuse, and neglect exist in the state; it also found that child labour, illegal adoption, child marriage, and exposure to domestic violence were prevalent[2]. However, such studies are of questionable methodology and throw little light on the statistical prevalence of child protection issues and their underlying causes. Consequently, we have attempted, as a start to this assessment, in relation to some child-related issues, such as education, substance use, and human trafficking, on which some data was available, to highlight some of the issues affecting children in the state.

A 2019 study by Tata Institute of Social Sciences (TISS), on human trafficking in Arunachal Pradesh revealed that child labour is a concern in the state. Children trafficked for labour tend to be from vulnerable populations in Assam or from Chakma villages of Papum Pare, Arunachal Pradesh. The modus operandi involves children from Itanagar being distributed across the state, by agents (who earn up to Rs.5,000 per child), primarily to work as domestic help in households of the upper socio-economic strata. The parents of these children, like elsewhere, are hopeful that their children will grow up with food as well as education. While these children are admitted to schools, they rarely attend classes and often drop out early. They also suffer much emotional and sexual abuse, and identity crisis because employers often change the name of the child (giving them their family name instead) and also because children tend to lose contact with their parents and families. The ‘owners’ of child labour often get these children, at a later stage, to marry each other, and sometimes, the owners themselves marry the young girls who came as child labour, ensuring that they remain in domestic work in their homes[3]. The TISS report also states that many women who fall prey to commercial sexual exploitation are school drop-outs, who as a result of early pregnancy, early marriage and polygamy, tend to become vulnerable to sex work[4].

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[1] Kumar, G. (2013). Geology of Arunachal Pradesh. GSI.
[2] Padu, A. (2022). Types and Causes of Violence Against Children in Eastern Zone of Arunachal Pradesh. Towards Excellence, 14(1).
[3] Tata Institute of Social Sciences (2019). Human Trafficking in Vulnerable Districts of Arunachal Pradesh State Report. Available at: file:///C:/Users/SAMVAD%20NIMHANS/Downloads/Arunachal%20Pradesh%20pdf.pdf
[4] Ibid.

According to National Family Health Survey (NFHS) (2019-2021), only about 18% to 20% of children attend preschool. It is well-documented that attending preschool programs in the years before starting school can promote children's healthy development[5], and that quality preschool education focusing on fundamental skills (which are less likely to be taught in school) can have lasting effects on educational and developmental outcomes in children[6]. Thus, low preschool attendance is likely to have adverse consequences for child development, education, and mental health. Furthermore, research suggests that developmental pathways to adolescent substance use may begin in preschool, setting the stage for susceptibility to engagement in relational aggression, which increases, in turn, youth's likelihood for substance use initiation in adolescence[7]-- possibly therefore, one of the factors that contributes to the state's substance use problem is the lack of preschool attendance.

While the NFHS shows 90% school attendance, for children between ages 6 and 17, it also indicates that this proportion of attendance drops significantly to 78% in adolescents between ages 15 to 17 years—bringing into sharp focus, once again, the substance use issue that reportedly also causes children to drop out of school. This postulation may be supported by a recent study at a tertiary mental healthcare facility in the state reflecting a disproportionate overrepresentation of substance use disorders among in-patients, with younger age groups being the most affected. The study also highlights the need for mental health program and policy initiatives, including the need to establish de-addiction centres, with rehabilitation and counselling services[8]. Another study, conducted in one of the tribal groups of Arunachal Pradesh also describes the significant impact of substance, particularly alcohol, on family and social life; it states that normalization of the use of alcohol within families causes children to use and abuse it early on, as part of their socialization processes, and that consequently the excessive consumption of alcohol by people, in times of personal crisis has led to violent behaviours and crimes, but also to acts of suicide[9].

Given that substance use emerges, both in the limited literature on the state, as well as SAMVAD's findings, as a cornerstone in child and adolescent mental health and protection problems in the state, it is likely also to have negative effects on parental marital relationships, including on issues of domestic violence, as well as the nature of parenting and child-rearing in the state. Research suggests that exposure to abuse and domestic violence, negatively impacts children's attachment to parents and increases the risk of antisocial behaviour in adolescents[10]. Given the salience of substance use issues in the family context of Arunachal Pradesh, and that the family is the main source of attachment, nurturance and socialization, there is the risk,

[5] O'Connor, M., Gray, S., Tarasuik, J., O'Connor, E., Kvalsvig, A., Incledon, E., & Goldfeld, S. (2016). Preschool attendance trends in Australia: Evidence from two sequential population cohorts. Early Childhood Research Quarterly, 35, 31-39.
[6] Yoshikawa, H., Weiland, C., & Brooks-Gunn, J. (2016). When does preschool matter?. The Future of Children, 21-35.
[7] Patwardhan, I., Guo, Y., Hamburger, E. R., Sarwar, S., Fleming, C. B., James, T. D., ... & Mason, W. A. (2023). Childhood executive control and adolescent substance use initiation: the mediating roles of physical and relational aggression and prosocial behavior. Child neuropsychology, 29(2), 235-254.
[8] Kena, T., Bagra, I., Doke, G., Yubey, M., & KOTHAPALLI, J. (2022). Patterns of Psychiatric Illness in a Tertiary Care Centre of Arunachal Pradesh: An Observational Study. Maedica-a Journal of Clinical Medicine, 17(3).
[9] Mene, T. (2022). The Association of Alcohol and Suicide: A Perspective from the Idu Mishmi Tribe of Arunachal Pradesh, India. Antrocom: Online Journal of Anthropology, 18(2).
[10] Sousa, C., Herrenkohl, T. I., Moylan, C. A., Tajima, E. A., Klika, J. B., Herrenkohl, R. C., & Russo, M. J. (2011). Longitudinal study on the effects of child abuse and children's exposure to domestic violence, parent-child attachments, and antisocial behavior in adolescence. Journal of interpersonal violence, 26(1), 111-136.

especially where children are concerned, of being impacted by unmet developmental needs, impaired attachment relationships, exposure to violence, and of using substance themselves[11].

In the light of the above, although not much data on child protection and mental health in the state is available, the limited understanding we have at present, with regard to substance use and parenting issues indicates that there are factors that are likely to place children at risk of emotional, behavioural, and learning problems, as well as of protection issues.

[11] Lander, L., Howsare, J., & Byrne, M. (2013). The impact of substance use disorders on families and children: from theory to practice. Social work in public health, 28(3-4), 194-205.

II. Objectives and Methodology

(a) Objectives

- Understand child and adolescent protection and mental health-related concerns of the state.
- Map the services available to children and adolescents with regard to preventive-promotive and curative mental health, and the gaps thereof.
- Identify potential stakeholders and opportunities for implementation of child and adolescent protection and mental health programs and services.
- Develop a detailed report on the above issues, along with state and context-specific recommendations, to inform state-level plans for implementing child protection and mental health programs and services.

(b) Methodology

(i) Selection of Respondents

In the light of the need to ensure that the understanding obtained on child and adolescent protection and mental health concerns reflected multiple service provider perspectives, and contexts, the **inclusion criteria** for respondents were:

- Administrative or implementation role and function in a child/adolescent protection, development and/or mental health related service or program.
- Serving in primary, secondary, or tertiary levels of child services, primarily in government agencies or civil society agencies recommended by the state government.

Consequently, as reflected in Table 1, the assessment undertook to draw respondents from four broad categories of stakeholders, namely:

- State Departments directly engaged in child services, namely the Departments of Health and Family Welfare, Women and Child Development and Education.
- State departments engaged with communities, and consequently interfacing with children, in specific functions, namely Rural Development & Panchayati Raj, Department of Labour & Employment, and Social Justice, Empowerment and Tribal Affairs.
- Legal and judicial personnel engaged in implementing child laws
- Non-governmental agencies (including public-private partnerships within the concerned departments or agencies; the specific programs and schemes serving the protection and mental health-related needs of children were identified, including the stakeholders responsible for delivering these services. Refer to Table 2 below for details on the State Department, program/scheme/initiative/agency, and position/designation of the respondents.

Table 1: Stakeholders Participating in Key Informant Interviews & Focus Group Discussions

State Department	Program/Scheme/Initiative/Agency	Position/Designation	
Health & Family Welfare	District Hospital (3)	District Medical Officer (1) Paediatrician (2) Emergency Doctor (1)	Program Officer, One Stop Centre, De-addiction (1)
	Primary Health Centre (3)	Medical Officer (4) Nurse (4)	
	Rashtriya Bal Swasthya Karyakram (RBSK) Mobile Team (1)	Medical Officer (1) Nurse (1) Nodal Officer (1)	
	RBSK's District Early Intervention Centre (DEIC) (2)	Centre Manager (2) Medical officer (1) Social Worker (2) Special Educator (2)	Early Interventionist (1) Physiotherapist (1) Dental staff (1) Ophthalmologist (1)
	District Health Society	State Nodal Officer for Child Health (NHM) (1)	
	Tomo Riba Institute of Health & Medical Sciences (TRIHMS)	Associate Professor, Dept. of Psychiatry (1) Chief Medical Superintendent (1)	
	Regional Mental Hospital, Midpu	State Nodal Officer, Mental Health (National Health Mission) (1)	
	Department-Level	Special Secretary Health	
Women & Child Development	Child Welfare Committee (CWC) (4)	Chairpersons (3) Members (10)	
	Juvenile Justice Board (JJB) (1) District Child Protection Unit (DCPUs) (4)	JJB Members (2) District Child Protection Officer (DCPO)—with primary charge of Deputy Director ICDS (2) Protection Officer (3) Legal-cum-Probation Officer (3) Counsellor (3)	Outreach worker (1) Data analyst (2) Assistant-cum-Data Entry Operator/CWC (2) Assistant-cum-Data Entry Operator/JJB (2)

	Government-supported Child Care Institution: Care and Protection Institution (3) Observation Home (1)	Superintendent (4) Para-medical staff (1) Child Welfare Officer (1) Protection Officer (1)	House Mother (1) Counsellor (3) Case Worker (1)
	Anganwadi (5)	Anganwadi worker (20) Anganwadi supervisors (13)	Mentors (3) Gram Sevikas (4)
	One-Stop Centre (OSC) (3)	Centre Manager (3) Legal Aid Officer (3) Para-medic (1) Counsellor (2)	Case Workers (2) Multi-purpose Worker (1) Social Worker (1) Nurse (1)
	Integrated Child Protection Scheme (ICDS) Department-Level	Child Development Officers (CDPO) (2) Joint Secretary	
Education	Government Secondary/High School (2)	Vice Principal (1) Principal (1) Teacher (1)	
	Department Level	Special Secretary	
Rural Development & Panchayati Raj	Block (2)	Block Development Officer (2)	
	Zilla Parishad (4)	Chairperson (2) Member (2)	
	Gram Panchayat (7)	Chairperson (9)	
	Traditional Village Authority Department -Level	Gaon Bura (2) +2 Secretary	
Other State Agencies & Departments	District-level Guwahati High Court, Arunachal Pradesh Bench	Deputy Commissioner (2) Chief Judicial Magistrate (JJB) (2)	

	Guwahati High Court, Arunachal Pradesh Bench	Special Court Judge (1)	
	Special Juvenile Police Unit (SJPU)	SJPU Officer (1) Additional Superintendent of Police (1)	
	State Commission for Protection of Child Rights (SCPCR)	Chairperson (1) Members (2)	
	Department of Labour & Employment	Secretary (1)	
	Department of Social Justice, Empowerment & Tribal Affairs	Director (1) Rehabilitation Officer (1)	
Non-Governmental Agencies	Amaaya Foundation	Coordinator (2) Documentation & Media Manager (1) Livelihoods-Child Rights Officer (1) Childline team member (1)	
	Hope Foundation Rehabilitation Centre	Founder (1)	
	Seed De-addiction and Correction Home	Counsellor (1)	
	Grace Rehabilitation Centre	Founder (1) Miscellaneous Staff (4)	

(ii) Location

Although Arunachal Pradesh comprises of 26 districts, due to the limitations of time, and given that we were undertaking a rapid assessment, we covered 5 districts, over a five-day period. (Refer to adjoining map and table 2 below for details of districts).

Districts Covered by SAMVAD's Rapid Assessment (indicated in red)

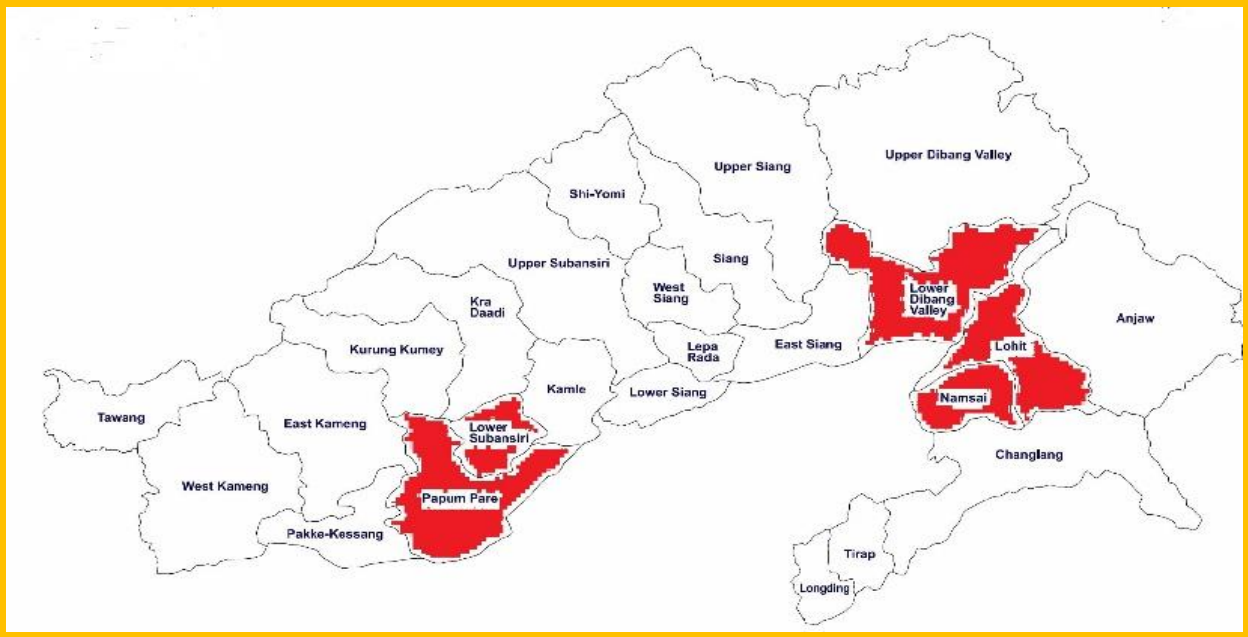

Table 2: Districts Covered by SAMVAD's Rapid Assessment

Districts	Circle/Town/Village
Lower Dibang Valley	Roing, Bolung
Lohit	Tezu
Namsai	Namsai, Lekang, Kababasti, Piyong, Chongkham
Papum Pare	Itanagar
Lower Subansiri	Ziro

(iii) Data Collection

The SAMVAD team visited Arunachal Pradesh for a period of a week, engaging with stakeholders through key informant and group interviews. Each interview lasted for about an hour with the completion of an average of 8 interviews per day. The team completed 44 interviews, including 11 key informant interviews and 33 group interviews. Data collected through interviews were recorded through field notes—comprising of the information provided by the respondents as well as follow-up notes with the interviewer's observations and interpretations immediately upon the conclusion of each interview.

(iv) Data Analysis

The team collated the field notes according to the categories and sub-categories of the respondents interviewed and organized the data into information focusing on three key themes, as relevant to the assessment, and to draw out recommendations for policy:

(a) Existing programs and schemes/ including descriptions of objectives, target populations served, services provided, requisite skills and training provided for implementation;
(b) Gaps and challenges in services (as stated by the respondent and observed by the SAMVAD team)
(c) Potential opportunities for integrating and incorporating or strengthening the child and adolescent protection and mental-health related components of the program/service.

The report concludes with overall recommendations for the state, to be able to strengthen its child protection and mental health programs and services.

(V) Limitations of the Rapid Assessment

Given the socio-cultural differences across Arunachal Pradesh, this rapid assessment may not be representative of all districts in the state. Furthermore, since our rapid assessment comprised mostly of a series of key informant interviews and focus group discussions, our data and information are reflective of the reports we received, about socio-cultural contexts and community-level problems i.e. we had no way of verifying or corroborating the accounts of the persons we interacted with. Consequently, we have attempted to reflect them as accurately as possible, also in as unbiased a manner as possible; we have also attempted to analyze and interpret our findings with a view to projecting possible implications for child protection and mental health, and the services thereof, by using global research and literature on child protection and mental health issues.

That said, this report provides us with a broad understanding of children's mental health and protection-related issues as well as programs, services and schemes and their functioning and gaps—at least sufficient for delineating particular technical areas and subjects for focus, and for initiating state-level plans and activities for training and capacity building of child service providers and functionaries.

III. Findings and Analysis

A. Primary Level

- Anganwadi Welfare Centres
- Primary Health Centre
- Gram Panchayat Chairperson
- Gaon Bura
  (Traditional Village Head)

A.1 Anganwadi Welfare Centres

Existing Issues, Services and Systems

There are about 6,225 Anganwadi centres in the state, providing Integrated Child Development Scheme (ICDS) services to about 1,81,587 beneficiaries. The number of children attending each Anganwadi centre varies across districts due to the state's large size and scattered population of tribes.

- **Nutritional services**

With regards to nutrition, Anganwadi workers provide meals (i.e., 'khichdi' is provided on an almost daily basis) to children. They also work with pregnant and lactating mothers and guide them on the importance of good nutrition practices. The POSHAN tracker is in use in all the Anganwadis that were interviewed. They, however, reported challenges pertaining to the usage of the tracker, namely that poor quality of mobile phones, lack of internet connectivity and difficulties with uploading large amounts of data; also, changes made to the tracker often do not reflect in the system. Another activity the Anganwadi workers engage in to promote nutritional and recreational practices is to engage children in the cultivation of a 'nutri-garden'. The anganwadi workers reported that they also conduct home visits in the community. Usually, 3-4 visits for each child per month, are planned, so as to educate parents on nutrition and immunization, and also to check on why children are absent from the anganwadi for a considerable period of time.

In the aspirational district of Namsai, under NITI AYOG, each Anganwadi centre has an appointed 'mentor' who works with growth monitoring and nutrition for children and assists anganwadi workers with the same. They are trained by the National Institute of Public Cooperation and Child Development (NIPCCD) on growth monitoring and nutrition. They also refer children who are Severe Acute Malnourished (SAM) to district hospitals for treatment.

- **Emotional, behavioural, and developmental (disability) concerns**

As such, no specific emotional and behavioural concerns in children were reported by anganwadi workers, indicating their lack of awareness of such issues. With regards to children with disabilities and development issues in children, children with physical disabilities were, to some extent, identified; however, those with intellectual disability, neurodevelopmental disabilities, learning issues, remain unidentified. Anganwadi workers reported that they were unsure about the existence of such children within communities—possibly due to lack of awareness.

Some anganwadi workers reported that although they did not have any systematic methods to identify children with disabilities and behaviour problems, due to their several years of experience they were able to identify problems in children through observation. They reported issues such as excessive shyness, temper tantrums (usually resulting from separation from caregivers); they said that they 'give these children special attention' and 'try to be more responsive to their needs' so that the children 'settle down'. Thus, they have no systematic interventions to address common emotional and behaviour problems in pre-schoolers.

During the interview, however, two children were presented to the SAMVAD team, as 'children with problems'—both children had moderate+ intellectual disability, with one of them having symptoms of Autism and Attention Deficit Hyperactive Disorder and the other having cerebral palsy. They also reported that there was another 15-year-old (girl) in the community, who was unable to walk and appeared like a 'young child'—indicating severe to profound intellectual disability. It, therefore, appears that anganwadi workers (like community members) perceive disability when it is severe, rendering a child dysfunctional, although they do not know what the nature of the problem is. It was also evident that they did not know that the child required referral to specialized facilities, and had not even referred the children to the district hospital i.e., they do not know how to respond to children with disability even where they are able to identify them. Many also said that no training had been provided to them on children with disability, and they had no protocols for assessment, identification, or referral of disability. A few anganwadi workers reported that have heard about and also come across cases of autism. In these cases, there are no government facilities for children and usually refer them to private facilities—near Itanagar, for instance, they refer them to K Blooming and Toko Rehabilitation Centres.

- **Non-formal education**

The general day at an Anganwadi begins at 8 am, where children are escorted to the Anganwadi Centre from their homes, to do non-formal education activities, based on curriculums provided by the state department. They are then taught the basics of the English alphabet and numbers; they are also engaged in activities such as physical play, drawing and colouring, identification of objects and cleaning of their space. They are then given lunch at noon, and sent home. Some anganwadi workers explained that since there is a scarcity of teaching aids and resources and they run from small rented rooms, they use whatever resources are available around them. For instance, they practice theme-based teaching, using the flowers, stones to learn about concepts like colours, objects, tracing etc.

- **Child Protection Concerns**

When asked what measures are taken for children who come from difficult contexts such as domestic violence, it was reported by some Anganwadi workers that they do home visits and intervene by speaking with the families- this was however only reported in one Anganwadi Centre of all the ones interviewed. No particular concerns on child protection i.e., relating to abuse and neglect were reported. Some Anganwadi workers were able to report that due to a lot of substance use and gambling issues in most parts of the state, children may be neglected. Some Anganwadi workers also reported that children of working mothers and domestic violence issues lead to children being withdrawn and quiet.

- **Work with Adolescent Girls**

Anganwadi workers also reported on their work with adolescent girls, through the Sabla Scheme, and that they hold periodic events at the Anganwadi centre to bring together these girls and teach them hygiene practices with regards to menstruation. Their role is, however, limited to mobilizing the community members. They also assist the ASHA

workers in data collection for the Health Department. They also invite doctors and nurses from the primary health centres, in their area, for these events so girls may learn about the science behind menstruation and menarche.

- **Training and Capacity Building**

The anganwadi workers also reported that the training for the workers is done at the 'Middle Level Training Centre' (MLTCs). The training task of Supervisors has been entrusted to MLTCs, which are run by the State Governments. The primary responsibility of providing technical support to these MLTCs lies with NIPCCD. However, in recent years all the newly recruited anganwadi workers have been untrained. They cited lack of funds for training as the primary reason for the same. There are currently 5 training centres, across the state, for the anganwadi workers.

Gaps and Challenges

- **Infrastructural Issues**

Due to the lack of infrastructural facilities, it was observed that most of the parents do not prefer sending their children to anganwadis. For instance, as the electrification of anganwadis was not completed, work with young children (without basic facilities like fans) became increasingly difficult. Anganwadi workers also reported a lack of water supply, as a result of which substantial time was spent fetching water from nearby sources. In terms of play and recreation, the Anganwadi workers reported having to work with children in small rented rooms, with few play materials, wherein activities for children's growth and development are challenging to conduct.

