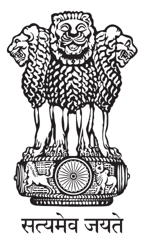
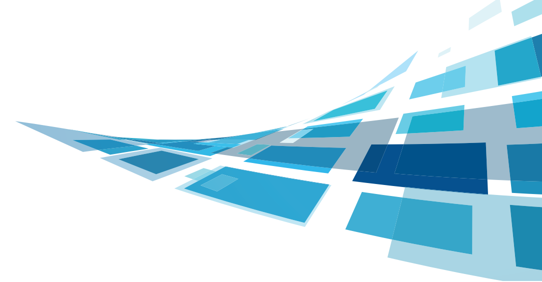


A Handbook on

COUNSELLING

For Training, and Skill Development of staff of Child Care Institutions (CCIs)

National Commisson For Protection of Child Rights (NCPCR)



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A Handbook on

COUNSELLING

For Training, and Skill Development of staff of
Child Care Institutions (CCIs)

National Commisson For
Protection of Child Rights (NCPCR)

स्तुति कक्कड़
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Chairperson

भारत सरकार
GOVERNMENT OF INDIA
राष्ट्रीय बाल अधिकार संरक्षण आयोग
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FOREWORD

Traditionally in India the responsibility of care and protection of children has been with families and communities. A strong knit patriarchal family that is meant to look after its children well has seldom had the realization that children are individuals with their own rights. Child and Adolescent mental health is a fundamental right of the children and the approach to ensure the fulfilment of these rights so far has always been more need based rather than rights based.

Many children around in our country grow up in Child Care Institutions instead of their own families or alternative ones. A very large number of children in the region live in institutions and many of them have been through grave life experiences-loss, abandonment, death of loved ones, violence, betrayal and neglect.

Children exposed to institutional care often suffer from structural neglect, which may include minimum physical resources, unfavourable and unstable staffing pattems and socialemotionally inadequate caregiver-child interactions. Children exposed to institutional care do not receive the type of nurturing and stimulating environment needed for normal growth and healthy psychological development. Physical conditions in many institutions in our country are compromised due to overcrowding, lack of space, inadequate sanitation and privacy.

There are limited child and adolescent mental health services in India. Mostly such services are restricted to urban areas. Access to mental health services for children with a mental, emotional or behavioural disorder is substandard, not provided early enough, in sufficient supply and accessible only to a fraction of children and adolescents.

We currently have tertiary care centres which attend to mental health related issues in hospital setting' They are therapeutic in nature and aim to treat and rehabilitate back to the society. However large gaps exist in the area of prevention, mental health promotion and early intervention programmes.

The importance of psychological well being in children and adolescent for their healthy emotional social physical cognitive and educational development is well recognized. There is now increasing evidence on the effectiveness of interventions to improve children's and adolescent's resilience promotes mental health and treats mental health problems and disorders.

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All children have mental health needs across different settings. It is very important to acknowledge that there is a strong need to promote positive mental health care for all children and adolescents, whether or not they are suffering from any mental health problem. There is a need to train manpower especially in child care Institutions (CCIs).

One of the main components of this Handbook is identification of mental health needs of children in CCIs and counseling to the children. In order to identify and understand the mental health needs of children in Child Care Institutions, it is important that the staff dealing with children should be qualified and trained. For their continuous development of professional skills, NCPCR with support of an Advisory Group comprised of experts of prominence in the field of Mental Health, from the concerned Ministries, various Govt institutions from pan India has contributed to the development of this Handbook.

This Handbook is intended to cover broadly the 'need' or rationale for developing such a Handbook and is intended primarily for the counselors and other staff (the stakeholders) who are working in various Child Care Institutions (CCIs) including Children homes and District Child Protection Units (DCPUs) addressing various concerns of children in difficult circumstances, and the process with which it will be applicable.

The Commission is grateful to the Members of the Advisory Group, who contributed their time and expertise without which it would have not been possible to develop this document.

I am extremely happy to state that it would not have been possible to develop this Handbook by the Commission without the help of Advisory Group Members and contribution made by Ms. Rupa Kapoor, Member, NCPCR and her team.

I am sure that this Handbook will prove to be useful to the CCI staff and will supplement their knowledge base when them in dealing with children living in CCIs.

Stuti Kacker

Disclaimer

This Handbook for has been developed to provide information about child rights, legislatives and basics of counselling. This handbook is intended to cover broadly the 'need' or rationale for developing the handbook, primarily for the counsellors and other staff (the stakeholders) who are working in various Child Care Institutions (CCIs) including Children homes and District Child Protection Units (DCPUs) addressing various concerns of children in difficult circumstances, and the process with which it will be applicable.

One of the main components of this Handbook is to identify psychological issues in children living in Child Care Institutions that require counselling.

This Handbook is recommended for use by counsellors and staff in all the Child Care Institutions of the country after getting training. It needs to be understood that there might be circumstances that require professional experience and technical knowledge of psychotherapies and it is advised that the counsellors develop their own locally available referral networks for their assistance.

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Abbreviations and Acronyms

CCI	-	Child Care Institution
NCPCR	-	National Commission for Protection of Child Rights
IHBAS	-	Institute of Human Behaviour and Allied Sciences
CPD	-	Continuing Professional Development
NIPCCD	-	National Institute of Public Cooperation and Child Development
AIIMS	-	All India Institute of Medical Sciences
NDDTC	-	National Drug Dependence and Treatment Centre
PGIMER	-	Post Graduate Institute of Medical Education & Research
MOH & FW	-	Ministry of Health & Family Welfare
GOI	-	Government of India
CIP	-	Central Institute of Psychiatry
CSA	-	Child Sexual Abuse
NGO	-	Non Government Organization
JJ Act	-	The Juvenile Justice (Care and Protection of Children) Act
POCSO	-	The Protection of Children from Sexual Offences
UNICEF	-	United Nations Children's Emergency Fund
WHO	-	World Health Organization

Acknowledgements

The preparation of this Handbook has been an intense learning experience that enables us to go into great depth into the child rights from a mental health perspective. National Commission for Protection of Child Rights (NCPCR), acknowledges the support it received from the members of the Advisory Group set up by the Commission. This Handbook would not have been possible without the leadership of Ms. Stuti Kacker, Hon'ble Chairperson of NCPCR. NCPCR is grateful to the members of the Advisory group constituted for promotion of positive mental health of children in CCIs for their valuable inputs. Our special thanks to Prof (Dr) Nimesh Desai and his team members Dr. Deepak Kumar, Dr. Amit Khanna, Dr. Jahanara from IHBAS for their valuable contribution in giving a final shape to this document.

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Rupa Kapoor
Member, NCPCR

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Section 1:
Introduction to the Handbook

Overview of Mental Health of children in Child Care Institutions

Across the Indian states, there are around 5000 Child Care Institutions both registered and unregistered that are involved in the care and protection of approximately 1,50,000 children and adolescents at any given time; who as a result of their adverse psychosocial circumstances are residing in these CCI's. A large number of these CCI's have a high turnover and most of these children for obvious reasons require psychosocial intervention. Psychosocial care with a preventive and promotive inclination is of utmost importance for these children who are in need of care and protection.

The children and adolescents living in the CCI's, most of whom come from low socio-economic families with fractured family ties require intensive psychosocial intervention in the absence of any significant family member or presence of reluctantly involved parent or guardian. Children and Adolescents living in CCI's suffer from a spectrum of mental health issues ranging from transient emotional disturbances to more severe psychological/psychiatric problems such as substance use disorders, Conduct disorders and varying grades of suicidality in the background of common and severe mental illnesses.

Institutionalized children and adolescents have higher rates of moderate to severe forms of psychological /psychiatric disorders making them a vulnerable group. With the changing socio-political scenario in India and across the globe with reforms in laws that govern the care and protection of children and adolescents; it is imperative that as a nation we focus on the needs of these children living in difficult circumstances. Perhaps, the single most important means to achieve this goal would be to focus on capacity and skill building of the counsellors and support staff.

According to the NCPCR inspection report of 2012 submitted to the High Court of Delhi (WP No 694/2012), more than 50% of the children living in Child care homes in Delhi had emotional and behavioral problems with 10-15% children having a diagnosable psychiatric syndrome, whereas for the majority the mental health needs were largely unmet. Further, the major mental health problems were Mild Mental Retardation, Depressive Disorder, Seizure Disorders, Conduct Disorder, Slow Learning and speech defects. Most researches report a similar and grim mental health scenario in institutionalized setups for children and adolescents across developing countries and hence there is urgent need to address the mental health needs of these children through multi-disciplinary teams and mental health networking and delivering a spectrum of curative, rehabilitative and preventive treatment interventions for this vulnerable group of children.