- **Nutrition**

Under the Supplementary Nutrition Program, Anganwadi welfare centres cover children below 6 years of age and adolescent girls (along with pregnant and nursing mothers). The supplementary nutrition package is not received by the centres of time, owing to a shortage in the food supply. By the time the ready-made food and the snacks reach the Anganwadi, they expire, leading to wastage of food materials as well as a shortage of food supplies for the vulnerable population that accesses the Anganwadi centres.

- **Technology**

The anganwadi workers face challenges regarding the usage of the tracker owing to poor quality of mobile phones, and lack of internet connectivity leading to difficulty in uploading large amounts of data. The login details for POSHAN tracker are not made available to the anganwadi workers.

- **Identification and Response to Disability, Developmental Problems or Child Abuse**

The anganwadi workers reported a lack of orientation to emotional, behavioural, and disability-related issues in children, owing to an absence of depth training initiatives on this subject and a lack of pre-service training. As a result of deficits in these critical capacities, early identification of mental health, protection, and disability concerns does

not take place. In addition to lack of identification and assessment, there is also no structured mechanism for referral in place.

Potential Opportunities

- While anganwadi workers use the state curriculum to deliver ECCE activities, these may be strengthened through deepening their knowledge on child development and the underlying conceptual knowledge, on which these activities are based. While this will strengthen the overall non-formal education of the anganwadi, it is likely to help anganwadi workers identify children with developmental delays and disabilities, as well as cater to individual children's needs.
- Considering their presence in the community, and their local knowledge of families and children, anganwadi workers, are a huge potential for referral of vulnerable children. They require training in identification and assessment of children in the context of developmental delays and disabilities, emotional and behavioural concerns, and vulnerability and protection issues, by equipping them with skills and simple screening checklists. Such a training component may be incorporated at the state level anganwadi training provided by the MLTCs.
- Considering that protection and early child development are critically connected and impact each other, anganwadi workers also need to be assisted in convergence with district agencies like the District Child Protection Unit (DCPU), to work with village authorities to identify, assist and refer vulnerable children and families to the respective schemes and other health institutions for further interventions. They may also be provided information on district level hospitals and District Early Intervention Centres (DEICs) where they may refer children with disabilities.

A.2 Primary Health Centre

Existing Issues, Services and Systems

The primary services facilitated through the PHCs with regard to children, like elsewhere in the country, include immunization and vaccination. The Piyong PHC, for instance, reported that significant headway had been made in immunization coverage with coverage currently reaching 85-90%. The staff of this PHC, however, also mentioned difficulties in implementing reproductive and child health programs, and consequently in reaching out child populations, due to the existence of floating migrant populations, and the hesitancies of communities in availing of institutional delivery i.e., home-based deliveries were reported as being higher than desirable levels. In addition to the Adolescent Health Clubs, this PHC (not necessarily true of others though) also conducts numerous awareness activities on reproductive and child health and the imperative for immunization. Folic acid distribution was also identified as a key health intervention at the PHC level. In terms of awareness, various programs are facilitated on menstrual hygiene, reproductive health, contraception, for girls, and on substance abuse and HIV infections,

given the large number of substance abuse cases reported in the PHC area, especially amongst adolescent boys. In severe substance use cases, the PHC reported that following emergency management, adolescents have to be referred on to the District Hospital or other higher centres for further treatment. Other types of community health awareness and home visits are conducted by the ASHA workers and Auxiliary Nurse and Midwives (ANMs), (often in coordination with Gaon Buras[12]), mostly focussed on menstrual hygiene and reproductive health, and who typically refer children to the PHC for further evaluation.

In an attempt to move from a selective approach to health care to deliver comprehensive range of services spanning preventive, promotive, curative, rehabilitative and palliative care, Ayushman Bharat (AB) has created (in a graded manner) Health & Wellness Centres (HWCs) to deliver Comprehensive Primary Health Care, that is universal and free to users, with a focus on wellness and the delivery of an expanded range of services closer to the community. Most PHCs in Arunachal Pradesh, like other parts of the country, have been upgraded to HWCs. HWC are envisaged to deliver an expanded range services that go beyond maternal and child health care services to include care for non-communicable diseases, palliative and rehabilitative care, oral, eye and ENT care, mental health and substance use, and first level care for emergencies and trauma, including free essential drugs and diagnostic services.

However, despite the inclusion of mental health services, as reflected by some of the PHCs in and around Roing, it was noted that counselling is provided by the existing PHC staff, with no additional counsellors appointed as yet. But there have been a few efforts in some PHCs with regard to psychosocial care: in the Piyong PHC, for instance, it was also reported that Adolescent Health Clubs had been initiated with 2 boys and 2 girls trained as peer educators from each village. These adolescent health clubs meet on a monthly or quarterly basis and spread awareness on key developmental changes observed during adolescence (not inclusive of any mental health and psychosocial issues).

Given their community-based services and local presence, PHCs were able to throw light on a range of issues with regard to child and adolescent mental health, as described below:

- **Substance Use**

Substance use was reported as a serious concern, at the PHC level, predominantly amongst adolescents. In addition to addiction-related health consequences, it was reported that these children also typically approach the PHC with respiratory and nutrition issues. A significant prevalence of substance use issues has been observed in the 12-19 age group. In cases of substance use, children may also present with insomnia and sleeplessness. Substance abuse has also contributed to school drop-out problems in the state. It was reported that use of substances like heroin, opioids and marijuana was common among adolescents and a result of unemployment and poverty. If caught by

[12] Gaon Buras are village-level functionaries and are responsible for administrative tasks such as the maintenance of law and order and the resolution of disputes in the village.

police, they are usually referred to the facility for health check-up for fitness after which they are referred to the police station. The PHC has no contact with the children thereafter.

In addition to substance use issues, the transmission of HIV as a result of intravenous drug use was a concern with awareness programs currently focusing on these aspects. The staff in one of the PHCs also reported concerns with problematic substance use amongst certain groups wherein members are from the same birth cohort (for e.g. 1990). These groups have been reported to engage in communal substance use. In light of the substance use, it was also reported that there have been reports of the prevalence of sex work and sporadic instances of violence as well within these cohorts. Members from these groups, as a result of the above, are also vulnerable to the transmission of STDs, following which they approach the PHC. SAMVAD, however, was unable to corroborate this information with any other stakeholder interviewed as part of this rapid assessment.

- **Adolescent Sexual Relationships and Pregnancies**

In the Piyong PHC, it was reported that 20-30% of the pregnant girls who approach the PHC are usually adolescents in the age group from 15-17 years. However, it was also reported that all underage pregnancies are in cases of early marriages. One of the key issues reported in underage pregnancies was poor nutrition. As a result, the PHC generally advises adolescents in underage relationships to access contraception and reproductive health services at the PHC. Again, like substance use, engagement of adolescents in sexual relationships and 'early marriage' also leads to school drop outs in this age group.

- **Children with Developmental Delays and Disabilities**

There were few instances of disability reported at the PHC level including one suspected case of polio, certain physical disability cases (such as rickets), and hearing impairments. Where required, cases are also referred on to the District Hospital (as was the case following identification of rickets). But, for the most part, the PHC does not engage much in work relating to children with disability-- they do not refer to check-lists or screening tools to comprehensively assess children with developmental issues. In instances where the disability is visible, they usually refer children to the tertiary care centres. Where PHC staff observe delayed milestones, they inform the parents and are referred to the district hospital.

- **Child Protection and Mental Health Issues**

Emotional and behavioural issues were generally not brought to the PHC. However, mental health issues that have been brought to the PHC have included anxiety, ADHD, and autism. Generally, it was reported that it is challenging to identify mental health issues on account of the lack of standardized screening and assessment proformas. The PHC is also not equipped with the provision of a dedicated counsellor. Similarly, there is a lack lack of knowledge and understanding around the different aspects of child protection issues, such as child sexual abuse. While PHC medical officers were aware of the POCSO Act and its mandate to address sexual abuse, they were unaware of how to

operationalise it in the context of their own roles. No cases of child sexual abuse have been reported or referred to PHCs.

Gaps and Challenges

- Floating migrant populations, especially the *Adivasi* migrant labourers have been reported as a challenging population to treat by the PHC. The staff reported that there is a low prevalence of health-seeking behaviours and a general unwillingness to seek advice or medical assistance from the PHC. This has resulted in greater focus on awareness drives amongst these communities. However, owing the seasonal nature of their work and temporary stay in the area, it is difficult for the PHC to monitor their compliance with health interventions.
- Additionally, one of the key challenges reported is the absence of screening checklists and assessment proformas for mental health issues and certain kinds of disability such as learning disorders. Although the PHCs, given their work in under-5 health, encounter many children, in the context of nutrition, immunization and other health issues, they are not equipped to identify children with developmental delays and disorders. Despite being upgraded to HWCs, their knowledge on child mental health and related protection issues is limited, as many PHC staff still have not received adequate training on all the issues that HWCs are expected to deal with.
- There is also a reported lack of clear referral mechanisms for these issues, complicating the provision of assistance to vulnerable children and families. While one PHC reported awareness of the RBSK Mobile Team, and their work in the schools and anganwadis, the other PHC reported a lack of awareness of the RBSK or the DEIC—which may also be because RBSK teams are not yet operational in all districts, and DEICs exist in the state in only 3 districts. The absence of a mental health professional, such as a counsellor, has also hampered the realization of the mental health mandate of the PHC.

Potential Opportunities

- Given their regular contact with the community, and children in particular, through their clinic-based services, as well as their outreach (through ASHA workers), their contribution to child mental health and protection would be critical, in terms of early identification of children with disabilities, as well as those who are at risk due to protection concerns. The PHC staff can be provided with simple screening checklists that will enable them to identify developmental, mental health, and protection concerns in children, and refer them by liaising with the DCPU, DEICs and other mental health facilities (where they exist).
- Also, in light of the mandate of the HWCs, the team observed that it is critical for the PHCs to be trained in the use of systematic assessment proformas, as well as in the provision of first-level mental health interventions (even in the absence of appointed counsellors). Additionally, there is a requirement for guidelines on referral and institutions that may be leveraged as higher centres for more complex mental health or disability-related issues requiring depth and specialized assistance.

- While the adolescent health clubs are currently advising fellow peers on matters related to adolescent sexuality and substance use, the team also observed that there was a need for implementation of standardized life skills methods, that can usefully be facilitated at the PHC level.

A.3. Gram Panchayat Chairperson

Existing Issues, Services and Systems

The Arunachal Pradesh Panchayat Raj Act, 1997 has vested considerable powers upon the gram panchayats, particularly in regards to the planning and implementation of community-oriented development works. However, it wasn't until recently that critical powers, particularly in relation to women and child development, were devolved upon the gram panchayats, thereby granting these critical local governing institutions financial and planning autonomy. The Gram Panchayat Chairperson (GPC), in this context, has a key role to play in shaping the planning process and in prioritization of key developmental initiatives. The Gram Panchayat Chairperson highlighted that key infrastructure development initiatives, pertaining to the development of schools and anganwadis were underway, including an initiative introduced by the Deputy Commissioner for integration of anganwadis with primary/secondary schools. Other information regarding community-level issues and children were also shared by the Gram Panchayat Chairperson as below:

- **Parenting and Family-related Issues**

One of the key issues raised by the GPC was in relation to parental incapacity, particularly in the context of identification of children with mental health issues and referral to the primary healthcare services. Family vulnerabilities such as marital conflict, re-marriage and altered familial structures, and domestic violence, were also reported to contribute behavioural issues amongst children. The GPC reported that within difficult family circumstances, children sometimes modeled their behaviours on the basis of their exposure to these issues. Gender roles were identified to have a significant impact wherein it was noted that boys are usually more susceptible to indiscipline and challenging behaviours, including school truancy and dropouts, in addition to substance use.

Changing socio-economic contexts were also observed to impact children's interest in pursuing educational opportunities. The GPC noted that in some instances where families received a sizeable inflow of financial revenue (as a result of land-related compensation), children typically expressed an unwillingness to pursue education and eventually dropped out. These children were vulnerable to substance use in some cases and faced significant challenges when the financial inflow reduced or disappeared altogether.

Additionally, the GPC also reported that parents do not generally discuss mental health or substance use issues with their children, owing to prevailing stigma, further contributing to a dearth of information amongst adolescents. In some vulnerable communities, owing to generational differences, the GPC also identified that instances

of corporal punishment prevail, which in some instances can also result in serious physical abuse. In these instances, children and adolescents have been observed to have exceedingly adverse reactions to such forms of disciplining, with mental health impacts including self-harm behaviours, reported amongst adolescents.

- **Substance Use**

Substance use was reported to be a serious concern amongst adolescents, with parents often seeking access to de-addiction services. The GPC noted that such substance use issues are regularly discussed in *gram sabhas*, wherein parents also express grievances with children who reportedly relapsed after rehabilitative interventions at the de-addiction facilities. This 'revolving door' phenomenon was observed to be a critical ongoing concern, given the serious implications for families.
At the school-level, the GPC noted that teachers are required to often remain vigilant to substance use behaviours, and in some cases, counselled children where such behaviours were observed. Lack of parental understanding of mental health and substance use, especially amongst vulnerable families in tribal communities such as the Idu Mishmi, were observed to have significant consequences for identification of these issues as well.

- **Impact of COVID on education and learning**

Increased access to technology and mobile devices were reported to have contributed to frequent screen time (wherein gaming has become commonplace). This was reported to be a cause for concern for children and adolescents, with addictive tendencies reported amongst adolescents as well. From a learning perspective, school teachers have also reported that children's abilities to apply conceptual learning has diminished (particularly after COVID), given the ease of access to information online.

Gaps and Challenges

- One of the key gaps in service provision is related to the absence of mental health and psychosocial support at the gram panchayat level. The GPC stressed that there is an imperative for a counsellor at the panchayat level, in addition to a counsellor in schools. One of the issues, in this regard, was reported to be the absence of trained and qualified counsellors. This was corroborated in interactions with the DCPU, which also highlighted the shortage of human resources (with trained and qualified counsellors being an issue across the state).
- Additionally, given the issues in parenting and family circumstances, the SAMVAD Team noted that there was an imperative for parental psychoeducation and awareness efforts to boost awareness on mental health, child protection, and substance use issues. These community-level interventions are also necessary to counter prevailing stigmas surrounding mental health assistance. School-based programs are also currently absent wherein key information and skills pertaining to mental health and protection issues can be provided.

Potential Opportunities

- In regards to the provision of mental health services, it is imperative for the HWCs to be capacitated to provide mental health and psychosocial support to children and parents. The absence of a dedicated counsellor was especially highlighted by the GPC in this regard. Despite the upgradation of HWCs, this remains an unfulfilled mandate at the primary level. While there exists a shortage of human resources to bridge this gap, current personnel can be provided capacity-building interventions that may equip them to provide basic screening and assessment of mental health and substance use issues.
- The GPC also highlighted that further training programs were required for panchayat functionaries, in order to develop an understanding of key pathways to vulnerability for children and adolescents and the necessary interventions required to address these concerns (including referrals where necessary). While there are in place successful nutritional programs (including the nutria-garden initiative) and school/anganwadi infrastructure development, the GPC noted that key child protection, mental health and disability issues are currently not a planning priority in the Gram Panchayat Development Plan (GPDP). It was noted that significant capacity-building initiatives were required, in this context, to realize the mandate of a child-friendly gram panchayat.

- The GPC also highlighted the difficulty in implementing certain schemes such as *Beti Bachao Beti Padhao* (BBBP) in the panchayat area. In Arunachal Pradesh, substance abuse is one of the major issues impacting children's school attendance; this issue disproportionately affects boys and their school attendance. Therefore, in a context such as this, it is essential to address school attendance issues not only in girls (who are also vulnerable, like elsewhere in the country), but also boys and their specific vulnerabilities.

A.4. Gaon Bura (Traditional Village Head)

Existing Issues, Services and Systems

The Gaon Buras (GBs) are the most significant traditional village authorities who work alongside the panchayat functionaries and other governmental authorities. However, the primary distinguishing feature of the GBs is that their roles and responsibilities are statutorily demarcated under the The Assam Frontier (Administration of Justice) Regulations of 1945. In essence, while panchayat system has been empowered to undertake key developmental functions, the Gaon Buras possess key law and order-related duties at the village level, which includes (amongst other functions), policing powers of apprehension, and adjudication of civil disputes (predominantly land-related disputes) and minor criminal offences such as theft, mischief, simple hurt, criminal trespass, and assault or using criminal force. In cases of heinous offences, the GB is required to inform the Deputy Commissioner and Police. Other information regarding community-level issues and children were also shared by the Gaon Bura as below.

- **Administration of Law and Order**

Given the traditional significance of the GB in the village, and their formal legal powers under the aforementioned statute, it is clear that GBs exercise significant control over law-and-order proceedings at the village level. However, given the realities of community-centric adjudication, and the community's preference for settlement over prosecution in most cases, the demarcation between the GBs and formal police, judicial, and administrative agencies, remain somewhat ambiguous in practice. This issue is best explicated through one of the accounts shared by the Gaon Bura wherein a heinous offence was settled at the village level, owing to the desire of the parties to not proceed with any formal criminal adjudication.

- **Child and Adolescent Issues**

Predominantly, the Gaon Buras reported the prevalence and increasing incidence of substance use as the most significant concern at the village level. While the GB tries to rehabilitate children in conflict with the law (in the case of minor offences), more serious offences (especially those committed by young adults) necessarily must be reported to the police authorities. The GB reported substance abuse as the most pressing community concern especially when distress land sales are made consequent to substance use.

Adolescent relationships and teenage pregnancies were also reported to be key issues at the village level amongst all communities, wherein families are sometimes counselled to settle the dispute through formalization of the adolescent relationship via early marriage. However, the GB emphasized that any early marriage is only entered into following agreement between the families. In other instances, however, adolescents run away together especially when there is strong resistance from the families and reluctance to accept the union. The GBs also reported some instances of suicide in the case of adolescent relationships.

In regards to the provision of educational services, the GBs also reiterated the issue of older children joining the anganwadi and their inability to cope with age-inappropriate learning modules. This was highlighted as a factor affecting dropouts as well.

Gaps and Challenges

While the GBs role is largely restricted to law-and-order activities at the village level, subject to reporting requirements to the Deputy Commissioner, one of the existing concerns is in regards to settlement of various disputes and criminal offences (including heinous offences in certain instances). This issue was also reiterated by the Chief Judicial Magistrate, Roing, wherein it was highlighted that a large number of criminal offences are settled at the village level, thereby affecting the reporting of even heinous offences in some instances. In the context of Children in Conflict with the Law (CICL) and Children in need of Care and Protection (CNCP), such family-based settlement of offences can have an adverse impact on the child's mental health and psychosocial well-being.

Potential Opportunities

The GBs functions vary significantly from those of the GPs. The mandate from the point of view of decentralization and implementation of child protection, mental health, and disability services, therefore, remains outside their purview. However, given the issue of the settlement of heinous offences at the village level, and indeed, the lack of clarity on the importance of rehabilitation, the GBs may be trained on key child-related laws. This would enable increased utilization of statutory reporting processes, where necessary. Additionally, GBs may also be provided a brief orientation on mental health issues, and information on referral services for children requiring further support or treatment. The GBs, in this regard, can be oriented to work more closely with the PHC and the GP.

B. Secondary Level

- Deputy Commissioner
- Zila Parishad
- District Medical Officer
- Rashtriya Bal Swasthya Karyakram
- One Stop Centres
- Special Juvenile Police Unit
- Child Welfare Committees
- Juvenile Justice Board
- Special Court Judge
- Integrated Child Protection Scheme
- Schools

B.1 Deputy Commissioner

Existing Issues, Services and Systems

The Deputy Commissioner serves as the executive head of district administration. From a child and adolescent perspective, the Deputy Commissioner is the foremost authority at the district level, who performs not just coordination-related functions, but is also mandated to oversee the discharge of statutory duties by all child-related stakeholders and monitor the implementation of relevant schemes. They exercise important administrative and planning functions vis-à-vis Panchayat functionaries, Gaon Buras, and child protection stakeholders under the Juvenile Justice System. In light of the key role of the Deputy Commissioner in delimitation of panchayat areas, law and order functions vis-à-vis Gaon Buras, and the enhanced role of the District Magistrates under the Juvenile Justice Framework, the SAMVAD Team sought to elicit information on key areas of focus for the Deputy Commissioners in their respective districts.

Despite the manifold duties of the Deputy Commissioners in regards to child protection (across contexts such as child labour, child marriage, education), child mental health, and early child care and development, they reported deficits in coordination with other key district-level stakeholders. One of the flagship initiatives, reported by the Deputy Commissioner in Roing, included the integration of anganwadis with pre-primary schools to facilitate a greater pooling of resources and in order to streamline children in the formal education system through closer contact with primary and upper primary schools. Various stakeholders such as anganwadi staff also highlighted this initiative in Roing as one of the key educational interventions. In addition to this, career counseling initiatives were also discussed as having been organised at the district-level in Roing, with efforts currently directed at establishment of a career counselling centre, at the school level, in the district.

In regards to performance of new functions under the Juvenile Justice framework, the Deputy Commissioners also provided a brief overview of the process by which adoption proceedings are completed in pursuance of applications for adoption orders. Prospective Adoptive Parents (PAPs) and children are typically interviewed separately by the Deputy Commissioner, following which the adoption proceedings are concluded and the order is passed, if the Deputy Commissioner is of the view that the child and the PAPs are agreeable to the adoption. While it was reported that this process usually takes 2 months, one of the Deputy Commissioners disclosed that separate guidelines on the manner of conducting adoption proceedings would be beneficial for District Magistrates/Deputy Commissioners.

Further information provided by the Deputy commissioners on child-related concerns at a community and district level are elaborated below:

- **Child rearing and Family Circumstances**

One of the key issues reported in the district related to challenges in child rearing and family circumstances, especially in the context of breakdown of marital relationships. While breakdown of marital relationships and subsequent re-marriage have introduced

complex relationship dynamics that have implications for child abuse within the household (in some instances), there is also a generally reported trend of low parental involvement in the lives of children. Low parental involvement has also resulted in children spending more unstructured time in the community, particularly in cases where children have dropped out of school or are engaged in truancy behaviours. These children are particularly vulnerable to substance use as well, with a higher reported prevalence amongst adolescent boys. The Deputy Commissioners also reported gendered parenting roles, with financial decision-making typically the prerogative of men, and women being tasked with more involvement in children's lives, including in cases of substance use and addiction, wherein mothers are responsible for accessing de-addiction centres and facilitating rehabilitative processes for their children.

- **Self-harm and Suicide**

Self-harm and suicide were identified as important concerns predominantly amongst adolescents. It was observed, in this context, that there is gross underreporting of suicides, given the community context of suicidality, and higher prevalence amongst certain communities. One of the key concerns, related to higher suicidality amongst tribal communities such as the Idu Mishmis, was reported to be strict customs and traditions in the context of legitimacy of relationships. Some practices include proscriptions on marriage, owing to lineal degrees of consanguinity extending back to 7 generations. These practices and community disapproval of adolescent relationships were reported to contribute to increased suicidality (especially in adolescent girls from the Idu Mishmi).

- **Adoption (Legal and Illegal) and Child Labour**

While legitimate adoptions are processed through the Juvenile Justice Act, these are few in number. It was reported that there is generally a low preference amongst tribal communities for adoptions through the formal system.
However, one of the Deputy Commissioners reported having processed 3 domestic adoptions within the country, and 1 inter-country adoption following her posting. One adopted child was returned by the adoptive parents following dissolution of the adoption owing to concerns pertaining to sexual abuse by the older child upon the family's biological child. In this regard, it was reported that pre-adoption counselling is currently not provided to prospective parents during the matching process, raising concerns pertaining to the viability of the adoption in the future.

In addition to gaps in the formal adoption process, one of the overarching child protection issues reported across the state, and echoed by the Deputy Commissioners is the issue of illegal adoptions and subsequent child/bonded labour. It was reiterated that instances of illegal adoptions and bonded labour are frequently observable in socio-economically privileged households. As discussed elsewhere, the children 'adopted' in such a manner are usually from migrant labour families who lack the means to provide childcare. These families may be from the states of Bihar, Assam or even from neighboring countries such as Nepal. It was also reported that there are frequent instances of violence against these illegally adopted children by their 'adoptive' families. This is compounded by their

responsibilities, as bonded labour, who are entirely dependent on the goodwill of the adoptive family.

- **Adolescent Relationships, Child Marriage, and Teenage Pregnancies**

Adolescent Relationships were reported as commonly observable amongst all tribal communities. While the Deputy Commissioners reported that there is community resistance to adolescent relationships (especially where there are customs and norms pertaining to consanguinity), most adolescent relationships are eventually accepted by the families, with many child marriages remaining unreported in such cases. It was also reported that there are instances of teenage pregnancies (within and without child marriage), with a greater reluctance in the community to discuss such instances. Teenage pregnancies are observed across communities i.e., amongst the local tribes and the migrant communities as well.

- **Substance Abuse and Crime**

It was reported that there is an increasing number of adolescents and young adults engaged in substance use across the state. Many adolescents (usually 15 and above) engaged in substance use are also apprehended in criminal cases after coming into conflict with the law, with most cases involving petty offences such as theft. As discussed above, low parental involvement, issues in quality of school education and consequent dropouts, and negative peer influences, in the community, contribute to increased substance use amongst adolescents. It was also reported that parents are reluctant to admit their children's involvement in substance use, due to concerns pertaining to consequences of a public disclosure. Such instances also contribute to widening the treatment gap.

- **School Education**

While the Deputy Commissioners reported improved efforts to encourage school education, there are critical systemic challenges that create barriers in accessing education. The scattered nature of the population has resulted in schools being geographically inaccessible for many families, who may be unable or unwilling to send their children to far away schools. This issue has also contributed to difficulties in securing teacher accommodation where required.

In addition to geographic challenges, one of the Deputy Commissioners also reported a general sense of laxity in the quality of educational services provided in the district, with a low emphasis on teacher and staff attendance (including the cook), the quality of teaching, provision of mid-day meals etc. While nodal officers were appointed for school visits, one of the Deputy Commissioners reported that there was insubstantial follow up. Low motivation amongst teachers and school management was observed to be a recurring issue.

Gaps and Challenges

- **Adoption Proceedings and Final Orders**

Following significant changes to the role of the Deputy Commissioner/District Magistrate in adoption cases under the Juvenile Justice Amendment Act, 2021, training has not been conducted to apprise the Deputy Commissioners of their new role i.e., to conduct adoption hearings and pass final orders. Therefore, there is a lack of clarity on the new role of the Deputy Commissioner, and the manner in which adoption proceedings are to be conducted. Adoption proceedings are largely conducted in an informal manner with vast discretion available to the Deputy Commissioner in the regards to the structure of adoption proceedings.

- **Lack of coordination and support**

Despite the many functions vested with the office of the Deputy Commissioner, one of the key challenges reported was in coordinating with other key district functionaries such as the Child Welfare Committee, District Child Protection Unit, District Task Force on Child Labour, Block and District-level Education Officers and other functionaries, given the limited information sharing by these key stakeholders. As one Deputy Commissioner reported, while the District Child Protection Committee and Committee to Monitor Child Protection Services at the Block level had been formulated, no meetings had been held since the Deputy Commissioner took charge.

As a result, the Deputy Commissioners averred that they are unable to assist children in many vulnerable contexts as information pertaining to cases are not regularly shared with them.

- **Lack of institutional support in service delivery**

One of the additional concerns, particularly in the context of mental health, was reported by the Deputy Commissioners. While awareness efforts in regards to mental health have received significant turnout and have contributed to initiating conversations at the community level, these camps have reportedly had little impact due to the absence of mental health professionals like psychiatrists. As a result, awareness efforts have remained sporadic and irregular.

In the context of protection services, the Deputy Commissioner for Lower Subansiri reported a lack of availability of observation homes for children in the district. However, as a positive intervention, the Deputy Commissioner also reiterated that land has been sanctioned for establishing an observation home, which should be functional by the end of current financial year since there are referrals to the district.

- **Lack of training and capacity-building**

During the course of interviews with the Deputy Commissioners, the SAMVAD team observed that there was limited information possessed by these key stakeholders on child-related issues such as child sexual abuse and disability. While the administrative functions of the Deputy Commissioners are manifold, thereby precluding the possibility of depth engagement with child-related concerns to the extent of other nodal officers (like the District Child Protection Unit staff), it was observed that a brief orientation on these issues was necessary for the Deputy Commissioners to exercise their mandate in regards to coordination, monitoring, and supervision.

Potential Opportunities

- **Guidelines for Coordination**

The District Magistrate has been vested with administrative control and oversight over a number of key child-related committees including the District Child Protection Committee, District Inspection Committee (overseeing child care institutions in the district), and District Task Force on Child Labour. Yet, the lack of periodic information-sharing and meetings to discuss case management issues, infrastructural constraints, shortage of human and financial resources, and other systemic challenges, currently impedes the exercise of key monitoring responsibilities of the Deputy Commissioner.

Keeping in mind the centrality of the Deputy Commissioner for effective delivery of key services to children and caregivers, guidelines for improved coordination amongst nodal officers may be developed to regularise and streamline coordination efforts in regards to issues affecting children and adolescents. These guidelines may specify notification of periodical meetings of key district committees, referral procedures for more serious protection and mental health concerns, linking of beneficiaries to available schemes, the provision of financial support where feasible, and other significant interventions.

The role of the District Task Force, in particular, is an urgent requirement, keeping in mind the widely underreported cases of illegal adoptions and child/bonded labour. Rescue and rehabilitation efforts may receive critical operational support from the Deputy Commissioner's Office through strict adherence to reporting frameworks and information-sharing procedures.

- **Setting up of DMHP**

In the context of mental health, while awareness efforts have been initiated, in addition to upgradation of Health and Wellness Centres (to include the provision of mental health services), the absence of institutionalised mental health service delivery, and lack of qualified and trained staff at the PHC level, has fructified the necessity for setting up of District Mental Health Programs (DMHPs) across the state. This will also ensure unrestricted availability of secondary mental health care, and reduce the overburdening of tertiary mental health institutions in the state.

From the point of view of the Deputy Commissioner, the presence of the DMHP will also streamline awareness and intervention efforts, in addition to facilitating a robust mechanism for referral by other block and district-level institutions such as PHCs, Child Care Institutions, Schools etc.

- **Capacity-Building & Awareness Programs**

Comprehensive training efforts to orient Deputy Commissioners on their new role under the Juvenile Justice Act, can help provide clarity on their roles and responsibilities. Such capacity building initiatives can also help leverage the Deputy Commissioners' vast experience to conduct adoption proceedings in a standardised manner, with incorporation of key child mental health and psychosocial perspectives in adoption-related decision making. Additionally, awareness programs on socio-emotional well-being can be critical in improving the utilisation of mental health services across the State.

B.2 Zila Parishad

Existing Issues, Services and Systems

Arunachal Pradesh has been governed by a 3-tier system of panchayati raj institutions for most of its history (formally since 1969), consisting of the Gram Panchayat, Anchal Samiti, and the Zilla Parishad. Following wide-ranging amendments in 2018[13], this system was consolidated into a 2-tier system of panchayat governance consisting of only the Gram Panchayats and the Zilla Parishads. Therefore, following dissolvement of the Anchal samitis, many of the functions and responsibilities, vested with these intermediary panchayat institutions, have been conferred upon the Zilla Parishads. Gram Panchayats have also been brought under the direct administration of the Zilla Parishads in this amended system.

In light of the above institutional framework, the following is an explication of findings from the key informant interviews conducted with the Zilla Parishad Chairperson and Members.

- **Administration**

Following the adoption of the SPICE (Sustainable, Participative, Inclusive, Comprehensive and Empowerment) model, by the Government of Arunachal Pradesh in 2021, significant changes were announced in the functioning of gram panchayats. The Government observed that legislative powers would be devolved to PRIs in accordance with 73rd Constitutional Amendment and the 11th Schedule. This includes issues under the key legislative subjects of women and child development, health and sanitation, education, family welfare, and social welfare.

In this context, the Zilla Panchayat Members and Chairperson reported that funds have been disbursed from the Zilla Parishad Fund, in addition to funds from State-owned revenues, tied and untied funds, and performance-based grants in accordance with the 15th Finance Commission to the Gram Panchayats. However, these district-level panchayat leaders emphasised that the funds disbursed till date have largely been utilised for infrastructure development. Even in the case of child-related initiatives at the panchayat level, the Zilla Parishad representatives reiterated utilisation of funds for child-related infrastructure development i.e., development of anganwadi centres, playgrounds, and other recreation/sport facilities. Other priorities in infrastructural developmental efforts included water-related infrastructure. Sports and recreation facilities were identified as significant sources of investment, given their positive impact on governmental efforts to divert children away from substance use.

However, despite the identifiable need for enhanced child-related infrastructure, particularly in the context of early childhood care, one of the issues identified was an unwillingness, at a gram panchayat level, to invest sufficiently in local developmental efforts apart from infrastructure and agriculture. A contributing factor is low awareness, amongst local residents, of the significance of non-infrastructural initiatives for children relating to rehabilitative and psychosocial care, especially in light of substance use

[13] Arunachal Pradesh Panchayati Raj (Amendment) Act, 2018

issues. This also has implications for developmental priorities set by gram panchayat representatives.

- **Substance Use & Rehabilitation**

Substance abuse was identified by multiple stakeholders as one of the predominant issues impacting child and adolescent health in Arunachal Pradesh. While it was observed that there are prevailing community practices surrounding the use of opium and opium products medicinally, primarily amongst older residents, opium addiction was identified as a growing concern amongst adolescents and young adults in recent years. Zilla Parishad Members reported that substance use has grown in scale and has resulted in serious health concerns, particularly in regards to the rise in number of HIV cases. During an HIV awareness and testing drive conducted in Roing, it was reported that 17 individuals tested positive for HIV, from a single catchment area, raising concerns that there are likely far more cases of HIV related to drug-use, that have as yet remained unidentified.

In terms of the genesis of this issue, Zilla Parishad Members adverted to the reality of these cases, wherein families only seek assistance once the situation has turned dire. This makes interventions difficult to implement in a timely manner, with awareness programs currently the most cited preventive intervention in place. De-addiction centres have also cropped up in recent years, and are often resorted to by families in cases of substance use that are more severe. The Zilla Parishad Members and Chairperson also identified that Arunachal Pradesh, as a frontier state, has witnessed a sharp rise in the inflow of drugs from border areas, with Namsai being a vulnerable transit point for other parts of Arunachal Pradesh like Roing.

A few cases of violence and harassment have come to the attention of the Zilla Parishad, wherein the concerned individuals were found to be intoxicated. However, these cases were identified as being low in number. While state and local governmental efforts targeting drug supply chains have intensified over the years, it was observed that it is difficult to secure long-term progress given Arunachal Pradesh's geographic and social location as a frontier state that shares borders with multiple countries.

From an intervention standpoint, one of the key issues discussed was in relation to the regulation of de-addiction centres. The Zilla Parishad Members identified that while some De-addiction centres are contributing significantly to rehabilitation efforts, there are centres without any regulatory oversight, wherein children have reportedly gotten more involved in drug use. The importance of regulation of de-addiction centres was reiterated through the course of interviews with the Zilla Parishad Members.

- **Accessing Health Services**

Primary Health Centres were identified as significant at the community level, particularly in regards to the provision of important services like vaccination (that assumed greater significance during the pandemic) and in the provision of an expanded range of basic health services under Ayushmann Bharat Scheme's Comprehensive Primary Health Care (CPHC) mandate. However, it was observed by Zilla Parishad Members that residents complained of issues at the panchayat level, in regards to the quality of services provided in PHCs vis-à-vis private medical institutions, and in regards to the skills of the ASHAs,

even in core health services pertaining to reproductive, neonatal, and infant health care services. While the PHCs visited by the SAMVAD team had been redesignated as Health and Wellness Centers (HWCs), Zilla Parishad Members reported that residents continued to express uncertainty over the provision of mandated health services (including pregnancy-related health services) and services in relation to non-communicable diseases including cancer. In addition to reported preferences for private health services, one of the Zilla Parishad Members also reported that residents preferred to access secondary health services in the District Hospitals and tertiary services (where feasible) over the primary health centers.

- **Anganwadis and Education Services**

The overarching issue of preference for private sector services extended to the provision of education. One of the Zilla Parishad members reported that parents typically preferred to admit children to private schools at the pre-primary and elementary level. This phenomenon extended to families with limited financial resources as well, owing to reported concerns with the quality of education received in anganwadis and government-owned and aided schools. The lack of attention provided to pupils at the primary and secondary level were reportedly areas of concern for parents. Additionally, one of the Zilla Parishad Members reported that serious concerns in regards to foundational learning persisted, amongst communities, at the anganwadi level, which has contributed to increased access to private schools. This issue has also contributed to exacerbated drop-outs in elementary school (particularly in the 5th and 6th standard).

School drop-outs were discussed not just in the context of their impact on the overall level of education and skill development, but also in relation to their compounding effects on the issues of child labour and substance use. Out-of-school-children (OoSC) were identified as especially vulnerable to substance use and addiction, given the large periods of unsupervised time spent in the community. A significant proportion of OoSC were also reportedly from migrant populations including migrants from other states in India like Bihar, Jharkhand and Assam, and bordering countries, like Nepal and Bangladesh. The Zilla Parishad Members reported that efforts are made to mainstream these children in government or private schools.

Due to reported issues in early access to education, it was also observed that there exist serious issues in mainstreaming of older children in anganwadi centers and primary schools, particularly when children are aged 5 and above. This issue was also corroborated by anganwadi staff, who shared instances wherein order children (aged 9-10) have found it challenging to adjust to foundational learning activities that are not age-appropriate. During the course of interactions with the SAMVAD team, Zilla Parishad Members did not report awareness about special training facilities (particularly in relation to children engaged in child labour) that is mandated under the RTE Act and Samagra Shiksha Abhiyan (SSA).

- **Child Labour**

Child Labour was reported as a significant issue particularly amongst migrant labourers in tea plantations across the state. However, whilst discussing the issue of child labour, the Zilla Parishad Members observed that there exists a reluctance amongst socio-economically well-off families to acknowledge the prevalence of child labour. As corroborated by other key informants, the SAMVAD Team observed that child labour is typically masked in the prevailing discourse, given its form within the family structure. Typically, child labour takes the form of illegal adoptions, wherein *Adivasi* children are either sold or 'handed over' to the indigenous tribal families, who then raise these children as members of the family[14]. The SAMVAD Team observed that the issue of child labour was predominantly reported amongst the migrant *Adivasi* population, while informants acknowledged that low-skilled work wage labour and contract labour was typically not performed by indigenous tribal groups. In this regard, the SAMVAD team noted entrenched socio-cultural beliefs, amongst indigenous tribal groups, in regards to the permissibility of the performance of low-skilled/low-paying work by these communities, in contrast to their traditional status-based occupations.

Children, illegally adopted within such family setups, are provided the family/community's name in their birth certificates (following the 'adoption'), and subsequently reside with their new families. However, their role in the family unit is essentially marked by the performance of household labour (and other chores). They are typically not vested with property rights like their adoptive siblings. In numerous instances, such child labour arrangements only come to the attention of the police, and other officials, when there have been instances of physical abuse (in some instances this may also extend to sexual abuse). In grave instances of this nature, a complaint is filed and an FIR is also registered by the police. There were conflicting reports by various respondents on this issue, with officials like the Zilla Parishad Members insisting that some families educate these children and even help them secure government jobs.

- **Adolescent Relationships and Early Marriage**

The Zilla Parishad Members and Chairperson discussed the issue of child marriages and observed that there had been a shift in societal attitudes towards early marriages. While child marriages were noted as a prevalent issue prior to the introduction of the Prohibition of Child Marriage Act (PCMA), 2006, it was observed that increasing prevalence of adolescent sexual relationships had emerged as a determinant of early marriages in recent years. It was highlighted that early marriages in many instances are found to be an acceptable settlement between families in cases wherein adolescents are in mutually consenting relationships. Typically, in such cases, while families chastise their children for entering such relationships, the Zilla Parishad Members noted that families are counselled to allow the relationship to be formalized through marriage. Such settlements were cited as a means through which animosity is avoided between families. In cases of adolescent sexual relationships, it was also observed that there have been instances wherein illegal abortions (in contravention of medically prescribed procedures under the

[14] In multiple interviews, key informants distinguished the migrant tribal population (referring to these groups as *adivasis*), from the indigenous tribal communities in Arunachal Pradesh, such as the Idu Mishmi and Adi tribes.

Medical Termination of Pregnancy Act (MTPA) 1971) have resulted in deaths of adolescents. This was also discussed as a factor in community efforts to identify such relationships in a timely manner and facilitate a settlement between the families.

- **Permanent Residency Certificate (PRC)**

One of the additional subjects discussed, in regards to its impact on tribal youth within the community, was the issue of youth involvement in contentious political issues such as grant of permanent residency certificates (PRC) and the distribution of allied government benefits. It was observed that while the issue of grant of PRC was a significant concern across the state, the contentious nature of the matter, and differences between tribal groups, have also had an impact on school drop-outs and youth involvement in community demands. One of the Zilla Parishad members noted that the subject was a sensitive issue for all tribal communities and one that necessitates dialogue. However, a lack of understanding amongst tribal communities of each other's customs has resulted in clashes between the communities, thereby prompting the involvement of adolescents and young adults in student organisations. The Member noted that these student organisations were promising in regards to the dedicated efforts of its leaders and student volunteers. However, the organizations' role in diverting students from school-related activities was one that required community involvement and deliberation.

Gaps and Challenges

- Following interviews with the Zilla Parishad Members and Chairperson, it became increasingly evident that one of the key issues related to the communities' preference for private educational and health services, despite the high out-of-pocket expenditures that these private services typically entailed. One of the key factors responsible for this phenomenon related to reported issues in the quality of primary healthcare services, and indeed, anganwadi and elementary school services in government-run institutions. Additionally, a paucity of skilled healthcare and education personnel was also a contributing factor reported in this context. In regards to health services, the lack of standardised and regulated de-addiction services was also identified as a concern, especially in light of the high incidence of substance use and allied health concerns such as the spread of HIV infections amongst adolescents and young adults.
- In addition to the above gaps and challenges, the issues of child labour and adolescent sexual relationships/early marriage, also brought to fore the imperative to facilitate greater involvement of child protection services, given the continuing prevalence of illegal adoptions and bonded labour arrangements (particularly affecting migrant children), and indeed, the solemnization of early marriages in the context of adolescent relationships. While the Zilla Parishad Members and Chairpersons noted that they work with the DCPUs, key decisions taken at the community level continue to be decided without sufficient involvement of the DCPUs, despite the adverse implications for children and adolescents.

Potential Opportunities

- The SAMVAD Team observed that the anganwadi, primary healthcare services and elementary school services were specifically discussed in the context of lack of quality service provision and uncertainty amongst the community in regards to availing of these key services. One of the important areas of intervention in this regard is extensive capacity-building of primary healthcare staff, anganwadi staff, and indeed, school teachers at the elementary level. Skilling of these key child-related stakeholders, with a particular emphasis on identification and referral of mental health issues, disability, and child protection concerns, are potential ways forward. Additionally, given the renewed mandate of the Health and Wellness Centers (in regards to screening and first-level interventions for Mental Health, Neurological, and Substance Use (MNS) issues, primary healthcare services require additional capacity-building interventions in relation to mental health and protection. School personnel, given their involvement in children's daily lives also play a significant role in the identification and referral of mental health, protection, and disability issues.
- The Zilla Parishad Members and Chairperson also noted that Community-based Organisations (CBOs) and NGOs working in the field could similarly benefit from capacity-building interventions on the subjects discussed above. One of the recommendations, in this regard, was for greater emphasis on youth participation in health-promotive community-centric activities such as sport and recreation. One of the Zilla Parishad Members noted with satisfaction that sport and recreation facilities had been setup in his district, as a means of diversion of youth from substance use and were an infrastructural priority. In this context, life skills interventions could also be efficiently implemented within a sport/recreation context to build psychosocial scaffolding for vulnerable children and adolescents. Student organisations may also be leveraged in mental health-promotive community awareness and intervention programs, so as to facilitate greater engagement amongst adolescents and young adults.

B.3 District Medical Officer

Existing Issues, Services and Systems

- **Paucity in human resources**

There is no psychiatry department in the district hospitals. It was reported that there is a shortage of mental health professionals and psychiatrists in the state. They reported that the 2020 recruitments had released a vacancy for a psychiatrist but there were no applications for the same.

- **Paediatric and neonatal services**

With regard to children, paediatric services, including Neonatal Intensive Care (NICU), have been relatively newly set up in the district hospitals visited. The out-patient Department in district hospitals reported seeing respiratory issues, gastro-intestinal

issues, and neonatal issues, as the major child-related cases that are seen by the paediatrician. In case of severe neonatal cases, due to unavailability of ground staff, the child is referred to Assam Medical College.

- **Services for children with disabilities**

While it was reported that systematic developmental assessments of young children are not done at the district hospitals, sometimes children with developmental delays such as Autism, Behavioural issues, ADHD and other neurodevelopmental disorders are identified. Such children are referred to Guwahati Medical College for treatment.