In an ideal scenario, the counsellor can not only implement individual components of the spectrum of care but also promptly and effectively implement a management plan for the holistic development of the child, but a realistic approach needs to be adopted wherein the counsellors can identify and diagnose various psychological/ psychiatric disorders in the overall realm of preventive care.

In compliance with the direction of the Hon'ble High Court order W.P.(crl) 694 of 2012 dated 01-06-2012, a team of Mental Health Professionals from IHBAS were taken on board by NCPCR for a time bound manner inspection of both Govt. and NGO run Children Homes in the State of Delhi. The professional expertise of IHBAS was primarily sought for the mental health assessment of the children in these homes along with other mental health and human rights agencies. Some of the significant findings of the final report of inspection of Children Homes submitted to the Hon'ble High Court were as follows:

1. The major mental health problems were Mild Mental Retardation, Depressive Disorder, Seizure Disorders, Conduct Disorder, Slow Learning and speech defects.
2. Lack of supervision in self-help skills including cleaning, eating or drinking.
3. Lack of adequate sensitivity, skills and empathy in majority of care takers.
4. No provision for psychosocial rehabilitation like – skills training, occupational training and vocational training.
5. No record of baseline evaluation of psycho social functioning.
6. No attempt of assessing and recording individual child's special abilities.
7. No proper and periodical behavioural assessment and its recording.
8. Problem behaviours such as restlessness, bed-wetting, stealing, lying, anger outbursts, bullying, verbal and physical aggression, and indecent behaviour were commonly reported in all homes.
9. About 10%-40% of the children were in need of some form of psychological intervention.
10. Corporal punishment and verbal abuses

The various modules in the Handbook for Counsellors have been prepared with the hope that the Child care institutions across India not only possess the requisite human resources with basic and necessary skills to manage children in distress; but also with the expectation that the Handbook and the subsequent training module that will follow will provide a platform for the Counsellors working in Child care institutions for continued professional development.

Background

From the observations and inferences drawn from the inspection of Child care homes (see inset) and the three series Continuous Professional Development workshop with Counsellors working in CCI's (For details refer to section 13 (a) annexure), it was felt that there was a **wide gap between the need and availability** of psycho social care structures in the children homes. While some homes had a robust mental health facility attached to it or in collaboration with a mental health institution, a majority of them were still trying to cope with the lack of skilled and trained manpower.

With this as the backdrop the National Commission for Protection of Child Rights (NCPCR) had identified specific concerns of mental health well being of Children in CCI's which needed to be addressed on a priority basis.

The issues of utmost concern were:

- Developing skills of care givers (counsellors, management staff) to identify, manage and rehabilitate and restore children with emotional and behavioural difficulties.
- To develop a preventive plan to ensure positive mental health of inmates which would include life skills training, engagement in recreational activities, and formation of peer groups.
- Training of counsellors in screening children who are victims of trauma, neglect, abuse, and specific psychological disorder, their care and rehabilitation.
- Training of counsellors in planning interventions for psycho social care.
- Imparting skills to staff and counsellors to manage their own concerns arising out of a high stress situation of the CCI's

Section 2:
Purpose and Scope of the Handbook

Purpose of the Handbook

From the observations and inferences drawn from the inspection visits of Child homes in the last few years by various mental health and human rights organizations, a wide gap between the need and availability of psycho social care structures in these children homes has been perceived.

This handbook which has been conceptually derived from the information shared and received from the CPD workshop (section 13 (a) annexure) is intended to cover broadly the 'need' or rationale for developing the handbook, primarily for the counsellors and other staff (the stakeholders) who are working in various Child Care Institutions (CCIs) including Children homes and District Child Protection Units (DCPUs) addressing various concerns of children in difficult circumstances, and the process with which it will be applicable. It is intended to comprise four sections, each highlighting both the theoretical, practical and skill building techniques pertinent to the practice of the counsellors in these settings. The handbook can be useful with or without training for the professionals, however would be more effective, if complemented with training.

Scope of the Handbook

The staff of Child Care Institution mainly Superintendant, Case worker and Counsellor play a primary role in running the institution effectively. Therefore it is important that the staff working in CCIs should be well equipped with child rights issues, basics of essentials of counselling, how to deal with children in difficult circumstances, child protection issues etc. It is the hope of the Commission that the topics covered in the Handbook will prove to be especially useful to the Case worker/ counsellor. The experienced staff of CCI may find new ideas and helpful suggestions in this handbook.

The Handbook has been prepared keeping in view the roles and responsibilities of Superintendents, Counsellor, CWO, Paramedical staff working in CCIs.

Section 3:

Child Rights: an overview

The Indian constitution accords rights to children as citizen of the country and in keeping with their special status the State has even enacted special laws. The Constitution promulgated in 1950, encompasses most rights included in the UN Convention on the Rights of the Child as fundamental rights and Directive Principle of State Policy. The Directive Principles of State Policy articulate social and economic rights that have been declared to be fundamental in the governance of the country and the duty of the state to apply in making laws (Article 37). These directives have enable the judiciary to give some landmark judgments promoting children's rights, leading to Constitutional amendments as in the case of the 86th Amendment to the Constitution that made Right to Education fundamental right.

Constitutional Guarantees that are meant specifically for children include;

- Right to free and compulsory elementary education for all children in the 6-14 age group (Article 21A)
- Right to be protected from any hazardous employment till the age of 14 years (Article 24A)
- Right to be protected from being used and forced by economic necessity to enter occupations unsuited to their age of strength (Article 39(e))
- Right to equal opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and guaranteed protection of childhood and youth against exploitation and against moral and material abandonment (Article 39(f))
- Right to early childhood care and education to all children until they complete the age of six years (Article 45)

United Nations Convention on the Rights of the Child

The Convention on the Rights of the child is the first legally binding international instrument to incorporate the full range of human rights-civil, cultural, economic, political and social rights. This treaty exclusively focusing on children promotes and protects their rights. It reaffirms the fact that children, because of their vulnerability, need special care and protection, and it places special emphasis on the primary caring and protective responsibility of the family. It also reaffirms the need for legal and other protection measures for the child before and after birth, the importance of respect for the cultural values of the child's community and the vital role of international cooperation in securing children's rights.

The Convention sets out these rights in 54 articles and two optional protocols. The cluster of rights of children covered by Convention are (1) Right to survival (2) Right to Development (3) Right to Protection (4) Right to Participation.

India has incorporated the principles of this treaty in its recent laws and policies which include the Commission for Protection of Child Rights (CPCR) Act, 2005, Juvenile Justice (Care and Protection of Children) Act, 2015, Protection of Children from Sexual Offences (POCSO) Act, 2012,

3.1 Role of Child Care Institutions under Juvenile Justice (Care and Protection of Children) Act 2015.

An estimated 200,000 children in the country are in about 5,000 Observation and Children's Homes (Child care institution) and the numbers are growing.

According to JJA Rule, 2016, minimum facilities of mental health needs of children in Child care institution (CCI) should be as follows:

- The environment in an institution shall be free from abuse, allowing children to cope with their situation and regain confidence.
- All persons involved in taking care of the children in an institution shall participate in facilitating an enabling environment and work in collaboration with the therapists as needed.
- A mental health record of every juvenile or child shall be maintained by the concerned institutions.
- Both milieu based interventions that is creating an enabling environment for children and individual therapy are must for every child and shall be provided in all institutions.
- Every institution shall have the services of trained counsellors or collaboration with external agencies such as child guidance centres, psychology and psychiatric departments or similar government and non-governmental agencies, for specialized and regular individual therapy for every juvenile or child in the institution.
- A mental health care plan shall be developed for every juvenile or child by the child welfare officers in consultation with mental health experts associated with the institution and integrated into the individual care plan of the concerned juvenile or child.
- The recommendations of mental health experts shall be maintained in every case file and integrated into the care plan for every child.
- No juvenile or child shall be administered medication for mental health problems without a psychological evaluation and diagnosis by appropriately trained mental health professionals.

  Medicines should be administered to the children only by trained medical staff and not by any other staff of the Home.