- **Substance abuse**

Mental health issues and disabilities in the tribal communities in Ziro mostly remain unidentified and unaddressed because there is lack of knowledge about mental health issues and disabilities. Even with regards to the substance use issues, it was reported that the adolescents and young people only come for treatment, at a stage, when the addiction becomes severe and medical interventions become extremely necessary. In order to control the substance abuse issues in the district, the Apatani Youth Association also initiated a “Zero Drugs Ziro” campaign on their 48th foundation day in 2022. The organization along with Apatani Women’s Association, Ziro has been working to create awareness on issues of substance use in communities since then.

While district hospitals do not have departments of psychiatry, they have services that address issues of substance use, a health problem that is rampant in the state. For instance, the Namsai district hospital has an Integrated Counselling and Testing Centre (ICTC) where patients are sent after screening for HIV and Hep B and C testing and confirmation. The district hospitals reported receiving cases of substance abuse through patients in withdrawal, experiencing chills, fever, vomiting and nausea. They also approach the hospital after contracting HIV and Hepatitis. This hospital also offers ART counselling through the National Viral Hepatitis Control Program (NVHCP) team based out of the district. They also conduct door-to-door testing of Hepatitis and HIV. Opioid substitution therapy is also given to these patients. They also offer antidotes to overdosing, link patients to social service schemes, refer them for higher services and provide basic screening and testing. The NVHCP held an Integrated Screening Campaign in October 2022 in the Chokham Block of Namsai, where a team from the National Aids Control Organization (NACO) held 6 camps over a two-day period, where 27 cases of HIV and Hepatitis B/ C were identified. The Integrated Health Screening (IHS) was then conducted, focussing on overall health, in order to encourage people to attend the screening; people were hesitant due to the stigma associated with HIV. The campaign involved community-based organisations, panchayati raj institutions, Gaon Buras, to sensitize the people of the community. Through the campaign, it was learned that the people who were infected never accessed these camps. Therefore, outreach workers were sent into communities to test groups they identify as high risk for HIV and Hep B/C. Thereafter, from February 2023 to 10th March 2023, over 117 cases of HIV and HPB/C were recorded. They now plan to work with panchayati raj institution members to identify people at risk and refer them for screening and treatment. Each village level team will

comprise of the ASHA worker, Anganwadi Worker, Gram Panchayat member and an outreach worker. They will together comprise the Strategic Expertise Technical Unit. The focus of the team is reportedly harm reduction. The ANM will collect the blood sample and tests will be conducted in mobile vans. They are, however, awaiting funds in order to execute the plans.

The above-described campaign experiences contributed greatly to the learning of the district hospital on substance use issues. The major drugs consumed by within communities are Opium, Heroin and other intravenous (IV) drugs. Itanagar and Namsai have been found to have the highest HIV and Hepatitis prevalence in Arunachal Pradesh. The tea garden areas were particularly reported to be a high-risk zone. The age group of 20-24 years is the highest among the HIV and Hepatitis affected population that accesses medical services at the district hospital. The root cause of HIV in these districts is unsafe usage of IV drug syringes.

It was reported that persons who engage in substance use usually begin at the age of 12-13 years. Some of them are children who come from difficult contexts such as child labour where early exposure and substance use as a means to cope with difficulties is rampant. There were a lot of cases of substance use issues during the COVID -19 pandemic, as a lot of adolescents and young people experienced withdrawal symptoms due to the unavailability of substances. In context of substance use, it was explained that the adolescents or young people who use substances typically come from a background of broken families or from families where polygamy is practiced, thus creating family dynamics that cause stress and trauma for children.

However, in districts such as Namsai, the primary reason for substance use was reported to be easy access to substances. The geographic location of Arunachal Pradesh and most districts like Namsai that share their boundaries with other states and countries, makes the entry of drugs easy as the borders are porous. Also, drugs such as opium have traditionally been cultivated at a household level for medicinal use. The culture of using opium for medicinal purposes has for many years also extended to its use at social occasions such as weddings, as well as regular use by adult members of the family. Thus, the normalization of the use of opium by adult members of the family, coupled with its easy household-level access has contributed significantly to adolescents using opium. This in turn has led opium to serve as a gateway drug for adolescents, as they develop a tolerance for it, and subsequently move on to experimenting with other drugs such as heroin.

There are no de-addiction facilities for children. The only efforts vis-à-vis adolescents with substance abuse are scattered awareness campaigns by a few non-governmental agencies. For example, in order to control the substance abuse issues in the district, the Apatani Youth Association initiated a “Zero Drugs Ziro” campaign on their 48th foundation day in 2022. The organization along with Apatani Women’s Association Ziro continues to work to create awareness on issues of substance use in communities.

- **Child Sexual Abuse cases**

District hospitals also respond to child sexual abuse cases i.e., when POCSO-related cases are referred to them by the police or the DCPU. It was reported that the paediatrician does not play a role in POCSO cases- they are handled by the Emergency

doctor. The process involves filling out an application that requires information on the age of the child, the nature of the assault, identification provided and the medical examination report. The investigations done with regard to POCSO cases are limited to medical evidence and gynaecologist consultations.

Gaps and Challenges

- The lack of a District Mental Health Program (DMHP) in many districts implies that identification, treatment, and referral services for mental health issues forms a huge gap at district level.
- District hospitals, which are the only secondary health services available to many communities are not equipped to cater to child issues relating to protection, abuse and disability.
- Treatment and services for de-addiction exist at district hospitals i.e., screening and medication to address immediate impacts of substance use. However, rehabilitation services, namely psychosocial and mental health supports to ensure recovery and reintegration, and prevention of relapse, do not exist. At present, there are no focussed or specialized services for adolescents—who require different approaches to mental health and substance use, as compared to adults.

Potential Opportunities

- There is a need to ensure the initiation and operationalisation of the District Mental Health Program. It has currently been established in only 6 out of 26 districts of Arunachal Pradesh—and there is a dire need for both DMHP and RBSK programs to be initiated in all districts.
- Investigations for POCSO cases are limited to medical evidence. Given the paucity of tertiary level mental healthcare services in the state, there is a need for district hospital staff, namely paediatrics and gynaecology services, to be trained in medico-legal responses to child sexual abuse issues, including providing the child with first level medical as well as psychosocial responses.
- Considering the on-going efforts at the district level in substance use issues, and that substance abuse finds its origins in adolescence, more support inclusive of mental health and life skills components may be provided to district hospital staff and NGOs conducting awareness campaigns, so that adolescents may find a special place in their prevention programs.
- Collaboration between the DCPU and District Hospital for referral for de-addiction services, screening and treatment would be helpful.

B.4 Rashtriya Bal Swasthya Karyakram: Mobile Teams and District Early Intervention Centres

Mobile Teams

Existing Issues, Services and Systems

The Rashtriya Bal Swasthya Karyakram (RBSK) was launched in 2013 by the Ministry of Health & Family Welfare, Government of India, under the National Health Mission. Mandated to provide Child Health Screening and Early Intervention Services, the RBSK is designed to be a systemic approach of early identification and link to care, support, and treatment. This program involves screening of children from birth to 18 years of age for 4 Ds- Defects at birth, Diseases, Deficiencies and Development delays, spanning 32 common health conditions for early detection and free treatment and management, including surgeries at a tertiary level. Children diagnosed with identified selected health conditions are provided early intervention services and follow-up care at the district level. These services are provided free of cost, thus helping their families reduce out-of-pocket expenditure incurred on the treatment. Since the RBSK works with children in schools and anganwadis, there is nationally, a strong convergence for the implementation of this program with the Ministries/ Departments of Education and Women and Child Development.

Comprising of a medical officer, nurse, and health assistant, the RBSK team at Roing, in the Lower Dibang Valley district, explained their program and service objectives, as detailed above. For children requiring surgery in these parts of the state, the RBSK collaborates with 'Smile Train India', an NGO that then provides the financial support to send children to Shrishti Hospital in Dibrugarh, Assam, for the requisite procedures. Children are also referred, where available, to District Early Intervention Centres (DEICs), and to Tomo Riba Institute of Health and Medical Sciences (TRIHMS) in Itanagar.

The RBSK team reported that they had not received any training as such, thus far. They have been functioning largely according to the screening checklists that are provided by the Ministry of Health and Family Welfare. These checklists contain brief screening checklists for birth defects, deficiencies, disease (such as skin and respiratory problems, childhood leprosy and tubercular disease), and developmental delays. While the team reported identifying and referring defects and diseases, such as congenital heart disease, cleft foot/palate, they did not report identifying developmental disabilities—except some cases of physical and sensory disabilities which they identify as 'defects'. They also stated that in anganwadis, for instance, they administer the developmental milestone checklists but do not focus on 'developmental delay' because *'every child develops in his own time…so, we just broadly check for functionality…unless we see something specific like Down Syndrome.'*

The team was not aware of other mental health concerns that school-going children, for instance, may have—such as specific learning disabilities or other emotional and behaviour problems. They stated that they had not come across cases of substance abuse in school children either, because these children tend to drop out of school.

Gaps and Challenges

- One of the challenges stated by the RBSK team were that when parents are informed about defects, deficiencies or disabilities in their children, the latter have much trouble accepting this—consequently, parents are reluctant to follow through with suggested referrals. Another difficulty pertains to migrant populations, such as those from Assam and Nepal, wherein follow up of children detected with a problem becomes difficult i.e., these moving families are hard to track. The third challenge the team stated was the difficulty they have with referral because often they do not have the knowledge (details) of facilities that they can refer children and families to.
- In addition to the challenges experienced by the RBSK team, the SAMVAD team's understanding is that the gaps in knowledge pertain to lack of adequate training and knowledge about child development and developmental disabilities. A lack of training, and consequently of knowledge of developmental disabilities and neuro-developmental disorders could be a reason why the team states that they do not identify developmental disabilities. (In fact, when the SAMVAD team visited some of the villages and communities to discuss developmental disorder-related issues with anganwadi workers, families who also participated in some of the meetings brought with them children with various types of neurodevelopmental disorders). Systematic screening protocols for screening children for specific developmental delays and disorders are also not available to the RBSK team—another reason why they have not been able to identify (and refer) such children for assistance.

Potential Opportunities

- It was difficult obtain information on whether RBSK teams across the state are functional. According to the State Consultant for RBSK, all districts have a functional RBSK team. However, the SAMVAD team could not always find them on-ground. In Namsai district, for instance, we were informed that there is no RBSK team. Given that 90% of children attend school, as well as the scale of operations of Integrated Child Development Scheme (ICDS), through anganwadis, there is tremendous potential for RBSK operations to be active across the state. A helpful first step forward would therefore be a scale up of RBSK teams across the state by ensuring that each district has one.
- Other than screening for the 4Ds and referring children, given the paucity of child mental health services in the state, it would be important for the RBSK team to strengthen their knowledge and skills in developmental disabilities as well as common emotional/ behavioural issues, including substance abuse, in children. Consequently, depth training, encompassing the use of screening checklists (in addition to the one that the RBSK currently has) as well as on first level responses (for mild to moderate problems) requires to be provided to RBSK teams. Indeed, depth capacity building of the RBSK team to enable strengthening of their knowledge and skills in child development, protection and mental health work would be key to reaching vulnerable children in communities across the state.

- In other words, in a state where there is paucity of resources for mental health services, the RBSK's role would need to be expanded beyond basic identification and referral—so as to allow for containment of a situation or de-escalation of problems at least, for children and their families. Else, the RBSK also runs the risk of feeling disempowered and de-motivated if they perceive themselves to be less effective in executing what is actually a critical child health mandate.

District Early Intervention Centre (DEIC)

As of now, there are 3 DEICs in Arunachal Pradesh. They are located in the districts of Pasighat, Lohit and Longding. SAMVAD visited two of these DEICs i.e., in Pasighat and Lohit, which were started in 2015.

Existing Issues, Services and Systems

Also, a part of the RBSK initiative, DEICs are established at the district hospitals to provide referral support to children detected with health conditions during health screening, primarily for children up to 6 years of age. They are intended to serve as follow-on mechanisms to the RBSK mobile health teams, which screen children for Defects at Birth, Deficiencies, Diseases & Developmental delays, including disabilities. DEICs therefore provide management and further support to children identified and referred by the RBSK teams.

The Pasighat DEIC comprises of a centre manager, social worker, physiotherapist, medical officer, laboratory technician, dental technician, special educator, audiologist, early interventionist, and optometrist. The Lohit DEIC (in Tezu District Hospital), is a smaller team, comprising currently of a centre manager, special educator, social worker, physiotherapist, dentist, and optometrist. Neither team has a psychologist at present. In addition to referrals from the RBSK mobile health teams, these DEICs also receive referrals directly from the District Hospital as well as from Asha workers.

In terms of case load, the DEICs reported receiving children with congenital diseases, neuro-motor issues, club foot, and cleft palate. Cases of children with neurodevelopmental disabilities and disorders (such as Autism, Intellectual Disability and Attention Deficit Hyperactive Disorder) are relatively few—possibly due to lower awareness and lack of systematic screening by the RBSK team for these issues. Overall, a majority of cases i.e., between 50 and 100 children per month, pertain to dental and ophthalmological problems. Only about 9 to 11 cases requiring physiotherapy and about 1 to 2 cases of neurodevelopmental disabilities and disorders approach DEICs for assistance.

With regard to interventions for children with developmental disabilities, one of the DEIC teams mentioned using the functional assessment proforma of the National Institute for the Mentally Handicapped (NIMH) while the other DEIC is reliant on psychological tests—which they do not receive adequate supply of. Treatment interventions include some

sensory integration and behaviour modification techniques with children and parent counselling. (The staff were unable to explain these techniques or give examples of how they use these approaches with specific types of children). Children are referred to tertiary care facilities such as TRIHMS in Itanagar but also out-of-state, to institutions such as North Eastern Indira Gandhi Regional Institute of Health & Medical Sciences (NEIGRIHMS) in Shillong, Meghalaya and Sky Hospital, Imphal, Manipur.

Thus far, there have been hardly any training and capacity programs for DEIC staff. In recent years, some of them have attended a week's training at Seth Sukhlal Karnani Memorial Hospital in Kolkata where they felt that they have benefitted somewhat by observing how cases of children with special needs are handled by multi-disciplinary teams there. However, most DEIC staff feel a desperate need for a lot more training, with a focus on specific types of disabilities; they feel that it would be useful to have a training program that is skill-based and intervention-heavy, helping them to deal with their daily challenges of parent counselling and poor follow up by families. Many of them completed their education and joined the DEICs immediately after, feeling that they are not adequately equipped to play the roles that they have been assigned. They stated that each year, they write to the Health Department, specifically asking for training and capacity building that would help them execute their functions better.

Gaps and Challenges

- Although ophthalmological and dental case loads are relatively higher, the case load, especially pertaining to developmental disabilities, is quite low and possibly indicative of the fact that DEICs are not being utilized to their full potential. The discussions with the DEIC teams, and our observations thereof indicate that there are gaps in knowledge and skills with regard to children with special needs. Their difficulty in explaining their work with children, and in describing assessment and intervention techniques, including parent counselling methods, are indicative of the need for training and capacity building in the DEIC teams.
- Other reasons that the DEIC is possibly not used to its fullest pertain to the challenges stated by the staff regarding community perceptions of disability and parenting issues. They stated that when children are referred to the DEIC (by the RBSK teams), parents are reluctant to bring children for treatment as well as to follow up after the initial visit to the centre. This is because of the following reasons: (i) stigma associated with disability; (ii) parents have little awareness of disability and how interventions work—they expect immediate improvements in children, following a visit to the DEIC and become disappointed and disheartened when such quick and magical results are not obtained; (iii) many are followers of tribal worship[15] and prefer to try local healers, whom they believe may invoke cures and quick improvements in children with disability i.e., religion/spirituality is the first recourse to health problems and hospitals are resorted to only after and if such recourse is not helpful; (iv) they are fearful when told about issues such as

[15] For instance, Idu Mishmi, Miju Mishmi and Digaru Minishmi tribes are practitioners of nature worship.

congenital heart disease, asking DEIC staff whether they (the staff) would 'take the risk' for surgical procedures to be conducted for the children.

- The DEIC teams also spoke about how many of the mothers with children with disability feel guilty and responsible for having children with disability. Thus, often blamed by fathers and/or other family members for the birth of a disabled child, they are also at risk of depression. Mothers also then feel disempowered and are unable to bring the child for treatment and struggle to implement home-based interventions and inputs which are required as part of treatment and training of children with disability.
- DEIC teams also raised the issue of parenting, striving to explain the cultural nature of parenting in many rural communities of Arunachal Pradesh. As many children accessing DEIC services are from rural and farming communities, parents, who engage in day labour activities do not have the time to travel to the DEIC. Another issue is parents tend not to be very involved with their children in general—and with regard to children with disability, this lack of involvement is intensified due to stigma associated with disability as well as the perception that there is no need to invest time and resources in these children. The average child, therefore, is often left in the care of grandparents, and tend to be engaged in traditional tribal activities such as hunting and craft-making. Children with disability therefore, who may not have the capacities to engage in these activities are even more at risk of being neglected than the average child.

Potential Opportunities

- Given the challenges of low awareness, parenting practices, difficulty with travel, it is unlikely that the DEICs catering to rural areas will be utilized to their full potential with their present ways of working. What might be helpful would be for members of the DEIC team to accompany the RBSK teams into the community and deliver interventions to children and their families at home. This may also motivate families to bring the child thereafter to the DEIC.
- Other measures to strengthen the DEIC include intensive training and capacity building of the staff, with an emphasis on skill-based learning in regard to neurodevelopmental disorders, so that their knowledge of disabilities, interactions with children and parents and repertoire of interventions is increased—these actions are likely to strengthen the work of DEICs, also helping them build greater credibility with communities, and consequently increasing the chances that children and families will access and utilize available DEIC services.

B.5 One Stop Centres

Existing Issues, Services and Systems

With a primary mandate to support women affected by violence, OSC services are implemented as per the central government mandate and guidelines under the Nirbhaya scheme. Each OSC comprises of a primary staff that includes a Centre Manager, ANM/counsellor, ANM/multi-purpose worker. While the Itanagar OSC receives about 5-10 cases per month, the Namsai OSC reported receiving 51 cases over two years (2021 to 2023), 2 to 3 cases of women per month, all pertaining to women above the age of 18 years. It appears that the services of the OSC in general are utilized, and it would call for more evaluations to understand the reasons for this.

Most cases received by the OSC relate to women's conflicts with their spouses in the context of polygamy and extra-marital relationships. The OSC has shelter facilities for aggrieved women where they can stay for up to 5 days, till they find a more permanent placement solution. The major contexts of women who access the services of the OSC are sexual abuse, gender-based violence, extra-marital affairs (of husbands), domestic violence and polygamy (in the context of custody and maintenance). It understood that certain tribals in Namsai and nearby areas practise polygamy in cases of infertility on part of the wife, the desire for a male child, or if the wife is unable to care for the family. Domestic violence is also reported – women come to access support from the OSC. Domestic violence cases are characterised by physical, sexual, emotional, and economic abuse.

One of the district-level OSCs raised a scantly-mentioned issue—that of gambling, amongst women. While substance use is widely prevalent, this more common to men; many women have an issue indicative of behavioural addiction i.e., gambling. Based on the economic capacity of the families, women gamble every day for a considerable duration of the day. This leads to various issues at home, including domestic violence, physical abuse, and neglect of children. In fact, it is observed by OSC staff that children who belong to such families engage in runaway behaviours and substance use, and have other emotional and behavioural difficulties as well.

In terms of intervention for women, the general process the OSC staff follow for the intake of women clients, a process of history-taking, and collection of information relating to demographics, duration of marriage, and their experiences of trauma and abuse. They then speak with the husband and the family (in case the latter are also involved in the case). Their major intervention is to try for resolution of the issue or refer the client for a legal case. They broker an agreement between the client and the husband/perpetrator by making them write an undertaking that he/she/they will not abuse or violate the client. In other words, the OSC staff then work towards helping settle these cases, through counselling, and by taking written 'undertakings' or assurances from the families/ spouses to state that the matter remains resolved thereon i.e., that no more conflict or violence will occur. For legal support, these cases are referred to the State Legal Services Authority.

With regard to training and capacity building in the area of women and violence, it was reported that no training has been provided to the OSC staff. The staff expressed their need for training of counsellors, as the appointed counsellor does not have a background in mental health, but a Bachelors in Science.

With regard to child-related cases, OSCs receive cases of child marriage as well as sexual abuse cases. The OSC staff were unable to report details of these cases because they refer cases of children (including adolescent girls) to the DCPU. In the context of child sexual abuse, the Child Welfare Committee refers children to the OSC for temporary shelter till either, the parents are found, or the child is referred to the child care institution (CCI) within 2 to 3 days.

In Namsai district, for instance, the OSC and the District Child Protection Unit (DCPU) were initiated at the same time, and have therefore formed strong convergence and referral systems. Thus, no interventions for child abuse per se are provided by the OSCs.

The OSC staff report that child marriage is prevalent in the state, but these cases are seldom reported. Most child marriage cases, however, happen in the context of adolescents running away from home and getting married. Within the labour groups that work in the tea plantations, children are married early- their customary laws dictate that a girl who attains menarche is ready for marriage. There is a large-scale ceremony within the community to announce the attainment of a girl's puberty.

Gaps and Challenges

Working in the area of women and violence is always challenging, due to the associated socio-cultural barriers, and stigma relating to help-seeking behaviours in this context. As a result, there is likely to be severe under-reporting of cases, and consequent under-utilization of services provided by programs such as the OSCs. However, gaps in training and capacity building of staff compound the issue of poor help seeking and service under-utilization i.e. if the community does not feel that the help provided by such services is effective, they are unlikely to come forward to seek support. It is noted that hardly any training has been provided to the OSC staff, who are then reliant on their own knowledge and resources to respond to an exceedingly complex and sensitive issue such as women affected by violence.

Potential Opportunities

Considering that the Government of India primarily mandates OSCs to work with women in the context of violence, that the guidelines and documents make very little mention of children, and that children received are referred to the state child protection system, it appears that OSCs at present, do not play a strong role in providing support to children in the context of abuse. However, at least an orientation on the impact of domestic violence/ violence against women on children, is required to be provided to the OSC staff, in addition to outlining the imperative for providing first level responses to children who come to the OSC with their mothers.

B.6 Special Juvenile Police Unit

Existing Issues, Services and Systems

At present, Arunachal Pradesh has established 18 Special Juvenile Police Units. For instance, the SJPU in Itanagar comprises Child Welfare Police Officers (CWPOs) from 8 police stations. However, it was reported that since many CWPOs are male, children are often sent to women's police stations, particularly for recording cases of POCSO.

Most of the children's cases that the police receive pertain to children in conflict with the law. These children are mostly arrested for petty crimes. The police often do not register these cases, and in many instances, give bail to these children, as there are no observation homes available in Itanagar or nearby districts. (As erstwhile mentioned, there is only one Observation Home currently, in Pasighat). According to the police, these children are drawn from contexts of dysfunctional families and substance use. The police also stated that in cases of CICL and substance use, they refrain from charging children under the Narcotic Drugs and Psychotropic Substances Act 1985 (NDPS); they focus instead, on targeting the peddlers who are the root cause of the problem. They explained that there are strong nexuses and children merely are the victims who are being used by the peddlers for the transportation of drugs.

In order to prevent recidivism, and to ensure that these children are cared for, the police usually collaborate with the NGOs to links the children with skills training programs. The parents of these children are also called, and with their permission, adolescents are linked with de-addiction programs. The police often help families, not only by linking them to rehabilitation services, but also negotiating with these centres to ensure that the services are available to children at a discounted price. However, they acknowledged that there are relatively few de-addiction services for children and adolescents.

Additionally, the police also informed that there were a significant number of POCSO cases reported in Itanagar. All these cases are transferred to the women police station. Following the registration of an FIR, Children's Section 161 statement (CrPC) is recorded by the police in both written and audio-visual forms. Describing one of the cases, the police officer also explained that, sometimes, in cases like these, if children have some kind of disability or have experienced trauma, due to which they are unable to give a statement or their evidence, the police officers ask for the parent's assistance as there are no counsellors/ special educators to assist the police officers with these issues. The police officer also highlighted that as per the law, a lady police officer must also be present during the enquiry in CSA cases. However, there are no lady police officers and the male police officers therefore are required to carry out all processes.

In other types of cases, of children in need of care and protection, police report, that where possible, they take the assistance of available child care institutions and NGOs working with children i.e., through getting their counsellors to interact with the children, before further decisions are made. Additionally, the SJPU also engages, through a reserve officer who liaisons with the school authorities, to conduct awareness programs on POCSO, cybercrime, and self-defence in schools.

Other than the cases of children in conflict with law and POCSO cases, there are also cases of sex work. These cases do not pertain to children but to college-going youth, who engage in sexual work to earn some pocket money and to cover their living expenses.

Interestingly, on the issue of child labour, it was reported that they had not received a single complaint. If, at all, parents make a complaint that a child is not being returned by the employer, the police file a complaint for kidnapping and abduction, but not under the Child Labour (Prohibition and Regulation) Act (CLPRA). Yet, in one of the districts, an SJPU officer perceived child labour as being the most pressing concern in child protection, with parents (from low socio-economic strata) being responsible for sending children to work, such as for domestic work or in tea estates, often to Assam.

When asked about attendance of training programs on issues related to children, the police officer explained that he had not received any such training. The last training program that he had attended regarding children, was 10 years ago, when he was entering the police service.

Gaps and Challenges

- Like elsewhere, for districts where SJPUs have not been constituted, investigations in offences against children, and offences committed by children, necessarily have to be conducted by regular police personnel, who typically lack orientation, skills and training in child work and interviewing. A related challenge is that there are relatively few female police officers. As a result, it is a struggle to record statements from women and children, such as in cases of POCSO.
- There is also a lack of training in child laws, child interviewing and other skills that police personnel require to engage with children (both those in need of care and protection as well as in conflict with the law), who form a very different group from those that the police usually deal with. Frequent and arbitrary transfer postings, like elsewhere in the country, also pose challenges by undermining capacity building efforts.

Potential Opportunities

- Training and Capacity building of the SJPU/ police personnel on all child related laws such as Juvenile Justice (Care and Protection) Act 2015, Child Labour Prohibition and Regulation Act 1996, Protection of Children from Sexual Offences Act, 2012, Bonded Labour System (Abolition) Act, 1976, Immoral Traffic Prevention Act, 1956.
- The training programs may extend to child interviewing skills for police, and providing a first level response when dealing with a child victim, and understanding children's vulnerabilities and contexts.
- There is within the Ministry of Labour and Employment, standard operating procedures, and provisions to constitute a District Task Force for Vigilance, and for taking action on issues relating to child labour, in the district. It would be helpful for SJPU officers to be made a part of this district task force.

B.7 Child Welfare Committees

Existing Issues, Services and Systems

It was reported that CWCs are constituted in all 26 districts of the state. CWC members reported that cases are typically brought to the attention of the CWC through police and CHILDLINE[16] referrals. The CWC is also tasked with coordination between the police personnel, CHILDLINE staff, and DCPU functionaries. The CWC Members also reported that there is currently no dedicated SJPU in place, with the implication that ordinary police personnel are required to take cognizance of child-related issues. In some instances, cases also reach the CWC directly through intimation from the media or direct contact with the CWC Chairpersons and Members.

All efforts are made by the CWC, especially in case of runaway children, to trace the families of children so that they can be repatriated i.e., once the family members are traced, the child is shown the picture of the family member, and then, if the child verifies the identity of the parents, she/he is sent back home. Since, according to CWC members, repatriation, and restoration of the children, to their families and communities, is the priority, even in cases where children do not wish to go home, 'they are counselled to return to their families'. In cases where the child has been trafficked and the family members are involved, the parent is made to sign an undertaking that he/ she will not violate the law in the future.

While CWCs use the proformas contained in the Juvenile Justice Act, 2015, they do not have systematic protocols for psychosocial and mental health concerns in children. Consequently, they do not, at present, have the knowledge and skills to identify mental health issues in children, as a result of which they report that 'only 2-3 children in the last 3 years needed mental health support' and services.

In terms of administration, the CWCs reported that financial matters are entirely handled by the CDPO (who also holds additional charge as the DCPO). One of the CWC Chairpersons also expressed concerns regarding the disbursement and utilization of funds for CNCP as this information is typically not provided to the CWC.

The CWC members threw considerable light on the issues that affect vulnerable children in the state, and come to the CWC for assistance (as detailed below). Most cases relate to runaway children (in child labour contexts) who are produced before the CWC following police referrals. In addition to child labour and runaway cases, the CWC also receives cases of children from intra-familial abuse and other familial contexts of neglect (particularly in relation to abandoned children and single-parent families), parental substance abuse and alcoholism, child marriage, and POCSO Cases. The CWCs emphasized that consensual POCSO cases i.e., involving mutually consenting adolescent relationships are typically not registered as POCSO offences, given the adverse implications for vulnerable children.

[16] At the time of interview, CHILDLINE was still operational in Arunachal Pradesh; they were also in the process of winding down operations over the subsequent two months.

- **Child Labour and Runaway Children**

The respondents observed that child labour cases, typically involving the migrant *adivasi* tribal groups, exist in the backdrop of a complicated socio-economic and socio-cultural landscape. Typically, these children are sold to indigenous tribal communities owing to severe socio-economic vulnerabilities of migrant populations employed in the tea plantations, or in some places, they may work as domestic help within families and households. However, working as domestic help is not recognized as child labour because these children have been illegally adopted by families (from higher socio-economic strata), from families who are poorer and may not have the capacity to care for their children. In some instances, the biological parents reportedly instruct children to complain against their 'adoptive' families after a couple of months, whereby the whole arrangement is brought to the attention of the CWCs. Most child labour cases come to the police after a complaint from the parent, when the employer refuses to return the child to them. There is often a verbal agreement between the parent and the employer, and, therefore, no case is filed against the employer. The reason stated for this was that parents are responsible for sending children into child labour, in the first place, and therefore they would (also) be penalized by the law.

Interestingly, some CWC members also believed that the child is better off with the employer because children's living conditions back home are poor; and the employer is actually doing a 'favour to the child' by allowing him/ her to stay with them. One consequence of this is that in child labour cases, a settlement is made between the employer and the parent, and in case any back wages are due, these are calculated by the CWC, and given to the (biological) parents of the child. The CWC reported that they also draw information for the Social Investigation Reports from the employer and not from the family – since they believe that the child has been with the employer's family, who would therefore know more about the child.

These commonly observed practices were reported to stem from the financial precarity of these floating migrant populations. In some instances, the CWC noted that there were reports of abuse by the adoptive families as well. In addition to the migrant children, the CWC also noted the precarious and increasingly contingent life circumstances of vulnerable tribal groups such as the Chakma ethnic refugee groups who originally hail from Bangladesh, but have since habitually resided for over 50 years in various parts of India, including parts of Arunachal Pradesh. Children from this community have also been rescued by the CWC from child labour contexts. In instances wherein children hail from bordering countries or other states in India, the CWC has also undertaken their restoration.

CWC members agreed that child labour was one of the most pressing problems, but said that one of the challenges was that it was severely under-reported. One CWC Chairperson, for instance, said that there continues to exist concerns regarding the underreporting of child labour cases by the police, giving rise to speculation regarding collusion with employers in common sites of child labour such as tea plantations and relatively well-off households.

- **Adolescent Relationships, Child Marriage and POCSO**

The CWC Members and Chairpersons highlighted that there are a significant number of mutually consenting adolescent relationships (between children aged 15-17 years), wherein the CWC does not pursue the registration of a POCSO case, and instead works with the families to seek resolution of the issue through settlements. One CWC Member reported having counselled parents in certain instances where they expressed an unwillingness to accept the adolescent relationships. These cases have usually involved solemnization of the relationship through marriage. However, it was further highlighted that this practice is slowly being deprecated, given the increased awareness of the existing legislation on child marriages.

It is significant to note that one of the CWC Chairpersons also highlighted that child marriage cases continue to remain largely unreported due to community fears of legal prosecution. In this regard, it was reported that while arranged marriages have reduced, a significant number of adolescent relationships continue to be formalized through marriage, and are settled at the village level through the Gaon Buras. These cases typically never reach the CWC owing to the settlement of the same. The Chairperson remarked that, “it is normal for a 16-year-old to be a mother of 3”, given the existing community norms pertaining to bride price, multiple marriages, and early solemnization of the same.

In regards to POCSO cases, the CWCs reported that there are a handful of POCSO cases at any given time. However, these were not observed to be significant in number. These cases typically involve intra-familial abuse (involving a step-parent) or abuse through known perpetrators (such as neighbors).

- **Familial Abuse and Other Issues**

In addition to the above, there are also cases pertaining to difficult family circumstances, such as single-parent families, parental alcoholism and substance abuse, child abandonment, or parental incapacitation (i.e., unfit for childcare). The CWC noted that there are a significant number of ‘broken families’ i.e., dynamic family arrangements involving marital conflict, parental separation, and subsequently, remarriage. In some of these cases, families have been reported to be unfit for child rearing, thereby necessitating intervention of the CWC to secure foster care, kinship case, institutional placement, or adoption, as the case may be. Adoption cases were reported to be few and far between, with the most recent case involving a child born from intra-familial sexual abuse.

- **Substance Use**

The CWC reported that families are unable to afford schooling in many instances, necessitating the child to spend more time in the community, wherein the child is susceptible to substance use. One of the concerns expressed with regard to widespread substance use, was the lack of sufficient progress in destruction of poppy fields which have been known to contribute to the supply of drugs in the state. In addition to alcohol, opium, heroin, brown sugar and other narcotics were observed to be used by

adolescents and young adults. It was also reported that children who come from traumatic family circumstances, and have previously faced issues in adolescent relationships, are more vulnerable to substance use.

Gaps and Challenges

- One of the key issues raised from the CWC respondents was in relation to the underreporting of child marriage and child labour and insufficient efforts to identify these children by police personnel and other child-related stakeholders. Additionally, the settlement of cases, particularly in the context of child marriage and adolescent relationships, was also significant to note. The SAMVAD Team observed that the CWC's orientation tends towards settlement, as opposed to ensuring a rehabilitative outcome in the best interest of the child. In light of under-reporting, this issue raises concerns pertaining to the efficacy of such an approach—and while it points to socio-cultural norms within the state that the CWC has to contend with, it may also be a matter of the CWC's understanding of child-related laws and of their roles and responsibilities in implementing them.
- The CWC personnel also shared that no systematic mental health assessments are conducted for children who are produced before the CWC. In this regard, one of the significant findings was in relation to the fact that counsellors often do not assess or refer children for further mental health assessment, except in cases that are evident: such as speech and hearing impairment or challenging behaviour. This further implies that no linkages are made between protection and mental health concerns—such linkages are critical to understanding children's contexts and problems, and therefore also to develop effective psychosocial and rehabilitation care plans.
- Some CWCs comprise members who are all advocates i.e., they do not have members from a social work background. (It was stated that often there are not enough applicants for CWC member positions). Consequently, there are gaps in understanding children's psychosocial contexts—care plans that are made purely from a legal perspective, without incorporating mental health and psychosocial concerns in a given child's case, is unlikely to yield care plans that comprehensively address the vulnerabilities and difficult subjective realities of a child's life.

Potential Opportunities

- Given the CWC's regular involvement with some of the most pressing child-related concerns, such as child labour and runaway children, capacity-building initiatives aimed at the systematic use of mental health and psychosocial assessments may contribute significantly to improving the accuracy and efficacy of rehabilitative interventions. As requested by the CWC personnel, capacity-building interventions may also extend to legal, protection and mental health aspects of child marriage, child labour and runaway children; substance use and addiction; and key child-related laws such as the Juvenile Justice Act and POCSO.

Additionally, in light of the reorganization of CHILDLINE, the respondents also expressed an interest in training sessions on the new helpline and its operational guidelines. Thus, integrated training on child protection, mental health and law issues would enable the CWC to effectively implement their roles as mandated by the Juvenile Justice Act 2015.

- Currently, rehabilitative interventions include placement (in institutional or non-institutional care), restoration, and admission to school. These rehabilitative interventions could also be made more contextual to the facts of each case, with requisite skilling in the use of standardized assessments.
- Additionally, there is also a need for a coordination framework between various departments including the Labour Department, Department of Women and Child Development, and Department of Education, in order to ensure enhanced reporting and identification of instances of child labour and child marriages. The district-level committees, including the District Task Force on Child Labour, also need to work under a convergence framework in connection with the above. On sensitive subjects like child marriage, wherein community perceptions do not lean in favour of the statute, more intensive awareness programs may be pursued to bring to fore the serious health and mental health consequences of early marriage.

B.8 Juvenile Justice Board

Existing Issues, Services and Systems

The CJM for Roing currently holds charge as the Principal Magistrate of the Juvenile Justice Board, in addition to other key positions, such as Secretary, District Legal Services Authority. At the time of this rapid assessment, the CJM reported that the posts of the Members of the Juvenile Justice Board have remained vacant since November 2022. As a result, all cases concerning CICL are currently being heard by the CJM.

The Non-judicial members of the Juvenile Justice Board in Ziro reported that the Board was reconstituted in July 2021, and convenes twice a month to hear a total of 18 cases involving juvenile offenders, which include petty, serious, and heinous offenses. To date, the Board has resolved seven cases, while the remaining 11 cases are at different stages of progress, such as first production, framing of charges, and witness deposition/presentation of evidence. Out of these cases, one was registered under the POCSO Act, wherein bail was rejected by the Board.

Other issues that were raised by the JJB members pertain to the following:

- **Reporting of offences**

The JJB members reported that in a majority of cases, settlement with regard to crimes is done at the village level and facilitated by the Gaon Buras. Even in heinous offences, in many instances, attempts are made to seek settlement between the parties at the village level, following which the offence is reported if no settlement is agreed upon. In instances where the child is 12 years or older, few cases come to court.

- **Inquiry Proceedings (including bail)**

In accordance with the JJ Act, the inquiry procedure is explained to the parents to ensure that the child is not intimidated, and to mitigate the adversarial nature of proceedings. It was also reported, in this context, that legal aid counsel is provided to parents.

With reference to bail proceedings, it was reported that bail is typically granted and custody is handed over to the parents. In addition to providing surety, bail conditions also elicit a commitment from the parents regarding the child's abstention from further criminal activities. An assurance is also elicited from child offenders, in this context, prior to release on bail.

- **Staff Vacancies and Capacitation**

It was reported that the JJB has not been notified and constituted, for all districts, because of a dearth of judicial officers and qualified members. The jurisdiction of one chief judicial magistrate may extend to 4 districts in some instances. It was reported that approximately 15 districts currently have constituted and functional Juvenile Justice Boards.

Additionally, one of the key issues raised by one of the CJMs was in relation the imperative for regularization of key staff posts such as the Probation Officers (POs) and Legal Cum Probation Officers (LCPOs), which are currently contractual. It was reported that contractual staff lack the necessary motivation and commitment to the work, resulting in poor contact with the CJM in cases pertaining to CICL. The issue of non-appointment of Members to the JJB is one that has continued to affect the timely hearing and disposal of cases, given the CJM's additional charge as Civil Judge and DLSA Secretary, in addition to administrative responsibilities.

Additionally, one of the CJMs (currently running his office with the assistance of lawyers in some instances) insisted that there must be a more concerted effort to appoint quality personnel who are appropriately qualified and can effectively discharge their duties as provided for in the JJ Act. One of the key issues highlighted was the qualifications of Probation Officers, who in many instances are, themselves, lawyers. Their lack of qualifications in social work, and allied areas, result in a lack of capacity of the POs in filling out the necessary details of the child's social background, in the prescribed format for Social Investigation Reports (SIRs) under the JJ Act. Additionally, these officials are not presently trained on the use of systematic assessment proformas for the implementation of provisions such as Section 15 of the JJ Act, wherein prioritization of the child's best interest and restoration requires capacitation in systematic methods of mental health and psychosocial assessment.

One of the CJMs also pointed out that typically no funds are provided to the JJB to aid in its sittings and in its hearings. This lack of support was specifically highlighted by the respondent, in regards to barriers to effective delivery of justice, in accordance with the principles of child-friendly adjudication under the JJ framework.

- **Lack of Child Care Institutions & implications for bail**

Another key issue discussed with the CJM was the dearth of child care institutions and its implications for CICL. Currently, the state is only provisioned for 1 observation home

(OH). As a result, if a child is to be placed in institutional care, the child may have to be placed in the Pasighat OH, which is at a significant distance from Roing and other areas in the state. The lack of JJB oversight over the institution and limited possibility of contact with the child has resulted in a judicial preference for grant of bail. In such situations, the CJM observed that bail conditions are set strictly to ensure that the child is brought before the JJB. Such institutional constraints, therefore, have a significant impact on placement decision-making and bail decisions, that are statutorily mandated to be taken in the best interest of the child.

- **Types of Offences**

The CJMs reported a low incidence of serious or heinous offences in the district, with most offences reported being petty offences. Typically, theft, violence-related cases, NDPS cases, constitute the most common cases where children come into conflict with the law. Heinous offences such as rape and murder are few. At the time of the interview, the CJM in Roing reported there was 1 murder case.

It was also observed that in numerous cases (including drug-related offences), adolescents come from challenging psychosocial contexts including 'broken families', school drop-outs etc. For many first-time offenders, the goal is rehabilitation with diversion.

- **Violation of JJ Act**

One of the most concerning issues observed was the detention of CICL in police custody. It was reported that there were numerous instances wherein CICL were observed to be detained in police custody, despite the fact that they are visibly underage. It was reported that children as young as 12 have been observed to be detained in police custody. In many cases involving 15–17-year-olds who have come into conflict with the law for theft, it was noted that they had been detained in police custody. Police officials were reported to not follow some of the key stipulations under the JJ Act, in this regard. In drug-related cases (which most frequently reach the court), it was observed that the police sometimes prefer to apply for the child to be sent to judicial custody, so as to avoid the possibility of withdrawal symptoms while the child is kept in police custody.

- **Preliminary Assessment and Adolescent Culpability**

JJB Members expressed that in instances of heinous offences, committed by adolescents aged 16-18 years, the JJB is inclined to transfer children to the Children's Court/Sessions Court. In their opinion, it must be inferred that children and adolescents premeditate their criminal behaviours, in heinous offences, with sufficient knowledge of the consequences of their actions, thereby necessitating transfer to the criminal justice system. Additionally, the Board's observations on the character of child offenders, and severity of their actions, were reportedly instructive in transfer decision-making. However, no cases of transfer were reported at the time of this assessment, despite some of the perspectives shared in regards to the same.

It was also noted from discussions with the Board, that in consenting adolescent relationships, transfer is not a suitable option, given the absence of harm. The Members

noted that some concession should be made, with the imperative for rehabilitative support as opposed to criminalization.

Gaps and Challenges

- **Lack of human resources and capacitation**

The primary issue observed by the SAMVAD team was a chronic vacancy in the JJB, which severely restricts its ability to function effectively. In addition to a lack of JJB Members, there was also the issue of capacitation in key JJ officials such as the POs and LCPOs and shortage of funds. The absence of capacity and skills in conducting systematic assessments was noted as a significant point of concern with implications for the final decision in the case, and indeed, for the child's rehabilitation. The team observed that there was also a requirement for recruitment and training of qualified counsellors who can assist in evaluating children's mental health issues, and provide important information on the child to the CJM. In this regard, it was observed that there are currently no systematic formats/assessments to conduct preliminary assessments.

- **Imperative for mental health in rehabilitation**

There is limited provision of mental health services as a part of rehabilitative interventions. The Board does not make many referrals for treatment of mental health issues and psychosocial care of children in conflict with the law, except in cases of substance use. It was reported that children and adolescents with substance abuse issues are referred to de-addiction centres. Government sponsored de-addiction centres in NAMSAI were reported to be functional, in addition to privately run de-addiction centres in various places including Lohit, Midpu, Chimpu, Changlang. Additionally, there is also an imperative for the establishment of more CCIs across the state, so as to ensure that rehabilitative assistance is provided where children are in need of institutional placement.

Potential Opportunities

While setting up some of the CCI infrastructure and provisioning of funds may be a longer process, capacity-building initiatives may proceed immediately, given the need for training in mental health and conducting systematic mental health and psychosocial assessments. The shortage of human resources, particularly in regards to appointment of POs and counsellors, can be addressed, to a significant degree, by facilitating training of these cadres.

The CJM, along with the prospective JJB Members may also be trained in key areas of the JJ Act's implementation and in facilitating rehabilitative interventions. As the CJM highlighted, informal diversionary methods are already in place for CICL and these initiatives may be further strengthened through capacity-building. Best practices may also be shared from other states through such initiatives.

B.9 Special Court Judge

Existing Issues, Services and Systems

During a meeting between the SAMVAD team and a Special Judge with jurisdiction over cases pertaining to the Protection of Children from Sexual Offences (POCSO) Act, it was disclosed that eight specialized courts have been established in different districts of Arunachal Pradesh. These courts are located in Yupia, Tezu, Pasighat, Bomdila, Aalo, Khonsa, Ziro, and Basar. Most recently, it was reported that the appointment of the Special Public Prosecutors for the POCSO Special Courts took place on May 14th, 2020. Following the appointment of the Special Public Prosecutor in 2020, it was reported that 33 cases had been registered under the POCSO Act. Out of these 33 cases, 11 cases have reportedly been disposed of, with a pendency of 22 cases and 3 recorded convictions till date.