- **Key Provisions under the Juvenile Justice (Care and Protection of Children) Act 2015;**

Mental Health

1. A mental health record of every child shall be maintained by the concerned institutions.
2. Both milieu based interventions creating an enabling environment for children and individual therapy are must for every child and shall be provided in all institutions.

   Explanation: For the Milieu based intervention is a process of recovery, which starts through providing an enabling culture and environment in an institution so as to ensure that each child's abilities are discovered and they have choices and right to take to decisions regarding their life and thus, they develop and identify beyond their negative experiences and such intervention has a critical emotional impact on the child.
3. The environment in an institution shall be free from abuse, allowing juveniles or children to cope with their situation and regain confidence.
4. All persons involved in taking care of children in an institution shall participate in facilitating an enabling environment and work in collaboration with the therapists.
5. Individual therapy is a specialized process and each institution shall make provisions for it as a critical mental health intervention.
6. Every institution shall have the services of trained counsellors or collaboration with external agencies such as child guidance centres, psychology and psychiatric departments or similar Government and non-governmental agencies, for specialized and regular individual therapy for every juvenile or child in the institution.
7. A mental health care plan shall be developed for every child by the child welfare officers in consultation with mental health experts associated with the institution and integrated into the individual care plan of the concerned juvenile or child.
8. The recommendations of mental health experts shall be maintained in every case file and integrated into the care plan for every child.
9. All care plans shall be produced before the Management Committee every month and before the Child Welfare Committee every quarter.
10. No juvenile or child shall be administered medication for mental health problems without a psychological evaluation and diagnosis by appropriately trained mental health professionals.

a When a child placed under the care of an Observation Home or Special Home or Children's Home or fit person or a fit facility institution under the provisions of the Act, is found to be suffering from a disease or physical or mental health problems requiring prolonged medical treatment, or is found addicted to a narcotic drug or psychotropic substance, the child may be sent by an order of the competent authority to an appropriate place for such period as may be certified by medical officer to be necessary for proper treatment of the child or for the remainder of the term for which he has to stay.

b When the child is cured of the disease or physical or mental health problems, the competent authority may, if the child is still liable to stay, order the child to be placed back in the care of fit person or fit facility institution from where the child was removed for treatment and if the juvenile or the child is no longer liable to be kept under the care of fit person or institution, the competent authority may order him to be discharged.

c The order of restoration of a child suffering from an infectious or contagious disease to his parents or guardian shall be based on the principle of best interest of the child, keeping in mind the risk of stigmatization and discrimination and discontinuation of treatment.

d Where there is no organization either within the jurisdiction of the competent authority, or nearby District or State for care and protection of children suffering from serious psychiatric or physical disorder and infection, as required under Section 93 of the Act, necessary organization shall be set up by the State Government at such places, as it may deem fit to cater to the special needs of such children.

Roles and Responsibilities of Superintendent, Counsellor, Probation Officer/CWO/Case Worker, House Mother/House Father & Para Medical Staff.

As per the Juvenile Justice (Care and Protection of Children) rules 2016; the suggested staffing pattern for an institution with a capacity of 100 children may be as below;

S.No	Personnel/Staff	Number
1.	Person-in In charge (Superintendant)	1
2.	Probation Officer/Child Welfare Officer/Case Workers(NGOs) A Child Welfare Officer may be designated as Rehabilitation-cum-Placement Officer	3
3.	Counsellor/Psychologist/Mental Health Expert	2
4.	House Mother/House Father	4
5.	Educator/Tutor	2 (Part time)
6.	Medical Officer (Physician)	1 (on call)
7.	Para Medical staff/Staff Nurse/Nursing Orderly	1
8.	Store keeper cum Accountant	1
9.	Art & Craft & Activity teacher	1 (Part time)
10.	Pt Instructor cum-Yoga Trainer	1 (Part time)
11.	Cook	2
12.	Helper	2
13.	House Keeping	2
14.	Driver	1
15.	Gardner	1 (Part time)

3.2 Duties of the Person-in-charge (Superintendent) of a Child Care Institution-(u/s 61 of JJ Rules 2016)

1. The primary responsibility of the Person-in-charge is of maintaining the Child Care Institution and of providing care and protection to the children.

2 The Person-in-Charge shall stay within the premises to be readily available as and when required by the children or the staff and in case where an accommodation is not available in the premises, he shall stay at a place in close proximity to the Child Care Institution till such time such accommodation is made available within the premises of the Child Care Institution.

3 The general duties and functions of the Person-in-charge shall include, to:

   i. ensure compliance with the provisions of the Act and the rules and orders made there under;

   ii. ensure compliance with the orders of the Board or the Committee or the Children's Court;

   iii. provide homely and enabling atmosphere of love, affection, care and concern for children;

   iv. strive for the development and welfare of the children;

   v. supervise and monitor discipline and well-being of the children and the staff;

   vi. plan, implement and coordinate all activities, programmes and operations, including training and treatment programmes or correctional activities as the case may be;

   vii. segregate a child suffering from contagious or infectious diseases on the advice of the medical officer of the institution;

   viii. segregate a child wherever required; ensure observance and follow-up of daily routine;

   ix. organize local and national festivals in the home;

   x. organize trips or excursions or picnics for children;

   xi. send a list of children in Form 40 in the Child Care Institution to the Board or the Committee, as the case may be, every week and bring to the notice of the Board or the Committee, if no date is given for the production of any child before the Board or the Committee;

   xii. allocate duties to personnel;

   xiii. maintain standards of care in the Child Care Institution;

xiv. ensure proper storage and inspection of food stuffs as well as food served;

xv. maintain the buildings and premises of the Child Care Institution;

xvi. maintain proper hygiene in the home;

xvii. provide accident and fire preventive measures, disaster management within the premises;

xviii. make stand-by arrangements for water storage, power back-up, inverters, generators;

xix. ensure careful handling of equipment;

xx. employ appropriate security measures;

xxi. conduct periodical inspections, including daily inspection and rounds of the Child Care Institutions;

xxii. take prompt action to meet emergencies;

xxiii. ensure prompt, firm and considerate handling of all disciplinary matters;

xxiv. ensure proper and timely maintenance of the case files;

xxv. maintain all records and registers required under the Act and these rules;

xxvi. prepare the budget and maintain control over financial matters;

xxvii. organize the meetings of the Management Committee set-up under rule 39 of these rules and provide necessary support;

xxviii. ensure monthly verification of the all records and registers by the Management Committee set-up under rule 39 of the rules;

xxix. liaise, co-ordinate and co-operate with the State Child Protection Society and the District Child Protection Unit as and when required;

xxx. co-ordinate with the legal cum probation officer in the District Child Protection Unit or the District or State Legal Services Authority to ensure that every child is legally represented and provided free legal aid and other necessary support.

xxxi. ensure the production of the child before the Board or the Committee or the Children's Court on the date of such production and to ensure that the dates for the said purpose are recorded.

4 The Person-in-charge shall inspect the Child Care Institution as often as possible but not less than twice a day. He shall make a record of the timings of his inspection and also note his observations in a separate book maintained for the purpose, especially with regard to:

i. maintenance of hygiene and sanitation,

ii. maintenance of order,

iii. quality and quantity of food,

iv. hygienic maintenance of food articles and other supplies,

v. hygiene in the medical center and provisions for medical care,

vi. behaviour of the children and staff,

vii. security arrangements and

viii. maintenance of files, registers and books.

5 Anything amiss that comes to the notice of the Person-in-charge shall be enquired into and set right and the date, time and nature of the action taken shall be noted in the book.

6 Where a problem of urgent nature has not been resolved within two working days, the Board or the Committee or the District Child Protection Unit shall be informed.

7 In case the Person-in-charge is on leave or otherwise not available, the duties of the Person-in-charge shall be performed by the Child Welfare Officer as designated by the Person-in-charge.

Duties of the Child Welfare Officer (CWO) /Case Worker. (Section 62 of the Act)

1. Every child welfare officer/case worker in the Child Care Institution shall carry out all directions given by the Board or the Committee or the Children's Court.

2. The child welfare officer/ case worker shall establish linkages with voluntary workers and organizations to facilitate rehabilitation and social re-integration of the children and to ensure the necessary follow-up.

3. The child welfare officer/ case worker available in the Child Care Institution at the time of receiving a child shall interact with the child received with a view to put the child at ease and befriend him and shall supervise the 'receiving of the child'.

4. On receipt of information from the police or Child Welfare Police Officer or on arrival of a child in the Child Care Institution, the child welfare officer/ case worker shall forthwith conduct social investigation of the child through personal interviews with the child and his family members, social agencies and other sources; inquire into antecedents and family history of the child and collect such other material as may be relevant, and submit the Social Investigation Report to the Board or the Committee or the Children's Court, within fifteen days.

5. All the children in the Child Care Institution shall be assigned a child welfare officer/ case worker and such child welfare officer/ case worker shall be responsible qua the child assigned to him in all respects viz. care and development of the child, reporting to the Board or the Committee or the Children's Court about the child or maintaining the child's record in the Child Care Institution.

6. Upon assignment of the child to a child welfare officer/ case worker, the Child Welfare Officer/Case Worker shall:

   i. Prepare the case file of the child;

   ii. Maintain the Protective Custody Card;

   iii. Prepare and maintain the medical record of the child and ensure that the treatment of the child is not interrupted or neglected;

   iv. Meet the child every day to ensure his safety, welfare and development; assist the child to adjust to the life in the Child Care Institution. A newly received child shall be met more often than once a day;

   v. Gather information about the child within the initial five days to ascertain the child's education, vocational status and aptitude and emotional status;

   vi. Have the necessary medical or mental tests, assessments and examinations of the child conducted;

   vii. Study the reports and prepare in consultation with the child and his family members, an individual care plan for the child in Form 7 for the period pending inquiry, to be placed in the case file of the child. The child welfare officer/case worker may consult the counsellor, psychologists or such other person as he deems fit in this regard;

   viii. In keeping with the individual care plan, a daily routine shall be developed for the child and explained to him;

   ix. Ensure that the child adheres to the routine so developed and take timely reports form the caregivers in this respect;

   x. Review periodically the implementation and effectiveness of the individual care plan and if necessary, suitably modify the individual care plan in Form 7 and/or the routine of the child with the approval of the Management Committee;

   xi. Resolve the problems of the child and deal compassionately with their difficulties in life in the Home;

   xii. Participate in the orientation, monitoring, education, vocational and rehabilitation programmes in respect of the child and attend the parent teacher meetings in schools in respect of children assigned to them;

   xiii. Attend proceedings of the Board or the Committee or the Children's Courts and furnish all information and file all reports that may be called for;

xiv. On receiving the copy of the order of declaration of age, to make the necessary changes in the record as regards the age of the child if any change is required and to place the copy of the said order in the case file of the child;

xv. Participate in the pre-release programme and help the child to establish contact which can provide emotional and social support to the child after the release;

xvi. Maintain contact with the children after their release and extend help and guidance to them;

xvii. Visit regularly the residence of the child under their supervision and also places of employment or school attended by such child and submit fortnightly reports or as otherwise directed;

xviii. Accompany the child wherever possible from the Board or the Committee or the Children's Court to Child Care Institution as the case may be;

xix. Maintain record of the next date of production of the child before the Board or the Committee or the Children's Court or for medical treatment and ensure the production of the child before the Board or the Committee or the Children's Court or for medical treatment on the said date;

xx. Maintain the registers as may be specified from time to time;

xxi. Any other duty assigned by the Person-in-charge of the Child Care Institution.

7. The child welfare officer/case worker who has been assigned the duty of verifying the daily cleaning shall do so twice a day, one after the morning cleaning and the other after the evening cleaning. The child welfare officer/case worker shall make a note of the same in the House-keeping register.

8. The child welfare officer/case worker who has been assigned the duty of verifying the daily cooking shall make a note of the same in the Meals register, in respect of every meal.

Duties of the House Mother/Father, Caregiver. (Section 63 of the Act)

1 Every house father/mother or caregiver shall abide by the directions of the Person-in-charge.

2 The general duties, functions and responsibilities of a house father, house mother and caregiver shall be as follows:

i. handle every child in the Child Care Institution with love and affection;

ii. take proper care of the child and ensure his welfare;

iii. provide each child upon his reception with all the necessary supplies like clothing, toiletries etc.;

iv. replenish the provisions/supplies as per scale and need of the child;

v. maintain discipline among the children;

vi. ensure that the children maintain their personal cleanliness and hygiene;

vii. look after maintenance, sanitation and maintain hygienic surroundings;

viii. implement the daily routine of every child in an effective manner and ensure the participation of the children;

ix. look after safety and security arrangements in the Child Care Institution;

x. escort the children whenever they go out of the Child Care Institution for purposes other than production before the Board or the Committee or the Children's Court;

xi. report to the Person-in-charge and to the Child Welfare Officer about the child assigned to the Child Welfare Officer;

xii. maintain the registers, relevant to their duties; and

xiii. any other duty as may be assigned by the Person-in-charge of the Child Care Institution

Duties of a Probation Officer

1. On receipt of information from the Police or Child Welfare Police Officer under clause (ii) of sub-section (1) of section 13 of the Act, without waiting for any formal order from the Board, the probation officer shall inquire into the circumstances of the child as may have bearing on the inquiry by the Board and submit a social investigation report in Form 6 to the Board.

2. The social investigation report should provide for risk assessment, including aggravating and mitigating factors highlighting the circumstances which induced vulnerability such as traffickers or abusers being in the neighbourhood, adult gangs, drug users, accessibility to weapons and drugs, exposure to age inappropriate behaviours, information and material.

3. The probation officer shall carry out the directions given by the Board and shall have the following duties, functions and responsibilities:

    i. To conduct social investigation of the child in Form 6;

    ii. To attend the proceedings of the Board and the Children's Court and to submit reports as and when required;

    iii. To clarify the problems of the child and deal with their difficulties in institutional life;

iv. To participate in the orientation, monitoring, education, vocational and rehabilitation programmes;

v. To establish co-operation and understanding between the child and the Person- in-charge;

vi. To assist the child to develop contacts with family and also provide assistance to family members;

vii. To participate in the pre-release programme and help the child to establish contacts which could provide emotional and social support to the child after release;

viii. To establish linkages with probation officers in other districts and States for obtaining social investigation report, supervision and follow-up.

ix. To establish linkages with voluntary workers and organizations to facilitate rehabilitation and social reintegration of children and to ensure the necessary follow-up;

x. Regular post release follow-up of the child extending help and guidance, enabling and facilitating their return to social mainstreaming;

xi. To prepare the individual care plan and post release plan for the child;

xii. To supervise children placed on probation as per the individual care plan;

iv. Facilitate and coordinate with agencies, individuals, corporates, recognised non-governmental organizations and other funding agencies to set up vocational training units / workshops in Child Care Institutions as per age, aptitude, interest and ability;

v. Mobilise voluntary vocational instructors who render services to carry out the training sessions in the Child Care Institutions;

vi. Inculcate entrepreneurial skills and facilitate financial and marketing support for self-employment;

vii. Prepare rehabilitation plans keeping in mind the nature of the offence and the personality traits of the child;

viii. Maintain the Rehabilitation Card in Form 14 and monitor the progress made by the child on regular basis and submit such progress reports to the Management Committee;

ix. Facilitate the child to get certificates on completion of the education or vocational or training courses;

x. Make efforts for ensuring effective placement of each eligible and trained child;

xi. Organise workshops on Rehabilitation programmes and services available under Central and State Government Schemes, spread awareness and facilitate access to such schemes and services;

xii. Organise workshops on personality development, life skill development, coping skills and stress management and other soft skills to encourage the child to become a productive and responsible citizen; and

xiii. Conduct regular visits to the agencies where the children are placed to monitor their progress and provide any other assistance as may be required.

3.3 Salient Features of the Protection of Children from Sexual Offences (POCSO) Act 2012

The Protection of Children from Sexual Offences (POCSO) Act, 2012 came into force with effect from 14th November, 2012 along with the Rules framed there under. The Act is a comprehensive law to provide for the protection of children from the offences of sexual assault, sexual harassment and pornography, while safeguarding the interest of the child at every stage of the judicial process by incorporating child -friendly mechanism for reporting, recording of evidence, investigation and speedy trail of offences through designated Special Courts.