Some concerns pertaining to children that were raised by the Special Court Judge are elaborated below:

- **Nature of Sexual Offences**

In nearly all the cases of sexual abuse, it was observed that crimes were committed by persons known to the child i.e., intra-familial abuse or abuse perpetrated by other known individuals such as neighbours. The Judge observed that children of all age groups had come before the court in POCSO offences, with some children being as young as 3 years of age.

- **Evaluations of Child Witness Competency**

When enquired about how evaluations of child witness competency are undertaken, the Judge observed that competency is typically assessed through utilisation of the *voir dire* test i.e., posing straightforward questions, such as asking the child's name, age, family background, and other similar queries. The SAMVAD Team observed that no mental health or disability assessments were conducted as a part of competency evaluations.

- **Pre-trial and In-trial Mental Health Support**

While noting the importance of support persons during the trial, the Judge also opined that the provision of mental health assistance can enhance the credibility of child victims and improve their reliability, and that they are more likely to provide trustworthy testimony with counselling and support, to alleviate some of the trauma of the abuse and distress in testifying before court.

Gaps and Challenges

- **Infrastructure**

Owing to a paucity of resources, infrastructural constraints were noted as affecting the quality of child-friendly proceedings, as mandated by the POCSO Act. For instance, it was reported that while land has been allotted in Ziro, for the establishment of a Special Court, there is currently no dedicated court that has as yet been established.

- **Children with disabilities**

Children with disability pose a challenge to Courts due to the lack of requisite personnel and infrastructural support, to record evidence in accordance with the POCSO Act, and general criminal laws such as the Criminal Procedure Code and the Indian Evidence Act. For instance, it was reported that the courts do not have special educators or sign language interpreters. As a result, little to no support is provided to children with disability. This is a critical issue in the dispensation of justice under the POCSO statutory framework.

As an exception, it was reported that 2 children with mental disabilities (on request from the directorate of health services) were sent to a tertiary care facility at Itanagar for treatment. However, due to overcrowding at the facility, children were unable to receive assistance. There is also a dearth of expert witnesses to assist the court in challenging cases under the POCSO Act.

- **Safety risks for child witnesses**

It was reported that the standard procedure followed required the accused to be presented in court for identification purposes. However, during the recording of evidence, the accused is required to step outside the courtroom, and the victim's testimony is recorded in their absence, as directed by the Judge. While this a welcome step in consonance with the POCSO Act, the initial encounter between the child victim and the alleged perpetrator can have the unintended effect of dissuading the child from testifying, thereby increasing the likelihood of witnesses turning hostile.

Additionally, it was observed, where the safety of a child victim may be at risk, particularly in the course of bail hearings where presence of the victim is necessary, appropriate measures are required to ensure reporting of those safety risks to 'appropriate authorities' and to protect the child from such risk before, during and after the justice process. In this context, the SAMVAD Team noted that the Witness Protection Scheme was not discussed by the Judge.

- **Compensation**

It was reported that all efforts are made, in conjunction with the DLSA, to award and process compensation for the victims' relief and rehabilitation. This compensation may be awarded at an interim stage, during the pendency of trial, as well as at the conclusion of the trial, as stipulated by the POCSO Act. Conceptually, while child victims may be repaid for material losses and damages incurred, receive medical and/or psychosocial support, and obtain reparations for ongoing suffering, none of these are currently being provided for through compensation.

- **Lack of mental health experts**

In addition to a shortage of professionals who are keen on working with children with disability, another major challenge is the insufficient number of mental health

professionals with the necessary skills for providing referrals and opinions, which creates a shortage of experts in the field. The Special Court Judge noted that integration of mental health with judicial processes was imperative in order to support and facilitate the child's rehabilitation.

- **Witness Hostility and Recording of Evidence**

One of the predominant concerns highlighted was that, in a majority of POCSO cases, the victim-witnesses and other witnesses turned hostile, making it exceedingly difficult to adjudicate such cases wherein acquittal was inevitable owing to insufficient evidence. As a result, the Judge reported that efforts are made to expedite the cases as far as possible, particularly in regards to recording of witness testimony.

Potential Opportunities

- **Capacity building on Child Forensics in POCSO Cases**

While there are currently limitations, in terms of access to mental health professionals in POCSO Cases, an area that could benefit greatly from the involvement of mental health professionals is the evaluation of children's testimonial capacity in POCSO Cases. The assistance of a Mental Health Professional, trained in evaluating child witness competency from a child development lens, is likely to be far more accurate than the *voir dire* test.

Additionally, child forensic interviewing, can go a long way towards ensuring that the child is able to provide forensically accurate information, in a non-threatening environment, after sufficient rapport-building is undertaken with the child. This could prove to be crucial in many cases, given the evidentiary value of the child's testimony, and the inaccessibility and daunting nature of the adversarial courtroom.

- **Coordination with the Child Welfare Committee and District Child Protection Unit**

Professionals should be trained in recognizing the likelihood of intimidation, threats and harm to child victims and witnesses in POCSO cases. Additionally, given the concerns pertaining to extra judicial settlement of the case, at the village level, support persons must necessarily play a more active role in assessing the child's community context, and in conveying this critical information to the CWC, so that decisions pertaining to institutional placement of the child can be made, where necessary.

Similarly, in the context of the child's safety, regular coordination between the Special Court and the Child Welfare Committee can ensure that the child's placement and bail conditions for the accused are comprehensive enough to secure the child's safety during the trial, and indeed, protect the child from adverse interference from the accused as far as reasonably foreseeable.

B.10 Integrated Child Protection Scheme Services: District Child Protection Units and Child Care Institutions

District Child Protection Units

Existing Issues, Services and Systems

- **Vulnerability and protection concerns**

The DCPU reported that most of the referrals of vulnerable children come from the police, Child Welfare Committee members, calls from local residents, NGOs, Sakhi centres and CHILDLINE. The DCPU reportedly deals with a range of cases, but among the most common are child labour and child trafficking, as well as sexual abuse cases (including rape and abuse) under the POCSO Act. Cases of run-away children who are made to engage in child labour, in the tea gardens, are the most reported cases. It was reported that it was in the tea gardens that children of labourers from Jharkhand, Assam and nearby states are employed. This area has been identified by the DCPU as a high-risk area where most children in the system come from.
Child trafficking cases were majorly reported as being brokered between parents and privileged households in the community for domestic labour. These trafficking cases were reported as 'illegal adoptions', where the family the child is sold to gives the child their family name and sends them to school. It was reported, however, that the children are often subjected to violence, domestic labour, and caretaking of farms.

The DCPU also reported that within all communities of the districts in Arunachal, certain familial and community norms place children at risk. It was reported that substance use, especially opium, is rampant and has been used traditionally in communities for medicinal purposes and is entrenched as a part of their daily life style. It was informed that the easy accessibility to substances has resulted in frequent substance use, often accompanied by domestic violence. Additionally, there is prevalence of a gambling culture among women from various tribal communities, regardless of their social status. The combination of drug and gambling addiction results in the neglect of children, while also promoting the normalization of substance use. It has been observed that within these communities, substance abuse plays a significant role in perpetuating poverty.

A counsellor shared their perspective on the initiation of substance use among adolescents. They highlighted that due to parental neglect, coupled with factors such as violence and economic hardships, adolescents are deprived of engaging in essential developmental activities. Consequently, this has contributed to a severe crisis of drug abuse among adolescents in the state of Arunachal Pradesh.

It was also reported that the child marriage rates are exceedingly high, but they are never reported, as it is a culturally-sanctioned practice. Due to rampant child marriage, it was reported that the school dropout rates are also high for girl children. The additional factors that exacerbate child marriage were reported to be poverty and difficulty in accessing education. It is reported that the quality of education is poor, and there is a dearth of teaching professionals. Most students who study beyond class 10 leave the state for

further studies for these reasons. The children who cannot afford to leave for education, reportedly are married and engaged in work. There is also a high prevalence of marriages performed when children run away with each other after romantic involvement.

- **Emotional and behavioral concerns of children**

Despite the many contexts of vulnerability concerns in children, few mental health concerns were reported. The counsellor reported that children referred to the DCPU due to challenging circumstances exhibit various emotional and behavioural issues, including resistance, guilt, shame, and self-harm behaviours. She also reported that children display conduct related issues and demonstrate sexual behaviours in child care institutions (CCIs). It was observed and also reported by the DCPU that they find it challenging to work with children with a mental health and vulnerability lens as they require training on the same. The DCPU also reported having no referral system for children to be referred for mental health assistance/assessments.

- **Roles and responsibilities**

The DCPU reported that their major role is to provide support to the child and monitor their cases and hearings. The counsellors reported that they meet with children as per CWC orders. In a given day, the DCPU counsellors assist children through the CWC sitting, accompany the child for medical examinations if required, and when he/she is transferred. They do not assist children through court processes. They document the medical procedure, case details (history and circumstances of coming into the system), any discussions had with the child, and the mental status of the child. Upon enquiring about the mental status assessment processes, it was reported that it is based on the interaction with the child and the general feeling and understanding of the counsellor. The individual care plan (ICP) is made in 3-4 meetings with the child. With regards to placement, the child's consent, counselling and interaction with family, the outreach worker's information on the contexts of the child, and traceability of the family, are factors on which placement decisions are made. The DCPU also reported that they assist CICL with education services, sports, and other activities. They even assist them with compensation through the Bal Swaraj Portal. They also assist sexually abused children in POCSO cases with compensation. During COVID, the DCPU also assisted with providing COVID orphans with compensation.

- **Convergence and collaboration**

The DCPU works closely with the District Hospital, One Stop Centres, Police, Teachers, Anaganwadi workers (for awareness) and the Gaon Buras. They also conduct awareness campaigns in remote areas of their districts on various child related issues such as child marriage, child labour, sexual abuse (POCSO) and legal adoption. They conduct these awareness campaigns in Community halls, anganwadi centres and schools.

The DCPU reported that their work in adoption is limited- they are trying to increase awareness on legal adoption and enlisting on the official CARA portal. Given the larger context of illegal adoptions, they believe the need for legal adoption systems to be strengthened is high. They also assist with declaring a child fit for adoption- they collect the relevant documents and medical records of the child.

- **Training and capacity building**

The DCPU expressed training needs on the following topics:

- Child related laws- such as the JJ Act, The POCSO Act, NDPS Act, Child Marriage Act
- Identification of mental health issues in children
- Understanding protection and vulnerabilities in children (and their linkages to mental health issues)
- Child counselling skills

It was reported that they had attended one training online, however, they do not remember the details of the same.

Gaps and Challenges

- The staff members at DCPU reported facing challenges in identification and understanding of child protection issues and the associated impact on children's mental well-being. They stated a lack of formal training in handling children who come from challenging backgrounds as a reason. Additionally, the report highlighted that the DCPU staff, including the counsellor, lacked qualifications in mental health, making it challenging for them to provide therapeutic assistance or cater to the psychosocial needs of the children effectively.
- Lack of logistical support that needs to be provided to the child at any time of the day or night for which the resources are reportedly scant. They also reported transport related issues.
- It is difficult to place children in the Observation home (OH) in Pasighat due to the distance and non-availability of transport and other logistic support. Given that there is only one OH in the state, most CICLs are released on bail- even children who may require institutionalised care and protection, further adding to their vulnerabilities.
- The DCPU assists in the declaration of the child to be fit for adoption. However, their role is limited to gathering relevant documents and medical records. There is a gap in knowledge with regards to adoption counselling of the child and prospective adoptive parents, the preparation of the child for adoption and other important assessments of the child and family. These are crucial stages in the adoption process to ensure successful adoptions.
- There is a general dearth of information regarding services in the already low-resource setting of Arunachal Pradesh. The DCPU does not have a strong referral system for mental health, rehabilitative and health services required for vulnerable children. The District Mental Health Program (DMHP) not being functional is an additional challenge to mental health referrals.

Potential Opportunities

- There is a need for the DCPU to be trained on integrated approaches of child protection, mental health, and law, in order to enable them to work with children who come from very complex and vulnerable contexts. Given that it is a low resource setting, and the DCPU staff do not have a background in mental health or social work, this training becomes more crucial for effective psychosocial work with children in the system.
- The need for training in basic counselling skills, identification of vulnerabilities, and child related laws, was expressed by the DCPU as well.
- Their training must also address the need for a strong referral system for mental health support (to rehabilitative services/mental health institutions) in Arunachal Pradesh.

Child Care Institutions

(a) Children in Need of Care and Protection

Existing Issues, Services and Systems

All Child Care Institutions (CCIs) interviewed were equipped with separate quarters for boys and girls across all CCIs. In some CCIs, however, for younger children, the provision for separate quarters for boys and girls was not available. CCIs across different districts reported being home to varying number of children- based on the number of cases in the districts that it caters to.

It was reported that children are brought to the CCIs upon the order of the Child Welfare Committee (CWC) and are placed with their peers based on their gender and age. Some efforts to ensure holistic development and facilitate adjustment of children to CCIs were shared. In a CCI in Itanagar, staff reported that one of the important roles of the counsellor and the staff of the CCI was to introduce the child to the home and the rest of the children in order to make the child comfortable. In a SAA in Itanagar, it was reported that over 50% of the staff recruited are *ayahs* (care takers). The rationale behind the recruitment was to ensure a high caregiver-to-child ratio so children get individualized attention and to ensure that young children have attachment experiences, which are crucial for the child's emotional and overall development. The staff at the other CCIs reportedly included a Superintendent, accountant, medical staff, child welfare officer, house father and house mother, counsellor, and other ancillary staff.

It was also reported by a CCI in Itanagar that that children from floating migrant populations form a majority of the population in the Homes. Due to economic constraints and poor living conditions, it was reported that the floating migrant families (largely referred to by respondents as migrants living in the tea garden areas) sell their children as bonded labourers to families belonging to higher socio-economic strata. Child trafficking for the purpose of labour was reported by all CCIs as the major child protection risk in the state.

The insufficient availability of child care institutions within the state has reportedly resulted in an increased burden on the existing system. This shortage of child care facilities has created a challenging situation where the demand for child care services surpasses the available supply.
In relation to previous capacity-building initiatives, the CCI staff reported that they had previously been trained on the subjects of POCSO, women trafficking, good practices and management of the CCI, and counselling, amongst other key areas.

- **Psychosocial Contexts of Children**

There were a varied group of CNCP at the CCIs from myriad psychosocial contexts and backgrounds. A large number of children included runaways (from difficult family circumstances including domestic violence and marital conflict), surrendered and abandoned children, children from single-parent households (including contexts of parental alcoholism), missing/lost children, child labour and trafficking victims, illegal adoptions (masked child labour in contexts of abuse).

- **Activities and Services at the CCI**

The daily schedule of the children reportedly included yoga in the morning, schooling, recreational activities, and tuition classes. Recreational activities included music and dance classes for children in the CCI. An institution in Roing had demarcated spaces equipped with basic speakers, guitars, and a stage within the home to encourage children to engage in performing arts. They reported that these spaces are actively used by children and are a source of fun and happiness to children- a very crucial aspect of childhood that is often overlooked, especially in the context of children who come from difficult circumstances of violence, abuse, and trauma.
Children are also provided counselling sessions, including specific sessions when behavioural issues and other concerns are reported by the CCI staff. CCIs in Ziro and Itanagar reported that placing children in school was a challenge due to lack of documentation. In Roing, the children were reported to receive elementary education at the school run by the parent NGO. Students admitted to 8th standard and above were sent to the nearby government school.
A private CCI in Ziro, that houses children with disabilities, reported that most people who avail their services approach them through word of mouth, as they hear about the institution from other community members who availed the services or are known to the staff at the institution. This CCI provides full time as well as part time care to children with disabilities which include permanent residents as well as children who live in the community. This CCI plays a crucial role in the caretaking of children with disabilities within its community- parents drop their children/ adolescents in the morning and bring them home in the evening. The staff at the home helps children perform and complete activities of daily living throughout the day, as well as run a day school. In a low-income context, such CCIs play a crucial role in facilitating workforce participation and income stability for family members of children with disabilities. These institutions provide essential caretaking services, allowing parents and caregivers to actively engage in employment and generate a steady income.

Activities of Daily Living (ADL) are given importance in the institution- they recognize the importance of ADL to help persons with disabilities to adapt to everyday life. It was, however, reported that the larger population of children with disabilities in the CCI fall under the severe to profound category of disability and are unable to perform ADL.
One of the major challenges they reported facing was the paucity of trained professionals in the field of disability- with a particular focus on children. The current staff at the CCI is also not trained in disability work. This is compounded by the fact that the CCI does not have fixed funding and is run by donations. These factors adversely impact the quality of care provided to children in the institution.

- **Adoption and Foster Care**

The CCI in Roing reported adoptions from older and younger age groups including children from as young as 2-11 months, to 7-10 years. However, given the low prevalence of adoptions in the state, the CCI staff reported that there were efforts to re-direct Prospective Adoptive Parents to Foster Care in Roing. Efforts to build a significant network of foster parents were reported as ongoing.

- **Concerns of children in the CCI**

In addition to behavioural issues and aggression, particularly amongst the older boys and adolescents, the CCI staff across all institutions also reported self-harm behaviours, particularly amongst adolescent girls aged 14-16 years, and issues in regards to the impact of these behaviours on younger residents who were reported to model their behaviours along similar lines. Cases of self-harm were also reported amongst children, in cases of disciplining by the CCI staff, raising significant concerns of underlying issues. The older children and adolescents were also reported to engage in substance use (specifically cigarette smoking).
To manage issues of children, it was reported in Ziro that a children's committee was formed in the CCI where one member was appointed a captain with the idea of creating a buddy system. A buddy system in a school is where a child gets paired with another child, usually one that is older. They believe that the buddy system helps to promote friendship, behavioural and social needs, and can foster a greater sense of belonging. The counsellors reported challenges in responding to children's emotional and behavioural concerns due to lack of training and relevant qualifications in the area of child mental health and protection.

Gaps and Challenges

- **Gaps in Knowledge and Skills of CCI Staff and Counsellors**

The staff working in CCIs, particularly the counsellors, lack comprehensive knowledge regarding the vulnerabilities, mental health issues, and protection concerns faced by vulnerable children. This knowledge gap hinders their ability to effectively assist and support these children. Due to limited understanding of the specific challenges faced by vulnerable children, CCI staff reported that they struggle to identify and address their unique mental health and protection needs. This lack of awareness can result in

inadequate support, overlooking crucial warning signs, or failing to provide appropriate interventions to vulnerable children.

The CCI staff, particularly the counsellors, reported challenges in assessing and providing first level responses for mental health issues, including challenging behaviours. The CCI staff in Roing highlighted that there exist no separate facilities for children with disability, in addition to difficulties faced by the staff in addressing challenging behaviours amongst this vulnerable group. The staff also reported that the absence of a special educator in the CCI has affected the provision of assistance to children with disability, and that lack of qualified mental health professionals has proved to be challenging in this context as referrals for specialized care becomes difficult.

- **Referrals, Linkages and Partnerships**

CCIs do not have established systems to refer children or connect with other institutions to provide necessary health and mental health care. This lack of coordination makes it difficult for the children in CCIs to access essential medical and mental health support from external healthcare providers.

- **Paucity of Funding**

Consistent funding is crucial for child care institutions to meet the logistical and financial requirements related to children's medical needs, daily necessities, and food expenses. These institutions heavily rely on donations as a source of funding, which is not guaranteed or fixed. Consequently, they face challenges in ensuring consistent and high-quality care for all children under their supervision.

- **Education**

Government schools and intervention services for children with disabilities like special schools and District Early Intervention Centres (DEICs) are unavailable in most districts of Arunachal Pradesh except Pasighat, Lohit and Longding. In Ziro and Itanagar, the CCIs send children with special needs to a private special school but find it exceedingly financially challenging as they have to pay for those services.

Potential Opportunities

- **Training and capacity building**

In light of the concerns shared with the SAMVAD Team, the CCI staff (with particular reference to the Counsellor) would benefit from intensive training and capacity building interventions on child protection and mental health knowledge and skills, with specific emphasis on understanding children’s contextual vulnerabilities, and providing responses by way of screening and assessment, and first level interventions. Such programs must also include the component of child law. By equipping staff with the necessary knowledge and skills, they can better support and assist children in overcoming their difficulties, promoting their well-being and overall development within the child care institution.
For staff members working in CCIs that cater to children with disabilities, it is essential to receive specialized training in interventions specific to various disabilities, mental health

issues, and protection concerns. Additionally, they should have knowledge of certification processes to ensure certification of children with disabilities. Familiarity with key schemes and laws, such as The Rights of Persons with Disabilities (RPWD) Act, 2016, is also necessary. There is a need for identification of institutions that work with children with disabilities to equip their staff on disability management and interventions. The expertise within existing special schools (such as in the Itanagar area) can be harnessed to train CCIs working with children with disability.

The limited number of child care institutions (CCIs) in Arunachal Pradesh highlights the need for government support in enhancing their capacities to respond to vulnerable children. This assistance is crucial for expanding the reach and impact of CCIs, allowing them to provide services to a greater number of children in need.

- **Utilising available resources optimally**

In resource-limited settings like our country, a recommended approach for building child care infrastructure efficiently is to extend existing institutions by enhancing their facilities, staff, and resources, while ensuring registration and monitoring by the government. By adopting this approach, we can optimize resources and infrastructure while ensuring that child care services meet the required standards of quality and safety. It allows for a more efficient utilization of available resources, leading to the timely expansion of child care infrastructure in resource-poor settings. While the Government is also engaged in constructing CCIs in Yupia, near Itanagar, and in Changlang district in the West Siang areas, it would simultaneously be useful to strengthen existing CCIs and systems through funds, monitoring, and registration.

- **Extending Government support to existing CCIs**

By extending Government support to existing child care institutions through adequate funding, training programs and resources, we can leverage the infrastructure and resources already in place, which will strengthen the current systems to accommodate and provide quality assistance to children from difficult circumstances while new infrastructure is being developed. This may involve providing financial assistance for facility upgrades, increasing the number of qualified staff members, and offering professional development opportunities for existing staff.

- **Registration and Monitoring of CCIs**

Furthermore, in order to ensure the quality and accountability in existing child care institutions, it is essential to establish a robust system of registration and monitoring by the government. This ensures that CCIs meet the necessary standards in terms of facilities, safety, staffing ratios, and quality of care. Regular inspections and assessments can be conducted to ensure compliance and provide necessary guidance for improvements.

(b) Children in Conflict with the Law

There is currently only one observation home in the state of Arunachal Pradesh. It is located in Pasighat, and all districts with children in conflict with law (CICL) send them to this home. Other observation homes are in the process of being built, in Yupia, near Itanagar, and in Changlang district, in the West Siang area.