This Act defines a chid as any person below eighteen year of age and is gender neutral. The Act identifies six types of Sexual Offences namely;

I. Penetrative Sexual Assault (Sec 3)

II. Aggravated Penetrative Sexual Assault (Sec 5)

III. Sexual Assault (Sec 7)

IV. Aggravated Sexual Assault (Sec9)

V. Sexual Harassment (Sec 11)

VI. Using child for pornographic purposes (Sec 13)

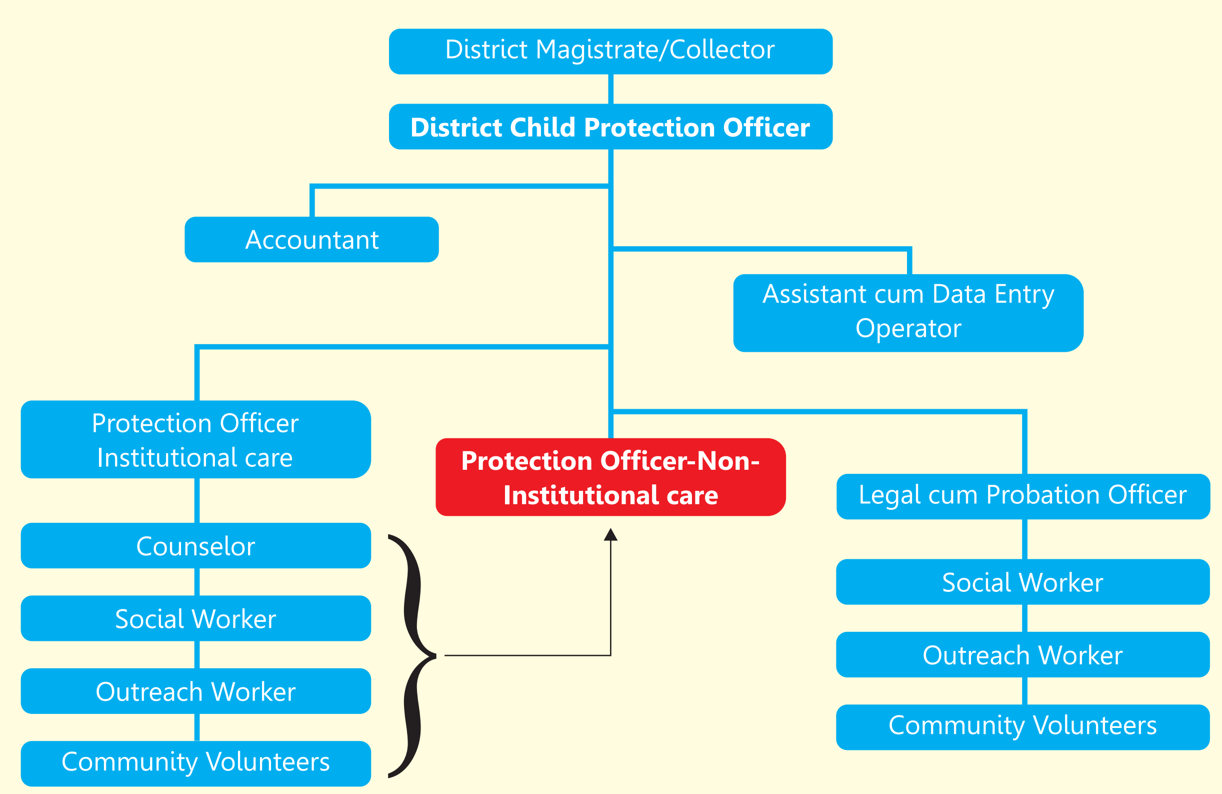
The Act deems a sexual assault to be under "aggravated" under certain circumstances such as when the abused child is mentally ill or when the abuse is committed by a person in a position of trust or authority vis-a-vis the child, a family member, Police officer, teacher or doctor. People who traffic children for sexual purposes are also punishable under the provisions relating to abetment in the Act. The Act prescribes stringent punishment, graded as per the gravity o the offences, with a maximum term of rigorous imprisonment for life, and fine.

The Act also provides for mandatory reporting under section 19(1) or sec 20 of the Act and provides punishment in case of none reporting of offence under this Act. This casts a legal

duty upon a person who has knowledge that a child has been sexually abused to report the offence, if he fails to do so, he/she may be punished with six months imprisonment and/or fine.

Thus staff of Child Care Institutions plays a significant role in identifying signs of sexual abuse against a child and in reporting and preventing a child from sexual offences.

2.2 Structure of District Child Protection Unit (DCPU)



Section 4:

Identification of Mental Health needs of Children in CCI's

Children and young people with mental health problems represent some of the country's most vulnerable people. Their mental health and wellbeing is of paramount importance to the future health, wellbeing and prosperity of our society. Emotional and behavioural problems in early life are predictors of poor outcomes in later years. According to a study conducted in Bangalore among children in general population, as much as 12% of the children aged 4-16 years had a prevalence of a psychiatric disorder. Enuresis, specific phobia, hyperkinetic disorders, stuttering and oppositional defiant disorder were the most frequent diagnoses.

Often children face a variety of traumatic conditions before presenting to the Child Care Institutions (CCIs), such as poverty, abandonment, child labour, physical or sexual abuse, broken families, conflict with law, etc., which predisposes them to behavioural and emotional problems, both currently and in the long run. Hence, institutionalized children are expected to have an even higher prevalence of mental health problems.

Mental health problems have adverse outcomes for the children (academic impairments, socio-occupational impairments, physical health problems) as well as the society (loss of productivity, increased burden on health services, increased conflicts with law). Hence, early identification of their mental health needs is important to implement effective prevention and management strategies and reduce the impairments and disabilities.

The assessment of mental health needs depends upon the type of interventions being offered, i.e., primary, secondary or tertiary prevention. Ideally, all three should be undertaken at tandem in all Child care institutions as all children may be going through a different stage of development of a mental health problem. The following sections provide an overview of the various identification strategies:

I. Identification of risk factors

This is done before the symptoms of mental health problems appear. The aim is primary prevention, i.e., preventing the development of illness by modifying the risk factors. The institutionalized children often come from a variety of traumatic backgrounds and counsellors need to be aware of all such possibilities:

a. Poor, unemployed, illiterate parents

b. Death of parents or abandonment

c. Harsh or punitive parenting or marital disharmony among parents

d. Over-expectations or over-involvement of parents

e. Lack of intellectually stimulating environment

f. Lack of love, supervision and care

g. Lack of schooling or school dropouts

h. Child labour or begging

i. Unhygienic conditions or unsafe food and water

j. Physical or sexual abuse, violence

k. Teenage pregnancies

l. Homelessness

m. Tobacco, alcohol and other drug use in children or their parents

n. Poor nutritional status or hunger

o. Displacement due to conflicts or natural disasters

p. Physical or mental disabilities or developmental delays

q. Children in conflict with law

Counsellors at CCIs must enquire about all these risk factors in all the children, preferably as early as possible, so that appropriate interventions could be undertaken. Children may initially be guarded about their traumatic experiences due to stigma, lack of trust, fear of incarceration. Counsellors should try to develop a rapport with each child even if it seems difficult to communicate with him or her. This may be enabled by developing a friendly atmosphere of non-judgmental acceptance. Counsellors should provide secure surroundings and unconditional love, and try to be children's playmates.

II. Identification of signs and symptoms

This is done after the mental illness or problems start appearing. The aim is early identification of the problems and to provide appropriate treatment, i.e., secondary prevention. The counsellors should assess for the following signs and symptoms in all children which may indicate a mental health problem:

1. Attention deficit and hyperactivity problems:

a. Poor attention

b. Distractibility

c. Restlessness

d. Impulsivity

2. Conduct problems:

a. Stubbornness

b. Disobedience

c. Quarrelsome behaviour

d. Aggressiveness

e. Temper tantrums
f. Truancy (running away from school or CCI)
g. Lying and stealing

3. **Learning difficulties**
   a. School refusal
   b. Poor school performance
   c. Reading, writing or arithmetic difficulty
   d. Forgetfulness or poor memory

4. **Emotional problems**
   a. Withdrawn behaviour
   b. Reduced interaction or refusal to play
   c. Appears worried or anxious
   d. Shy or clingy
   e. Cries easily
   f. Irritable
   g. Breath holding spells, fainting spells or fits
   h. Stuttering or stammering
   i. Enuresis (bed-wetting) or Encopresis (passing stools in clothes)
   j. Reduced or increased sleep or appetite
   k. Self-harm behaviour

5. **Somatic problems**
   a. Dizziness
   b. Aches and pains
   6. Psychotic problems
   a. Hallucinations (seeing or hearing things which do not exist)
   b. Delusions (believing in false ideas)
   c. Talking or laughing to self

It should be kept in mind that these signs and symptoms may also be present in normal children occasionally. Only those children who have such symptoms repeatedly over prolonged periods and multiple situations should be suspected to have mental problems. Such an assessment should be done for all the children at the time of entry in the CCI and then periodically subsequently. Counsellors may use screening or diagnostic instruments such as Diagnostic Psychopathology Check-List (DPCL), Mini International Neuropsychiatric Interview for Kids (MINI-Kid), etc., which are quick and easy to use with little amount of training required. In case a mental problem is suspected, a Psychiatrist or Clinical Psychologist should be consulted for the same.

III. Identification of disabilities caused by mental health problems

This is done in children who already have diagnosed mental illness. The aim is to reduce the disability caused by the mental disorders. The following impairments should be assessed by the counsellors:

a. Academic dysfunction, i.e., poor performance at school or inability to learn

b. Social dysfunction, i.e., inability to make friends or mix up with peers, poor level of interaction, inappropriate behaviour, stigma

c. Familial dysfunction, i.e., inability to adjust with family members when restored to them

d. Legal problems, i.e., behaviour which is in conflict with law or potentially hazardous to others

e. Occupational dysfunction, i.e., inability to acquire or sustain a job, inability to meet the demands of workplace. May be seen in older adolescents.

Appropriate rehabilitation and counselling measures need to be undertaken in consultation with a mental health expert in case any such disability is found to minimize its impact.

IV. Protective factors or strengths

Apart from identification of risk factors, symptoms and disabilities, a mental health needs assessment should also include identification of protective factors or strengths. Such factors help to design individualized therapies or plans for each child so that their strengths could be maximized to reduce the impact of the mental health problems. The protective factors which should be identified by the counsellors include:

a. A helpful elder willing to take responsibility of the child

b. A helpful peer group

c. A constructive interest

d. A special talent, such as sports, crafts, music or dance, etc.

CASE STUDIES

A. **Sumit**, an 11 year old boy was a beggar at a traffic signal. He was rescued by a NGO and brought to the CCI by CWC. Upon arrival, the counsellor of the home interacted with Sumit. It was found that his mother was also a beggar and had died due to an illness one year back. He had never known his father and was fending for himself since his mother's demise. He used to sleep at the footpath. He never went to school and had only a pair of clothes donated by a passerby. He had been bullied and beaten up multiple times by older beggars and vendors at the traffic signal who snatched his money. Many times he had to remain hungry for few days and sometimes resort to eating from food which had been thrown in garbage. Initially he was reluctant to talk to the counsellors and tried to run away from the CCI suspecting punishment or captivity. But, as the counsellor was able to offer unconditional love and a secure environment, he gradually started trusting him. He further revealed that he had to steal sometimes to be able to eat, and had used bidis occasionally offered by other beggars.

In this case study, the counsellor could identify multiple risk factors for the development of mental health problems, including begging, parents' death, homelessness, hunger, physical abuse, unsafe food, drug use and conflict with law. Some of these were revealed only after the counsellor was able to strike a rapport with the child and gain his trust. The child has suffered significantly traumatic conditions at a very tender age and would require interventions by the counsellor to be able to develop into a physically and mentally healthy and productive individual.

B. **Kavita,** a 13 year old orphan girl was living at children's home for 4 years, and had been transferred from a home for younger children to one for older children around 6 months back. She was finding it difficult to adjust to the new environment and was subject to bullying by senior girls. The counsellor of the CCI noticed that she was interacting much less compared to her previous self and would rarely go out to play. She would appear anxious and start crying easily. She would be often found tossing and turning in her bed during night hours, unable to get sleep, and was often refusing to eat. Earlier she was performing well at school, but this time in her class tests she flunked in 3 subjects. When the counsellor started enquiring about her recent behaviour, she did no talk to the counsellor and started crying.

In this case study, the child has pre-existing risk factors for mental problems- death of parents and bullying. Counsellor could identify definite signs and symptoms of a mental illness in the child, including withdrawn behaviour, refusing to play, appearing anxious, crying easily, reduced sleep and appetite, and reduced school performance. These symptoms were worrisome as they had been persisting for almost 6 months. A psychiatrist was consulted who diagnosed Kavita to have depression. Medicines as well as counselling sessions were started and she recovered in next 3 months.

Section 5:
Framework of Counselling

Counselling is a special form of interpersonal communication in which feelings, thoughts and attitudes are expressed explored and clarified. Counselling seeks to enhance self-determination, boost self confidence, and improve family and community relationship and quality of life.

Counsellors in most institutions use both individual and group therapies with children. The most common methods of helping adolescents are conditioning (using positive and negative reinforcements), observational learning, motivating to change, and behavioural modification. Many counsellors use the principle of differential reinforcement for encouraging positive behaviour and discouraging bad behaviour. Adolescents can be counselled and motivated to persist in certain tasks, to overcome frustration and sense of failure. Children learn a lot from each other and the staff. The therapist also has to help these children identify their strengths and weaknesses and deal with them.

5.1 What is Psychosocial Counselling?

Counselling is a planned intervention between the child/victim and counsellor/helper to assist the child to alter, improve, or resolve his/her present behaviour, difficulty, or discomforts. It is a process of helping the child to discover the coping mechanisms that he/she found useful in the past, how they can be used or modified for the present situation, and how to develop new coping mechanisms. counselling is about strengthening the ability of the child to solve problems and make decisions and is different from giving advice. The process involves a mutual responsibility between the counsellor and the child. counselling enables the child to discuss feelings and worries freely without cultural, gender, and social discrimination. counselling should reduce these disturbing conditions. By talking to the counsellor, the child can express worries, release tension, and share feelings of suffering. Talking in detail about problems often has a clarifying effect for the person and through this; strategies for change can be explored.

The counsellor's emotional detachment in assessing the child's case is extremely important. There is, however, a continuous gradation between detachment and closeness, between which the counselor must find the correct balance; this is important in promoting the well-being and problem solving skills of the client.

Box 1: Essential Principles of counselling
■ Unconditional positive regard and non-condemning attitude
■ Trust and confidentiality
■ Empathy
■ Genuineness Essential Principles of counselling

The counselling Process

Emotional support is essential throughout the entire process of counselling.

I Identification of the child and or problem: The type of intervention should be relevant to the problems presented and should be based on the criteria for intake such as, the expressed need for the intervention; emotional imbalance; psychosocial problems; disabled daily functioning due to such problems, etc.

II Beginning the counselling process:

- Introduce yourself
- Set the atmosphere/ build a rapport with the child.
- Ask questions like: What is your name? Where do you live?
- Explain counselling. Paraphrasing like: What brings you here? How can i help you? What he expects etc.
- Ask for the child's expectations.

III Getting at the problem/Assessment:

- Explore and structure the problem.
- Understand the situation/problem.
- Explore the positive qualities such as strengths of the child.
- Create mutual awareness about the problem.
- Look at underlying causes of the problem
- Discuss the problem in detail with possible solutions coming out from the child.
- Make decisions together to start the process.

IV Formulating goals for counselling/helping plans:

- Formulate the child's preferred outcomes.
- Priorities which goal to start with
- Decide the relevance of the goals together

V Implementation of counselling goals and decisions:

- Stimulate solutions or strategies for change.
- Discuss advantages and disadvantages of these.
- Formulate and Implement a plan of action
- Work with/on coping strategies, and work with social and cultural resources.

VI Ending the counselling process/evaluation:

- Prepare for termination.
- Discuss reasons for termination.
- Summarize the entire counselling process.
- Provide feedback and focus on positive elements.
- Discuss the transition phase.

VII Follow up and if necessary co-ordinate linkages

5.2 Attributes of a Good Counsellor

This implies to the general attitudes and the facilitation of the interview process by the counsellor which determines a successful interview

1. Be yourself and maintain professional boundaries. Try and be spontaneous during the interview and not stiff as it hampers communication. Express your pleasures, displeasures and concerns freely. By doing so, the client is encouraged to be free in his/her communication as well using the counsellor as a role model.
2. Maintain an attitude of respectful, serious attention- Donot trivialize the clients complaints no matter how silly they may be especially in the case of children. Pay attention to the details and gently guide him/her through the rambling, if at all without demeaning the client.
3. Emphasize the positive-Although it is necessary to explore what is going wrong in a clients life but it is equally important to focus on the positives in his life and try and tilt the balance towards the same.
4. Be alert to the patients Non-verbal Behaviour- Tone of voice, hesitancies in speech, facial expressions and gestures need to be observed in the interview. Commenting on non-verbal behaviour should only be done after gaining trust of the client else it can increase the uneasiness of the client.
5. Focus on the present- Although the behaviour may be maladaptive because of long standing problems and interpersonal issues, but the counsellor must remember that the client has come only after exhausting all his resources of coping and hence, focussing on 'here and now' will help unshackle the mind of the client. However, this should not deter one from taking a full history which will establish a good rapport with the patient.
6. Interpret but sparingly- attend to the points/statements made by the client which have been overlooked can offer explanations to the maladaptive feelings and behaviours. Premature or implausible interpretations can devastate the foundations of the counselling process.
7. Repeat what has been heard either precisely or with some modifications- This reassures the client that he has been heard and attended to and encourages him to elaborate further.
8. End the interview by summarizing major points and always give an opportunity to the client to ask questions or seek clarifications.