Existing Services and Systems

The observation home consists of two buildings, one for boys and one for girls. At the time of SAMVAD's visit, there were 5 boys and 1 girl resident in the home. On an average, the observation home may receive up to 13 children, usually between the ages of 15 to 18 years of age. Most children come in conflict with the law for (petty) theft and/or substance abuse-related issues, for which they (mostly boys) are apprehended under the Narcotic Drugs and Psychotropic Substances (NDPS) Act, 1985. Often children resort to stealing due to their need to procure substances. Other offences include murder and POCSO-related charges, but according to the observation home staff, these are fewer in number. Petty cases are usually accorded bail, while children with alleged heinous offences are housed in the observation home.

The children of the observation home have a daily routine of breakfast in the morning, followed by cleaning and chores; they then spend the rest of the morning playing indoor games (such as carrom). After lunch, they have time to rest; from 3 to 5 pm they are outdoors in the extensive grounds of the home, wherein they play volleyball and other outdoor games. The remaining part of the evening is spent watching television, after which they eat dinner and go to bed by 9 pm.

In addition to a superintendent, house mother and welfare officer, the home has a counsellor who stated that counselling was conducted with the CICL there. On being asked to explain the nature of counselling processes, she said that children were asked about their family backgrounds, how they came in conflict with the law i.e., the incidents following which they were apprehended, and their peer group. Interventions were explained as consisting of rapport building and discussing consequences of behaviours that children had engaged in. No mental health concerns are observed or documented. Neither the counsellor nor the protection officer and welfare officer, or the superintendent were aware of the changes made in the Juvenile Justice Care and Protection Act, 2015, with regard to CICL i.e., of the inclusion of section 15 and juvenile transfer—they said that they had never heard of this provision in the law and that no child in Arunachal Pradesh, to the best of their knowledge, was transferred to the adult criminal justice system.

Thus far, the children have not received any education or vocational training in the home. Recently, the Dept. of Education has sanctioned teachers for the home, so possibly some educational activities may begin in the future. However, although the home staff have contacted the handloom and textile industry for vocational training assistance, there has been no response until now.

Training has been provided to the observation home counsellor and officers as well as to Juvenile Justice Board members by NIPCCD- Guwahati in the year 2020. This training focussed on issues of nutrition, health, and hygiene for CICL—it did not include issues of mental health, counselling and law. There is also a newly appointed Juvenile Justice Board now, who are not likely to have been trained.

Gaps and Challenges

The gaps in the running of the observation home and services for the children are considerable. As of now, it is more akin to a centre where children are simply detailed for long periods of time, especially when they do not have family support and so cannot avail of bail. The children's daily routine has no component of education or vocational training, nor are the counselling services adequate in terms of addressing children's behaviour problems and their need for transformation. Training programs conducted thus far do not appear to be addressing specific issues relating to CICL, such as the law. For instance, the staff, including the Protection Officer, were not aware of the latest developments and changes in the Juvenile Justice Act, particularly those pertaining to juvenile transfer.

Potential Opportunities

Now that there are newly appointed Juvenile Justice Board members across the state, it would be helpful to conduct depth training for them as well as the staff of the observation home(s) so that more effective assistance to CICL may be provided. Furthermore, in a state where substance abuse, starting mostly during adolescence, is such a major concern, it seems unlikely that the numbers of CICL would be so small. In the brief time we spent in the state, and given that we were unable to meet many JJB members, how and for what offences children are apprehended, and the basis of giving them bail, were still largely unclear. More research and study would be required to understand how systems work to address and assist CICL and their concerns.

B.11. Schools

Existing Issues, Services and Systems

As SAMVAD was, in its limited time, able to visit only a few high schools, the findings documented in this report are restricted to high school education and students. Arunachal Pradesh lacks a state board, and thus, the school follows the curriculum prescribed by the Central Board of Secondary Education (CBSE). As reported by one of the school principals, a substantial proportion of students, even after completing their education up to the 8th grade, exhibit significant deficits in basic reading and writing skills. This poses a considerable challenge when it comes to effectively explaining complex concepts to these students, as they go to higher grades. The principal further emphasized that their ability to express themselves in written form is extremely limited, with most struggling to compose even a single paragraph. Aside from Specific Learning Disabilities, which, in any case, only some children might have, one possible reason for these reading and writing issues, as also explained by the principal, is that the community culture is

strong in Arunachal Pradesh. The medium of instruction in high schools in Arunachal Pradesh, is English.[17] There are, however, 26 major tribes in the state, and each tribe speaks a different language subsequently making it difficult for students (especially for first generation learners) to grasp formal education that is provided in a different language from their own.

Another unusual feature of high school students in Arunachal Pradesh is that a significant proportion of high school students reside in rented accommodations in the capital city without parental supervision. Of these, only a few have the support of relatives or a caretaker. Thus, these children are, in effect, without adult supervision during their vulnerable adolescent years. This lack of supervision places these students, particularly boys, at risk of substance use; it also leads to students dropping out of school.

Schools, like other child settings, are contending with substance use issues in their adolescent students. From 8th grade onwards, they tend to eat '*ghutka*', and smoke cigarettes. The reasons for using substances are the same as explained erstwhile in other contexts, by other stakeholders: the normalization and legitimization of substance use by parents, as well as the easy accessibility to certain substances at the household level. School authorities also report making efforts to talk to children about substance use, call parents and take undertakings from them (stating that the school could expel the child if there was repeated use of substance) with a view to prevention of substance abuse, but given how rampant a social problem it is, schools also struggle to contend with it. Another problem that is reported is that of adolescent engagement in romantic and sexual relationships. Coming from a perspective that adolescents do not have the right to engage in such relationships, as 'this is the age to study,' there appear to be conflicts between adolescent students and school authorities on how to manage this developmental stage and its normative behaviours. Schools admitted to using corporal punishment (as a last resort) to manage both substance use and adolescent sexuality issues.

No specific emotional, behavioural, and disability-related concerns were raised by schools. This is possibly because teachers are not oriented to such concerns, nor do schools have counsellors. Some schools report having appointed certain teachers to play the role of an interim counsellor but none of these teachers are trained to handle child mental health related issues.

Unlike in some other states, schools also do not have a comprehensive policy in place for child protection and safety. While there is some awareness on the existence of the POCSO Act 2012, school personnel are unsure of what they would do in case of an incident of child sexual abuse (CSA), nor do they have requisite knowledge on this issue; other than occasional 'awareness' sessions for students, on "good touch and bad touch",

[17] In Arunachal Pradesh, medium of instruction in schools until Grade 5, and preferably till Grade 8, is the local language/mother tongue.

they do not have an understanding on responses to CSA, nor on how the law needs to be operationalized in a school context.

Gaps and Challenges

Given the limited knowledge and understanding amongst teachers in schools of mental health issues in children, and the absence of counsellors in schools, there is little chance for children to receive the mental health interventions they require, whether in the context of substance use, and sexuality or learning problems. Likewise, the lack of child protection policies and know-how on child sexual abuse issues is a gap that requires consideration.

Potential Opportunities

- Schools and Teachers are best positioned service providers for identifying vulnerability and risk in children, and for, thereafter, providing first level responses, and ensuring they are linked with the relevant mental health and protection services. In this regard, capacity-building programs are necessary for key child-related stakeholders, especially teachers to orient these stakeholders on issues related to child mental health, child developmental disorders, and psychosocial well-being. Such training programs must include child protection concerns such as child sexual abuse. Training efforts can, thus, also focus on orienting teachers and school staff on the POCSO Act, to facilitate the operationalization of their roles and responsibilities under the Act, and to assisting them in drafting a child safety and protection policy for their schools.
- Apart from child sexual abuse, teachers may also be trained to link children in need (for other protection concerns) to the District Child Protection Unit. Linkages between the District Mental Health Program (DMHP), District Early Intervention Centre (DEIC) and the District Resource Centre (DRC) are crucial, especially with regards to children with disabilities to enable them to get the assistance and stimulation they require. The school teachers can be trained in identifying potential cases of children with disabilities for assessment and referral. Through these training initiatives, teachers can assist parents and families in securing benefits under the various legal entitlements for children with disabilities.

C. Tertiary Level

- Tomo Riba Institute of Health & Medical Sciences
- State Mental hospital, Midpu

C.1. Department of Psychiatry, Tomo Riba Institute of Health & Medical Sciences

Existing Issues, Services and Systems

During a meeting with the SAMVAD team, it was reported that the entire state of Arunachal Pradesh has only eight psychiatrists available to cater to a population of 1.7 million people. Out of these eight psychiatrists, three are situated in Tomo Riba Institute of Health & Medical Sciences (TRIHMS), three in the Regional Mental Hospital located in Midpu, one at the district hospital, and the remaining psychiatrist works as a private practitioner.

Established in the year 2017, TRIHMS is the first and only medical college in Arunachal Pradesh situated at Naharlagun town of Papum Pare district. It is a 300-bedded teaching hospital, with in-patient and out-patient services. The Institute runs MBBS and DNB courses, to whose trainees the Dept. of Psychiatry provides mental health inputs; however, post-graduate courses in psychiatry have not started within the facility.

The Dept. of Psychiatry at TRIHMS comprises of 3 psychiatrists, 2 at associate, assistant professor level, and one at senior resident level. Currently, there are no social workers or psychologists in the department. The department has a 9-bedded in-patient facility of which 6 are for males and 3 are for females. There are no beds in Psychiatry for children (i.e., those below 18 years)—who are currently admitted in the pediatric ward.

The department receives on an average, 20 patients per day, of which 3 to 4 are children. Thus, it receives about an average of 15 to 20 children in a week. Children who come to avail of services, are from across the state; they are usually referred by general physicians or pediatricians. The types of cases received are mostly of intellectual disability, autism, mood disorder/ depression, school refusal, disruptive behaviours, and seizures. With regard to disability services, these are primarily restricted to disability certification i.e., on the 2nd and 4th Friday of each month, the Disability Certification Board that convenes, comprising of a psychiatrist, psychologist and pediatrician. Given that it is mandatory to have an assessment done for the certification process, the applicant is either referred to State Mental Health Hospital, Midpu or the assessment is conducted by the psychologist on the Board. In other words, the Department's treating team does not provide services and interventions for childhood developmental delays and disorders. Such problems are addressed by the Department of Pediatrics—and should children have other related problems such as speech delay, they are referred to the relevant departments (such as the Department of Ear, Nose and Throat). These cases of childhood disability are thus not even referred to the Department of Psychiatry. Also, in case of other child and adolescent mental health problems, such as mood disorder, depression etc., children are provided psychiatric medication and referred to State Mental Health Hospital, Midpu or private practitioners, for counselling. This is because the TRIHMS Department of Psychiatry has only psychiatrists on its team—and their understanding appears to be that counselling would be difficult for psychiatrists to do.

A large number of cases of substance use are also received, between the ages of 15 and 18 years; cannabis and opium are the commonly used substances. Most adolescents with substance use issues, also have conduct disorder and mood disorder as co-

morbidity; they come from urban areas, from dysfunctional families, and tend to be school drop-outs. Interventions include parent psychoeducation, detoxification for the child i.e., this entails admitting children to the in-patient facilities for a period of 15 days. They are, thereafter, then referred to private de-addiction facilities which are privately run—although these facilities rarely admit individuals below the age of 18 years. There are currently three such private de-addiction centres in Itanagar; one government de-addiction centre is currently being built and is likely to begin functioning in a few months.

With regard to child sexual abuse (CSA) cases, these are usually received not by the Department of Psychiatry, but at Emergency Services or by the Pediatrics Department, usually because CSA may have resulted in bodily harm and injury. That said, children who present with depression/ mood disorder, and problems such as self-harm and substance abuse, also disclose CSA during the consultation at the Department of Psychiatry. When this happens, the department suggests to children and their families, to report to the police. However, when children and families refuse, as often happens, because of the close ties that tribal families share, the department does not persist with actions with regard to CSA. Again, they refer such cases of CSA to State Mental Health Hospital, Midpu, for assistance.

The department does not receive referrals directly from CWCs. However, children from institutions come to the department for treatment of behaviour problems, mainly through referral from Oju Welfare Association (an NGO in Itanagar). JJB referrals, for conducting preliminary assessments under Section 15 of the Juvenile Justice Act 2015, are rarely received i.e., only about once in every 6 months. The department also convenes a Board to conduct such forensic assessments for children in conflict with the law; the members of the Board are pediatricians, members of the forensic team of the hospital, radiologists, psychiatrists. It was stated that the Board conducts age determination tests and mental status assessments—however, there was no clarity on how the Board arrives at conclusions regarding children's mental capacity and on children's understanding of consequences.

Community outreach programs are undertaken occasionally by the department, on special occasions such as World Mental Health Day. These are often conducted at colleges and universities or in police headquarters, on issues such as substance use. Thus, no community outreach programs currently target children and adolescents.

Gaps and Challenges

The gaps pertain, first and foremost, to lack of mental health professionals within the Department of Psychiatry i.e., there are at present, no psychologists, or social workers, due to which there are no counselling services that should critically form part of treatment processes, especially with children and adolescents. The nursing staff that the department has is currently shared with the Departments of Pulmonary and General Medicine. These nursing staff also do not have regular positions, and so longer-term investments such as for training, are not made.

As mentioned, there are infrastructural gaps, with no in-patient facilities for children who come to the Department of Psychiatry, nor are there play rooms for conducting therapy as required by children.

Orientation to children and child work appears to be a major gap in the department, with the current staff restricting their roles only to providing psychiatric medication to children and adolescents. Childhood mental health disorders do not necessarily require medication, but certainly need for counselling and therapeutic work to be done with children and families. Referring all such children to the State Mental Health Institute, Midpu, is hardly a feasible or sustainable solution. It is also concerning, in this regard, that children with disability either do not visit this department, or when they do come, they are unable to receive interventions.

Many of the cases pertaining to child sexual abuse issues and childhood disabilities should be referred, from a domain-expertise perspective, to a department of psychiatry, rather than paediatrics; or at the very least, the department of paediatrics should be working in close collaboration with the dept. of psychiatry, in order to assist children with protection and mental health problems. In light of this, the functioning of the Department of Psychiatry at TRIHMS, which is meant to be a specialized tertiary care facility, is considerably perplexing.

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C.2. State Mental Hospital, Midpu

Existing Issues, Services and Systems

Established in 2016, the State Mental Hospital, Midpu, is a tertiary mental healthcare facility with a capacity of 30 beds (although the current infrastructure can only accommodate about 20 patients). The Hospital currently comprises of 3 psychiatrists, 1 psychologist and 2 social workers.

On an average, it receives 5 to 7 patients per day in its out-patient facility; of these, a maximum of 2 might be children. According to the staff, one of the reasons why they receive low numbers of patients is that the hospital is located far from Itanagar i.e., on the out-skirts of the city, and access is poor due to inadequate public transport in the state. Children are usually referred by private practitioners as well as by TRIHMS for assessments pertaining to developmental delays and disabilities, such as intellectual disabilities (most commonly), Specific Learning Disabilities, Attention Deficit Hyperactivity (ADHD) and autism. Disability certification is also done by the hospital, which has a Board to conduct the requisite processes for certification.

Some of the common problems that children between ages 3 and 8 years access the hospital services for, are speech problems, ADHD, autism, epilepsy and learning difficulties (at school). Children above the age of 8 years, access services for emotional and behavioural problems such as depression and mood disorders, anxiety and panic attacks, adjustment problems within school or family, bullying, body image issues, and anger problems. Adolescents also come for treatment of substance abuse disorder.

Interventions for developmental delays and disabilities, comprise of psychoeducation for parents, setting up a routine for children, home-based programs focused on stimulation and environmental modification, and inputs for parents to manage their own anxieties and other emotional problems resulting from having a child with disability. Children are

also referred to specialized disability centres and schools (there are two in Itanagar), in case of need. It is observed that although families are encouraged to follow up on treatment, one of the challenges is that they often do not—possibly because of distance and accessibility issues; but as the DEICs stated, it could also be due to families being disheartened and de-motivated by the relatively slow progress that children with disability make, even with treatment and stimulation activities.

With regard to emotional problems, interventions entail helping children 'vent out' their emotions, and 'speak about' their problems. In many of these instances of emotional difficulty, the Eysenck Personality Questionnaire, EPQ-R, is administered, in order to understand the 'mental condition' of the child, including 'whether he/she has depression'. This test is used to 'better understand' the child and 'confirm whether what the child is saying in the session is… [actually how the child feels]'. In case of behaviour problems, such as anger issues, conduct problems and temper tantrums, the staff state that they 'do not engage with the child due to security issues' i.e., 'they may pick up objects and throw them or attack the therapist'. They therefore conduct sessions primarily with the parents, and try to focus on exploration of the root cause (triggers) of the anger. When the causes of the anger are established, the child is then referred to the psychiatrist—because there is a belief that counselling cannot help much with anger control.

In case of adolescents with substance use (which begin in the context of experimentation and peer pressure), it was reported that they often come with other conduct issues, such as stealing. Interventions in these cases include journaling and following the routine that was set by the de-addiction agency the adolescent went to; conversations with the child centre around children's views on substance use and why it is not desirable to engage in substance use. In the course of therapeutic exploration, the staff feel that the withdrawal symptoms that children experience after de-addiction treatment is what motivates them to quit.

Sessions may be conducted with children either individually (including on a walk), or jointly with parents. Relaxation exercises and meditation exercises may be included, as well as 'drawing' and 'talking'. No specific methods and techniques in particular contexts of disorders were described. The rationale provided for use of some of these methods such as walks and relaxation, were that 'children with emotional problems are moody—and they are unlikely to engage in any specific activities.

Most child sexual abuse and domestic violence cases are referred by the CWC. In such cases, the hospital staff conduct a minimum of 3 sessions with the affected children. Following each session, a report is submitted to the CWC. The purpose of these sessions is to gather evidence from the children, for legal processes. No recommendations for placement or rehabilitation are made to the CWC. There are also instances of CSA disclosure made by children seeking treatment in contexts of other disorders. However, children are reluctant to inform their parents or the police due to fear of breaking up of their families and loss of family reputation. The hospital staff stated that since the abuse is often by known people, they consider it a serious child safety issue, and therefore try to convince children to at least inform one of their parents. Thus, no further attempts are made to follow through with the POCSO law's mandatory reporting clause. No specific interventions are provided to assist children to deal with their abuse experiences either.

The Hospital also receives, from time to time, some referrals for children in conflict with the law, from JJBs, for preliminary assessments under Section 15 of the Juvenile Justice Act 2015. As part of this assessment, the staff conduct a mental status examination, check for neuro-cognitive processes and record the behaviour of the child during the assessment processes. However, questions on mental capacity and children's understanding of consequences, or on their circumstances are not responded to by the assessment, as required by the JJ Act: "My job is just to tell whether the child can comprehend and has memory abilities…" Thus, there appears to be no clear understanding on the purpose or the ways in which to implement the Section 15 and preliminary assessments, as also acknowledged by the staff.

Gaps and Challenges

In addition to gaps pertaining to infrastructure i.e., lack of early stimulation and play rooms and play materials, the main challenge appears to be with regard to therapeutic knowledge and skills in various areas of child mental health. One area where this is evident is in case of children who come in contact with legal and quasi-legal systems, including the CWC. Knowledge and skills pertaining to forensic assessments, and treatment and rehabilitation interventions for sexually abused children and children in conflict with the law, is poor. However, therapeutic methods and skills for children with conduct and substance use disorders are also lacking. As acknowledged by the staff, there is a tremendous need for training on essential child and adolescent mental health issues, so that their practices may be duly strengthened.

Potential Opportunities

TRIHMS and the State Regional Mental Hospital, Midpu are currently the only two tertiary mental healthcare services available in the state. It is therefore critical to equip the mental health professionals within these institutions with skills and capacities in child and adolescent mental health. Broadly, this would entail: (a) stronger conceptual understanding of essential child and adolescent mental health issues from a clinical as well as a public health perspective; (b) intensive skill training in therapeutic interventions for various child and adolescent disorders; (c) specialized skills in child forensic work, namely in dealing with child sexual abuse (CNCP) and children in conflict with law cases i.e., the interface of mental health with child law issues, and the role of the mental health professional in facilitating assistance to children in medico-legal contexts.

These tertiary care institutions may also avail of training opportunities at institutions such as NIMHANS, whose Dept. of Child & Adolescent Psychiatry, offers various fellowships/internships to enable skill building for mental health professionals ranging from 1 month to 6 months. They may also attend SAMVAD's comprehensive child and adolescent training program, as well as its specialized child forensic training programs. However, in order for capacity enhancement initiatives to be effective, the above-mentioned institutions would need also to appoint allied mental health professionals from the fields of clinical psychology and psychiatric social work, which TRIHMS, for instance, currently does not have.

D. Other Administrative Stakeholders

D.1. Department of Health and Family Welfare

Special Secretary, Health and Directorate of Health Services

The SAMVAD team interviewed the Special Secretary, Health and District Health Services who provided the following information, on key aspects of health services, as they pertain to mental health:

- There are currently 212 Health and Wellness Centres functional in the state of the 543 sub-centres. Also, since ANM's are burdened with a number of responsibilities, the staff at the health and wellness centres can work in collaboration with the teachers.
- The doctors at the health and wellness centres can work with the teachers to help with referrals, identification of children with disabilities. There was a consensus that all stakeholders who work with children, especially the teachers should be trained. The teachers can subsequently also work with parents to help them understand better. However, there are concerns regarding schools' lack of initiative in independently reaching out to the Rashtriya Kishor Swasthya Karyakram (RKSK), or Rashtriya Bal Swasthya Karyakram (RBSK) to organize mental health awareness programs.
- Mukhya Mantri Mansik Swasthya Yojana is a flagship program initiated by the Government of Arunachal Pradesh to address the widespread prevalence of substance use and related criminal behaviour. In the context of suicidality, it was observed, that the cases of reported suicides are higher amongst children and elders within Anini and Anjaw districts of Arunachal Pradesh.
- The required personnel have been recruited and the Tele Mental Health Assistance and Networking Across States (Tele MANAS) portal will soon be functional.
- Substance abuse and child labour are key issues that concern children in the state.
- One of the biggest challenges of the community, is the prevalence of shame and stigma surrounding the disclosure of mental health issues. Therefore, in terms of awareness initiatives, the RBSK and RKSK programmes require strengthening in their governance and implementation. It was reported that, under the RBSK and RKSK programme, the doctors seemed to have delivered the training to the field staff but the retention of the training program and its implementation on the field is questionable.
- There were also geographical challenges reported due to rough terrain and uneven topography across some parts of the state. Combined with rains and bad weather, some areas of the state are rendered inaccessible for a significant part of the year, thereby impeding the delivery of awareness programs at the community level.

D.2. Department of Education

Key information obtained from the Department of Education Officials included the following:

- In terms of the educational workforce, in the context of elementary and secondary education, it was reported that within the state of Arunachal Pradesh, there are a total of 10,000 Permanent teachers and 7000 temporary teachers. The enrolment ratio for female students (60%) is observed to be higher than male students (40%).
- It was also reported that there have been significant changes to the Department for administrative efficiency and greater oversight over various components of education in the state. As a result, the erstwhile Directorate of School Education was bifurcated into two distinct and separate Directorates on 28th October' 2010 namely, the Directorate of Elementary Education [DEE] and the Directorate of Secondary Education [DSE]. The Directorate of Elementary Education looks after the entire educational system of Elementary Education i.e., from Class – I to VIII. Meanwhile, the Directorate of Secondary Education is responsible for the administrative governance over institutions and teaching personnel engaged in providing educational services from Class IX to Class XII.
- In regards to the skewed enrolment ratio, as reported above, it was reported that higher prevalence of substance use amongst adolescent boys has resulted in a higher dropout rate, thereby contributing to reduced enrolment ratios for male students. Lack of motivation and sufficient opportunities for further study and work was identified as a concern amongst adolescent boys, who are usually wary of engaging in low-paying and irregular jobs, especially in light of community perceptions regarding the permissibility of certain vocations vis-à-vis traditional tribal status and identity.
- While identification and treatment of child mental health disorders takes place through the use of clinical and standardized psychological assessments, there seems to be a lack of skill and understanding in providing treatment and interventions in the context of psychosocial concerns. It was reported that teachers do not make use of assessment methods, including proformas to systematically evaluate and understand children's protection/mental health issues and psychosocial concerns. Additionally, teaching staff have reportedly not been trained in recognizing learning disabilities and other mental health and disability concerns. Issues pertaining to availability of teachers across the state was also reported, given geographical challenges and personal preferences that disfavour postings in rural areas.
- There are 11 District Early Intervention Centres (DEICs), which cater to large populations across many districts. As a result, these centres are not easily accessible for many schools and other child-related stakeholders. Additionally, at the school level, there is insufficient capacity to identify possible cases of children with disability and limited knowledge regarding institutions for referral. Teachers have also not been provided with standard check-lists or screening tools to comprehensively assess children with developmental issues.

- It was reported to the SAMVAD team, during the visit, that there is also an imperative to facilitate training for teachers on approaches to education, in terms of curriculum design and pedagogy. Since there are many tribes with each tribe having a language/dialect of its own, the NEP 2020 outlining the need to facilitate education in the local language may not be beneficial within the state of Arunachal Pradesh, given lack of linguistic competencies amongst teaching staff to cover the disparate dialects across the state. As English is the formal medium of instruction across the state, this is imperative for standardisation of teaching instruction and materials across the state.
- Substance abuse has been identified as an important concern in Schools, but there is a lack of trained mental health professionals at the school level. Subject-specific teaching staff, do not have the requisite capacity to address such challenges at the school level. As a result, insufficient capacitation of the PHCs and inaccessibility of District Hospitals has created a barrier in accessing mental health and disability services for children.

Given that there is a dearth of mental health professionals, there needs to be task sharing with key stakeholders such as with the Department of Health and Family Welfare. Additionally, effective coordination and referral guidelines need to be provided to schools and educational institutions so that children may be referred to the DEIC (for children with disability), and to the nearest PHCs or District Hospitals for identification and treatment of mental health issues. The teachers may also subsequently undertake psychoeducation initiatives to build awareness amongst parents on key child mental health and protection concerns. While there are challenges in identifying protection risks, and limited knowledge regarding processes to follow in reporting of offences, training initiatives can help schools with adoption and institutionalisation of these processes.

Furthermore, teachers' staff, special educators, interpreters, and other key school staff are central to assessment of mental health, protection, and disability issues amongst student populations. While referral and coordination mechanisms are important, the first level of identification has to effectively take place at the school-level. Due to a paucity of information on mental health, children's issues in many instances go unnoticed or are actively penalised at the school level. Therefore, assessment and identification of potential mental health and protection concerns need to be discerned through standardised assessment proformas, wherein referral can subsequently follow.

D.3. State Commission for Protection of Child Rights

The Arunachal Pradesh State Commission for Protection of Child Rights (APSCPCR) was recently established on 10th August 2020. The APSCPCR currently has one chairperson and six members. Since its inception, the APSCPCR has covered 21 districts and carried out activities such as inspections and legal awareness. As per their mandate, the commission also takes *suo moto* cognizance in cases of child abuse, which are reported in the media or brought to the notice of the commission through the police. Soon after the commission was constituted, the Covid 19 pandemic had begun with subsequent travel restrictions across the country. As a result, the commission did not get a lot of opportunities to travel, inspect or engage in cases.

During much of the pandemic, the Commission was engaged in online training and capacity building programs organized by National Institute of Public Cooperation and Child Development (NIPCCD). However, the Commission members could not recall some of the training program themes and key inputs. The commission has also been involved in awareness building activities in the school and has also commissioned two documentaries to raise awareness on child abuse and POCSO in the communities.

While sharing the data for offences committed against children, the Commission also highlighted that critical data, on this subject, is not sufficiently highlighted in National Crime Records Bureau (NCRB) reports available in public domain. Although, the quantum of case disposals in offences against children, such as child sexual abuse, child trafficking, physical assault, child marriage, kidnapping, etc., is not significant vis-à-vis the overall incidence of crime in the state, it is significant to note that 11 POCSO cases had been disposed off over a nearly 2-year period.

District-wise distribution of cases, registered for offences against children across the state, over a nearly 2-year period, also disclose that the highest proportion of registered cases are under the POCSO Act, 2012 (with 69 cases reported from all districts). The next offence category, in terms of number of cases registered, includes unnatural death (13), followed by child labour (11), and other offences. From a quick perusal of these records, it is concerning to note the low number of child labour cases registered, despite widely-held perceptions of its ubiquity.

Some of the challenges that the APSCPCR highlighted pertain to the issues below:

- **Child Labour**

The Commission reiterated that child labour cases are largely unreported across the state. In addition, owing to infrastructural constraints, the Commission reported a lack of availability of rescue vehicles to carry out rescue operations.

- **Child Sexual Abuse and POCSO**

It was highlighted that there are only 8 Special Court Judges in the state. In addition to issues pertaining to higher caseload and pendency, it was reported that the victims of sexual abuse are, in many instances, discouraged by the police to file a complaint against the alleged offender, further contributing to concerns of underreporting. Additionally, in regards to medical evidence, the absence of a forensic lab in Arunachal Pradesh was

highlighted as a critical concern, given the reality that all the evidence is forwarded to Gauhati and other places.

- **Mental Health Service Delivery**

Across the state, a lack of mental health services was observed to widen the treatment gap in the state, particularly in relation to children in vulnerable and difficult situations. Additionally, in terms of personnel, shortage of qualified personnel has resulted in appointment of counsellors with qualifications in professional backgrounds other than mental health. Given the lack of capacity-building efforts, the lack of sufficient qualifications was reported to accentuate the quality of service provision in regards to mental health.

Given that the APSCPCR is newly established, it would be essential to conduct an in-depth training program on child protection issues, child related laws, so that the commission can better understand these issues and intervene in individual cases, as well as carry out child rights awareness programs. In this regard, building capacities and knowledge on issues related to child protection and the law will allow APSCPCR to take *sou moto* cognizance in more cases of child rights violations and monitor the cases reported in the state.

E. Non-Governmental Agencies for Collaboration

Existing Issues, Services and Systems

Hope and the Seed De-addiction Centres are both private facilities founded by individuals who are recovering addicts themselves. They recognized a lack of de-addiction and correctional services in Arunachal Pradesh and decided to take action.

The patients are either self-admitted or brought by their families or local authorities. The patients range from 15 years of age to 45 years. Additionally, the centres provide counselling services to support patients on their journey towards recovery. There is a monthly charge for these services and it is based on the financial status of the family. It was also reported that the major reasons for patients to be admitted to the facility are substance use due to life stressors, issues in romantic and interpersonal relationships and economic circumstances.

Hope, a residential rehabilitation centre, has a structured daily routine for its residents. They begin their day at 6 am with breakfast and tea, followed by yoga, grooming, and bathing. Throughout the day, patients have the opportunity to read, meditate, participate in counselling sessions provided by recovered addicts, and engage in various activities such as singing, music, dancing, watching TV, and playing indoor games like chess. After lunch, they also engage in reading, group discussions on various issues/difficulties. They also hold Narcotics Anonymous and Alcoholics Anonymous (AA) meetings. They engage in motivational prayer and participate in extracurricular activities. They are encouraged to engage in self-help activities and self-care by partaking in the daily chores of running the centre. The rehabilitation centres encourage their patients to read books that are motivational and provide different perspectives on the way to lead one's life. A lot of reading circles are also held here. For patients who are unable to read and write, discussion and verbal discourse is encouraged. Importance is also given to sports and leisure activities.

The counselling techniques are derived from the 12-step AA model which largely focus on changing their mindset and adjusting to life without drugs. They envision for the rehab centre to be a space of community and fraternity. It was also discussed that many patients in the rehab facility have Hep C and HIV due to intravenous drug usage. Considering that most patients are Christian, and the treatment philosophy is also based in Christianity, the patients also perform Devotion- acts of service and prayer. The stigma associated with these issues also prevents people from accessing assistance. They also have liaisons with the psychiatrist, at Margherita Hospital, and the Regional Mental Hospital, in Itanagar, who they consult in case they notice severe mental health issues in patients. Some patients also have cases ongoing under the Narcotics Drugs and Psychotropic Substances Act. The rehabilitation centre assists them with taking them to court for their hearing.

With regard to managing difficult behaviours by clients, it was reported that medication is given sometimes by a visiting psychiatrist, but they reported that, otherwise, there are not too many instances of unmanageable behaviour by the residents of the facility. The minimum time period for the admission is 3 to 6 months.

They also reported that there is no institution in the district of Namsai and Lower Dibang Valley area or around that caters to substance related interventions particularly for children and adolescents. With regard to one of the major reasons for adolescents to engage in substance abuse, it was reported that opium is a very regular household substance in communities. Parents use it as medicine for children for stomach aches, etc. This leads to early consumption and eventual use of opium and harder drugs as tolerance increases.

The counsellor at the Seed Deaddiction centre, at Bolung, shared an informal assessment they had conducted by collecting data of the patients in the rehabilitation centre regarding the presence of drug use in the nearby districts. They reported that the data shows the highest number of drug consumption is by youth between the ages of 16-20 years. The data also indicated that the districts with the highest number of substance users were Changlang, Tezu, Namsai and Roing. The rehabilitation centre also runs a 'Recovered Club', for patients who have completed the program every week, where they have group meetings to create a space for accountability and support- this is their attempt to prevent relapse of patients after returning to the community.

Their assessment process involves taking previous history, the duration of the use of substances and current mental status at the time of admission. It was reported that they do not deal with mental health issues directly, but consult a psychiatrist and medical specialist once in 15 days. Their consulting psychiatrist is based out of the Regional Mental Hospital in Itanagar.

It was reported that the maximum cases that they saw were those of heroin addiction. A considerable number of cases prevailing in these districts were also of 'poly-addiction'- which involved addiction to multiple forms of substances like alcohol, drugs, and various pills.

When asked about the adolescent population in the centre, it was reported that the age range of adolescents who access these rehabilitative services is 16-18 years. They are majorly brought into the centre for admission by their families. Adolescents in the communities around Bolung and other parts of the Lower Dibang Valley engage in use of substances that are cheap and easily available, due to economic constraints. It was reported that they engage in substance use out of curiosity, peer pressure and easy availability.

They also reported that 36 out of 40 cases in the rehabilitation centre currently have NDPS cases against them. They assist with taking them to court for hearing as well as provide a bond for bail. They also provide guarantees to the court for the beneficiaries.

Gaps and Challenges

- There is a dearth of de-addiction services in the state. Most of what exists are run by non-governmental organizations who charge considerable fees for admission to their programs. A paucity of investment in these programs by the government therefore results in poor access of services to those who need them the most. This problem is compounded by the lack of linkage between the district hospitals and the rehabilitation centres. Likewise, the absence of District Mental Health Program (DMHP) in most

districts, at present, also creates gaps in convergence and linkages, impacting people's access to services.

- Furthermore, the few NGOs that offer these services, do so only for adults. This is a tremendous gap, especially from a prevention perspective, considering that substance use issues find their roots in adolescence. Admitting the odd adolescent within what is essentially a treatment program for adults is also problematic—as children and adolescents require different approaches to assessment and intervention from adults in any given context, including substance use.
- There are no formal psychosocial and mental health assessment proformas or checklists to assess patients for the circumstances and reasons for engaging in substance use- the treatment is focussed on prevention of drug use through abstinence- they focus on the behaviour of substance use. This limitation in the understanding of the relationship between mental health issues and substance abuse, leads to a considerable gap in the treatment strategy used. If emotional difficulties and mental health problems are not considered in the treatment of substance use, there is a larger possibility of relapse because the core issue (emotional difficulty, if any) is not addressed.
- The method of treatment is the 12-step AA model, and while this is a well-known, tried and tested model, it does not fully account for the imperatives to treat mental health co-morbidities in substance use (such as clinical conditions—ADHD/Depression etc), which require psychiatric medication and other forms of treatment. in-depth psychological and psychosocial support is not accounted for in the treatment.
- Due to the terrain, access, as well as paucity of resources, there are no follow-up mechanisms with regard to patients that have returned home or to their communities.

Potential Opportunities

In order to address the paucity of de-addiction services in the state, Government support is required to the existing de-addiction and rehabilitative services with regards to funding and monitoring. It is crucial to provide services specifically catering to the needs of children and adolescents for assessment and intervention in substance use. Initiating the DMHP in all districts will also help in strengthening linkages between people requiring treatment and rehabilitation services and the specialized centres that exist.

Further and more intensive training and capacity building of the staff running the services at the de-addiction centres is required. It would be helpful to connect with established de-addiction centres such as Kripa Foundation (Meghalaya being the nearest state where the foundation works) so as to improve upon their residential treatment and care model; it would also be important to connect with mental health institutes that run specialized centres and services for addiction medicine such as are found in NIMHANS, Bangalore and All India Institute for Medical Sciences (AIIMS Delhi) so that clinical and mental health perspectives can be integrated with the psychosocial care models that these NGOs already use.

IV. Recommendations for Action

(a) Ensuring access and coverage – initiating requisite government programs and services in all districts

Given that many aspects of administrative governance have developed in Arunachal Pradesh after 1987, post the establishment of statehood, there are many nodal agencies and administrative frameworks that are still in the process of development in the state. As a result, a number of services, particularly in the context of child protection and mental health, are yet to reach many districts. For instance, there are only 3 DEICs in the state, insufficient number of CCIs (including just 1 Observation Home), and a nascent DMHP infrastructure. Until these programs and services are put in place, universal access and coverage for child protection and mental health services will not be achieved; the requisite capacity building of nodal functionaries will also not be feasible.

(b) Addressing issues of paucity in human resources

In light of the shortage of qualified and trained personnel in the state, it is recommended that the state may take under consideration a proposal for inviting applications for child-related professionals from other states. Keeping in mind the significance of statutory and scheme-related services such the JJB and the DCPU, long-standing vacancies can have a debilitating impact on the functioning of these bodies, and by extension, their engagements with children.

The Government of Arunachal Pradesh may also view this interim arrangement as an opportunity to provide handholding support for in-service professionals who may not possess the requisite qualifications (such as the Counsellors appointed from non-mental health backgrounds). Such guidance and utilisation of technical expertise, whilst provisional, may help entrench certain best practices, in engagements with vulnerable children, that are systematic and standardised.

(c) Utilising available resources optimally

As multiple stakeholders averred, the population is scattered, thereby affecting access to basic services like the Health and Wellness Centres- PHCs. However, in some areas with a low population, multiplicity of statutory services like the Child Welfare Committees and Juvenile Justice Boards has not contributed to improvements in the administration of justice and rehabilitation.

With this context in mind, it is recommended that the state considers districts with low populations wherein two districts can be brought under the jurisdiction of one CWC. Factors that can inform the government's decision to combine districts, under the jurisdiction of a given CWC, may include feasibility, by way of overall population, geographic access, availability of transport, etc. Such streamlining of powers (vested in

a given CWC) may help ensure that the CWC is functioning effectively and responding children's concerns.

(d) Re-examining the compounding of roles and charge of child development and protection functionaries

It is important to acknowledge that scarcity of human resources necessitates some degree of task sharing i.e., assumption of greater responsibilities by designated officials. However, it is equally important to note that while the Child Development Project Officer (CDPO) has additional charge of the DCPU, lack of operational autonomy for the DCPU, and subordination of its functions to the office of the CDPO, engenders delays in key decision-making contexts such as disbursement of compensation and other financial matters. Ultimately, such functioning can severely impede the DCPU's ability to respond to vulnerable children in a timely manner. It is, therefore, recommended that administrative superintendence of the DCPU be separated from the office of the CDPO, so as to ensure effective and timely functioning of this stakeholder.

(e) Training and Capacity Building

Once the mandated programs and services are initiated and established across the state, with requisite appointments for staffing them, it would be critical to provide them with the requisite training, so as to build and strengthen their knowledge skills and capacities in child work. For instance, there is an imperative for DMHP and RBSK teams to receive standardized training on child & adolescent mental health issues, including signs and symptoms and management of child and adolescent mental health disorders, as per the Diagnostic Statistical Manual, so that they can use systematic assessment protocols and interventions (including preventive and curative interventions that incorporate life skills approaches) to assist children in communities and child care institutions; DEIC staff would require training to focus on knowledge and skills relating to different types of developmental disability, and related mental health (co)morbidities, protection risks in children with disability, developmental screening and use of psychological testing scales and requisite interventions for specific disabilities; and ICPS staff would require training on integrated approaches to child protection and mental health issues, to take cognizance of children's vulnerabilities, mental health and psychosocial needs (including child interviewing and systematic assessments of children's contextual needs), and also on child law issues tent, as relevant to placement issues, decision-making on rehabilitation of children, and application of child laws in the country. Thus, training and capacity building programs on child protection, mental health and law maybe adapted to fit the roles and responsibilities of various state level functionaries and service providers entrusted with children's health and well-being[18].

[18] SAMVAD has developed standardized training curriculums on integrated approaches to child protection, mental health and psychosocial care for child protection, education, law and mental health functionaries. These are already being used across the country in various states, as per the mandate of the Ministry of Women & Child Development, Government of India, to deliver standardized, technically accurate training on children's issues.

(f) Harnessing available expertise in child mental health from around the country

In order to further capacitation efforts, the secondary and tertiary mental health institutions in Arunachal Pradesh, such as the Tomo Riba Institute of Health and Medical Sciences (TRIMS) can be connected with NIMHANS and other tertiary centres in the region, such as the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur etc. Initiatives such as short transfers and postings may be explored between these institutions. Psychiatrists and Psychologists from tertiary centres may also be encouraged to undertake an observership in NIMHANS, to develop the skills and capacities of mental health professionals in child mental health and psychosocial care.

(g) Leveraging the knowledge and experience of Community Service Organisations Pan-India

As illegal adoptions and child labour/bonded labour are widely observable across the state, Community Service Organisations such as MV Foundation, may be requested to assist the Government of Arunachal Pradesh in ending non-formal education for these out-of-school-children, to provide culturally-reflexive bridge courses and facilitate age-appropriate learning eventually. One of the commonly discussed issues, by multiple stakeholders during this rapid assessment, is the enrolment of older children in anganwadis and lower primary classes, despite the method of instruction and learning materials remaining incongruent with the child's age and developmental level.

Following from the previous point, CSOs can provide much-needed technical expertise to non-governmental organisations, such as de-addiction centres in Arunachal Pradesh. It is worth noting that one of the de-addiction centres reported having received technical inputs and assistance from the reputable Kripa Foundation in Meghalaya.

However, such arrangements eventually depended on the concerned de-addiction centre, with wide disparities noted in the quality of de-addiction services provided across different rehabilitative institutions in the state. As a result, despite the burgeoning need for accessible de-addiction centres, the quality of services provided and technical approaches adopted has created cause for concern in the state, with some centres reportedly acting as hubs for further entrenchment of substance abuse and addiction. Therefore, it is recommended that the Government of Arunachal Pradesh consults with reputable CSOs such as the organisations mentioned above, in order to receive technical inputs, and advise on program management, in addition to monitoring/compliance initiatives such as audits and inspections of de-addiction centres, from a technical perspective.

(h) Ensuring mechanisms for accountability and monitoring

In regards to ensuring monitoring and compliance, it is strongly recommended that residential institutions housing children and adolescents (even partially) such as the De-addiction centres, be mandatorily registered in accordance with the provisions of the

Juvenile Justice Act, 2015 i.e., Section 41 (registration of child care institutions), and the Juvenile Justice Model Rules 2016 i.e., Rule 21 (manner of registration of child care institutions). While registration is a statutory obligation for all child care institutions, it is also imperative that these provisions are properly enforced, so as to bring about quality control in the provision of de-addiction services, and ensure that abusive institutions are not allowed to remain operational.

(i) Clarifying roles and responsibilities of village-level functionaries in child protection and psychosocial care

The Judicial Officers interviewed for this rapid assessment i.e., the Special Court Judge, and the Chief Judicial Magistrates, provided an overview of the issue of compounding of non-compoundable offences (including more serious criminal offences) at the village level. No First Information Report is registered in these instances, with the implication that special laws like the POCSO Act, are not properly implemented. When settlements are reached between the parties, in such cases, the child survivor's best interests are subordinated to larger community dynamics. Such evasions of accountability may also have long-term implications for the child and the perpetrator.

Therefore, while the Gaon Buras role play an exceedingly important role as traditional village heads, there is a requirement for greater clarity on the role of the Gaon Bura vis-à-vis key child-related functionaries such as the District Child Protection Unit and the Special Juvenile Police Unit. The possibility of developing coordination guidelines for role clarity, and division of responsibilities, may also be explored.

About SAMVAD

SAMVAD (Support, Advocacy & Mental health interventions for children in Vulnerable circumstances And Distress) is a National Initiative & Integrated Resource for Child Protection, Mental Health and Psychosocial Care established by the Ministry of Women & Child Development, Government of India. This initiative is located in the Dept. of Child & Adolescent Psychiatry, NIMHANS. With the aim of enhancing child and adolescent psychosocial well-being, through promotion of transdisciplinary and integrated approaches to mental health and protection, SAMVAD was established to extend its support and activities to all the states in the country. It comprises of a multi-disciplinary team of child care professionals, with expertise in training and capacity building, program and policy research pertaining to child mental health, protection, education and law.

SAMVAD has been mandated by the Mission Vatsalya Guidelines of the Ministry of Women & Child Development, Government of India *"to develop and increase counselling capacity as well as resource persons at the State/UT level, including Psychiatric counselling and mental health wellbeing of children in coordination with Support, Advocacy & Mental Health Interventions for Children in Vulnerable Circumstances And Distress (SAMVAD)- National Institute of Mental Health and Neurosciences (NIMHANS)."*

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