5.3 Basic counselling Skills:

1. Active Listening

Active listening involves not only the use of one's sense of hearing but all the senses. To enable the child to feel our **warmth, acceptance,** and **understanding. The Caretaker/ Counselor** must hear verbal messages, perceive non-verbal communication, and respond appropriately to both. Talk where needed & pause when required.

Short term goals: develop and maintain communication and make the child feel understood. Discuss immediate issues and long term ones.

Long term goals: Child learns to express own opinion, to develop personal strengths, and problem solving abilities.

Active Listening - Why?

Active Listening - Gives attention to the child.
Respects the child's problems and feelings and take the child seriously at all times.
Develops self-reflection and analysis the problem and find solutions.
Gives structure and is an objective problem solving method.
Facilitates and stimulates communication and encourages expression.

Active Listening - How?

- Help the child to find his/ her problem, verbalise it or state it. Put it in words.
- Structure the problem.
- Gather as much information as necessary.
- Clarify the message and describe the situation without judging it.

2. Communication Skills

2a. Non-verbal communication is often more sincere and obvious than spoken messages. Non-verbal communication should be identified in the child and used correctly by the helping a child. The counsellor can encourage the child to continue talking by nodding and saying 'hmm' in acknowledgement; these are forms of non-verbal communication. Other forms of nonverbal communication include silences (don't be afraid of them, they can be useful for rest and structuring thoughts), eye contact, smiling, facial expressions, nodding, reassuring, affirmations etc. Through Non-verbal communication one can also make oneself feel available to the child or attend to the him/her for eg such as sitting in a relaxed way, leaning slightly forward, eye contact(as culturally appropriate), and the counsellor's full concentration and attention, not busy in writing notes, talking over phone etc.

2b. Advanced Communication skills- Involves focussing on a situation or problem, interpretation of meaning and problem solving, reassuring and summarizing. These may be useful especially in older children.

Summarizing an essential part of counselling and specially helps to:

1 Check if you, as a listener have understood the story and the message of the child.

2 To give the child the feeling that you really are listening to him/ her.

3 Encourage the child to continue talking, either to clarify or to specify.

4) Give structure and a rest to the conversation (often involving a great amount of information) both for you as the receiver of information, and for the child so that s/he does not lose track of his/her story.

For example: Counselor: "So if I understand correctly you are saying that ..." B2-Reflection of feelings The counselor should reflect on the emotions the child expresses, directly or indirectly. This is one of the most powerful skills to show you understand the child's situation and to focus on underlying things that might be the cause of the presented problem.

For example: "I have the feeling that you are sad because you had a fight." "You don't feel like going to school anymore because you feel they are all against you." "You are angry with your friends; that's why you don't feel like going to school.

3. Paraphrasing

The counsellor echoes or repeats different words, the essence of the child's message.

Paraphrasing helps to encourage the child to continue a certain topic and it reflects the counsellor understands of the core of the child's expressions.

(Often paraphrases and reflections of feelings are combined.) For example: "You say that you have had difficulties at home and that it is therefore difficult for you to concentrate." "If I understand what you are saying, is that you no longer want to stay at home but you are not sure of the consequences of such an action."

4. Effective Questioning Skills

Open questions enable the child to give any answers in his/her own words. This stimulates the child to structure his/her thoughts and explore the situation. Use open ended questions. For example: "Can you tell me more about how you are feeling?"

Closed questions, these questions are useful at the beginning of the conversation, to gather information, however be careful because these questions limit the child in his/her response. For example: "Do you like staying here? Do you often fight with your roommate?"

Suggestive questions, these are not good for this process because they give a reflection of your ideas and not of those of the child. The answer lies in the question. For example: "You must be very angry at him, no? Don't you think that that was a stupid thing to do?"

5. **Supportive attitude** means politeness, openness, comforting (e.g. touching when appropriate) encouraging, showing interest and concern. Avoiding judgments or having evaluative responses skills to relate to the child to convey a supportive attitude: Accept the child as she/he is. Take each child as a unique individual. Protect the confidential nature of the interviews. Allow the child to participate and become determined in his/her plan of action. Respect and listen to the child's perspective. Allow the child to ask questions about you, the counsellor. Use clear, understandable, and simple (and possibly own) language to be at one with the level of the child's.

   Overview of assessment process means finding out information that is relevant to the child or the child's problem/situation, and should lead to the decision whether or not to start counselling, and how to proceed.

   1. **Interview** Information about development and life history, Specify the problem behaviour/complaint Information about strength, coping, resources. How the child presently functions.

   2. **Observation** A counsellor/case worker can gather a lot of information by observing the child during the interview or in another situation. For example: Physical appearance; eye contact with the counsellor; mood of the child; non-verbal communication, etc.

   3. **Projective Techniques:** Projective techniques are used for inquiry and diagnosis. Projective techniques have been developed specifically for use with adults as well as children. For example: Drawings Sentence completion test etc.

   4. **The child's environment** Counsellor/case worker does can gather a lot of information through the child's parents, school or teacher, community, or peers. This is possible through interviews or observation.

5.4 Techniques of counselling:

Play through imaginative play, the child can tell his/her story, express emotions. Try to direct the situation through play to release some (sub-) conscious desires and at the same time have fun.

'Buddy' technique, be a friend or a 'buddy' to a child and he/she is more likely to express his feelings and experiences to you which are very important in understanding the emotional state of the child.

Drawing Ask the child to draw something relevant (as specific as possible, e.g. ask the child to draw a time when s/he was angry or sad). You can discuss the process together during counselling. You can also ask the child to draw a feeling, a memory, or a person relevant in the counselling process.

Painting Give children paints and big sheets of paper and allow them to express their feelings or thoughts (abstract or realistic). They can do whatever they want and even use other materials. This can be evaluated by the counsellor.

Relaxation techniques: Use relaxation exercises, such as yoga, breathing techniques, etc. These techniques are a form for stress/anger/fear management.

Drama (Street) drama is especially useful for group sessions. Through drama, the group is able to tell a story, interact, express, and try out activities in an enjoyable setting. The drama could have a certain theme that is relevant to the counselling process.

Role-play Use role-plays to try out newly learned skills or ideas. It can also function as a practice for a particular 'task', for example having to talk to somebody. Furthermore, it can also be a means of expression of thoughts and emotions. This is especially useful for dealing with problems in relationships.

Journal writing/Letter writing Children can keep a diary between two sessions or a longer period. In the diary, the child can focus on a particular feeling (expression) or goal. If the child's situation involves other people, the child can also write letters to them to resolve conflicts (the letter can then be sent or not, according to the wishes of the child).

Process of relating to children:

- Be warm
- Be friendly
- Be Empathetic
- Be with the child
- Be honest, open and clear
- Accept the child
- Avoid flooding of advice
- Respect the child
- Points to be remembered by the Technical staff/counsellor
- Knowing one's limitations:
- Self-disclosure
- No favours
- Special precautions:
- Positive and negative transference

Layout of Therapy Room or Room for child

- Walls to be painted in colorful paintings - child friendly
- Some art and craft material (pencil, drawing sheets, color pencils, clay, etc) to be kept in the room.
- Some toys and story books to be kept
- Some sofa and chairs only, no table.
- Some toffees/chocolates to be kept
- Be aware of each child's feelings, anxieties and stress related issues. Help child by talking, listening patiently and assuring that you love them and understand them

5.5 Ethical issues in counselling

1. **Commitment to clients:** Counsellors cannot help a child if there is no element of trust. Before moving into counselling, establish trust. Children feel free to express and share their concerns, when they can trust somebody.

2. **Self-Determination:** The child can make his/her own decisions about life, as much as can be realistically possible. The role of the counsellor is to provide OPTIONS and OPPORTUNITY, or to help children explore alternatives best suited to his/her capability and situation (coping strategies).

3. **Privacy and Confidentiality:** Respect the privacy of the child. Assure him/her that everything will be kept in strict confidence. Confidentiality in the entire process of counselling is very important and enhances the dignity of the child.

4. **Conflict of Interest:** It's important to remember that throughout the counselling process, the counsellor needs to maintain objectivity and neutrality. Anything that tends to influence the counsellors own emotions or interests in continuing the therapy process will hamper responsible decision making and judgement. The Counsellor needs to be aware of this and not take up cases or seek a fellow colleagues assistance in case there is conflict of interest.

5. **Competence:** Manage cases for which training has been received. Often there may be situations which are beyond the professional realm of the counsellor and in such cases appropriate referral should be made without fail.

6. **Follow Ethical, Moral standards of treatment with the clients.**

7. **Documentation:** Note the important fact to be done during or after the counselling session.

8. **Termination of Services:** Inform the client whenever the decision is taken for terminating the counselling sessions. The process needs to be systematic giving the client some time to understand and deal with his emotions.

Box 1: Some Common counselling Errors to watch out for and avoid are:
■ Directing and leading - controlling rather than allowing and encouraging the client's expression of feelings and needs.
■ Judging and evaluating, as shown by statements that indicate that the client does not meet the counsellor's standards.
■ Moralizing, preaching, and patronizing- telling people how they ought to behave or lead their lives.
■ Labelling and diagnosing, rather than trying to find out the person's motivations, fears and anxieties.
■ Unwarranted reassurance, diverting a client's attention from an issue and humouring the client- trying to induce optimism by projecting the clients problem as minor issues.
■ Not accepting the client's feelings- saying that they should be different
■ Interrogating - using questions in an accusatory way. “Why” questions almost always sound accusatory.
■ Encouraging dependence - increasing the client's need for the counsellor's continuing presence and guidance

5.6 Knowledge, Attitude and Practice (KAP) paradigm

The KAP paradigm states that a person's knowledge determines his attitude and practice in the real world setting. In a simplistic sense, the relationship between the three would be considered to be linear and unidirectional. However, over the years with research and evolution of science, this historical concept has evolved into a more complex model. It's now very clear that the relationship between these three factors is necessarily not linear but more complex.

To take an example, the fact that cigarette smoking causes cancer does not necessarily translate into change of attitude or practice of abstinence in some subjects.

This concept is important to understand for counsellors in the context of counselling. Counsellors posted in CCI's come from diverse backgrounds with differences in educational standards and may feel inept in dealing with cases. They may feel that perhaps, further knowledge in psychotherapy will chisel their skill, which in an ideal situation surely would but may or may not translate into a change of practice. This has been well researched in India that any person with an average competence and interest in learning psychotherapy can excel as a therapist provided one believes in a mutual commitment between one self and the client.

Hence, the counselor posted in the CCI is not only receiving maximum information from the real world situation through different cases of children and adolescents and can assimilate and accommodate the same depending on the intellectual level; but also should not consider themselves any less competent from their peers or even superiors as long as they maintain the 'human touch' in the counseling process.

Further, preconceived notions about the nature of disorder in the children, or repeated incidents of disturbing behaviours such as deliberate self harm, substance use or verbal and physical aggression should not be allowed to shape the attitude of the counselor towards the index child and effect practice in any way, reducing the counselling time and the humane touch getting lost in process.

5.7 Self Awareness of Counselors: Impact on practice

Self awareness in counseling refers to the ability of the counselor to differentiate between the boundaries of self and that of the client. It is an important means to develop personally and explore one's own dimensions. Often counselors find that the problems that the client presents with is more a less a reflection of the counselors own situation forcing him to err into biased decision making. The counselor at this moment needs to know the boundaries of his own 'ego' and know that even if the problem may be similar, it is not the same and objectively help the client. It is also not too uncommon for counselors to get excessively involved with the counseling work with some clients in comparison to others not realizing the development of transference in the client and counter transference feelings in the counselor himself. In such situations the counselor ought to watch his own feelings, thoughts and actions and give it a positive and meaningful direction. Adolescent young girls with maladaptive personalities and fractured family ties may find a role model in the counselor and may naturally invoke

feelings within the counselor which need to be accepted first and not shrugged off. If the counselor is not able to deal with such a situation, it would be prudent to hand over the case to another counselor or bring in a co-therapist to prevent conscious or unconscoius manipulation by the client.

Another great strategy to develop self awareness is to have group sessions with peer counsellors or superiors with whom one can reflect on one's thoughts, feelings and actions and develop a problem solving approach to the difficult situation.

Counsellors also need to have few minutes of 'personal time or leisure time' in a day like all individuals should, to connect to themselves and relieve work related stress. With these strategies one can prevent burnout and psychological fatigue in one self and continue to develop and evolve as a counselor and therapist.

It is pertinent to mention here the concept of 'Johari window' developed in 1955 for self awareness and group process. Accordingly each person is seen in four quadrants, the Arena is the area which is known to self and to others, the Blindspot is the area known to others and not to self, the Façade is the area not known to others but known to self and the Unknown the area not known to either self or others. As group processes continue one begins to 'open up' easily and talk about the feelings, thoughts andf actions known to self but not to others. Also one learns more about oneself through others ie he/she is likely to understand the blindspots and assimilate and accommodate the feedback to become a better person and a professional.

	Known to self	Not know to self
Known to others	**ARENA**	**BLINDSPOT**
Not Known to others	**FACADE**	**UNKNOWN**

Diagram: Johari Window

Box 2: Some common counselling errors to watch out for and avoid are:
■ Directing and leading - controlling rather than allowing and encouraging the client's expression of feelings and needs.
■ Judging and evaluating, as shown by statements that indicate that the client does not meet the counsellor's standards.
■ Moralizing, preaching, and patronizing- telling people how they ought to behave or lead their lives
■ Labelling and diagnosing, rather than trying to find out the person's motivations, fears and anxieties.
■ Unwarranted reassurance, diverting a client's attention from an issue and humouring the client- trying to induce optimism by projecting the clients problem as minor issues.
■ Not accepting the client's feelings- saying that they should be different
■ Interrogating - using questions in an accusatory way. "Why" questions almost always sound accusatory.
■ Encouraging dependence - increasing the client's need for the counselor's continuing presence

Box 3: Some of the important Do's in counselling:

Do's Verbal Communication:

- Using language that the client understands
- Conveying interest - a) remembering details
  b) addressing client by name
- Conveying acceptance
- Conveying willingness to help
- Paraphrasing - a) determine basic message
  b) rephrase in fewer words
  - Encouraging statement
  - 'yes' 'I see', 'go on'
  - Reflection of feelings
  - Focus on feeling and content
  - Giving needed information
  - Addressing client in a manner appropriate to his/her age
  - Using humour or other means of reducing tension
  - Speaking audibly, slowly, clearly

Non-Verbal communication

- Maintain suitable conversational distance
- Maintain eye contact
- Attentive body posture
- Nod appropriately
- Use facial expression
- Use occasional gestures

Box 4: Some of the important Don'ts in counselling:

Don'ts

Verbal Communication:

- Advising
- Giving moralistic judgments
- Criticizing or blaming

Box 4: Some of the important Don'ts in counselling:

- Scolding or threatening
- Discussing your personal problems
- Interrupting
- Imposing your own values
- Rejecting
- Premature interpretations
- Excessive curiosity
- Asking questions in a direct and embarrassing manner
- Forcing unwilling disclosures
- Taking sides
- Arguing
- Controlling
- Labeling and diagnosing
- Unwarranted reassurance
- Not accepting patient's feelings
- Interrogating
- Encouraging dependence
- Talking too much

Non Verbal

- Looking away frequently
- Inappropriate distance
- Looking bored, irritated
- Fidgeting, yawning, looking at the watch
- Writing while client is talking
- Unpleasant tone of voice
- Sneering

Section 6:

Application of counselling skills to Children in special circumstances

6.1 Children with Disabilities:

Mental Health of Children with Disabilities in Child Care Institutions: Global and Indian Scenario

Globally more than 93 million children suffer from some form of disability or 1 in every 20 children have moderate or severe disability. Estimates across countries vary depending on the methodology adopted for assessment of disability and largely reflect higher estimates of disabled children in developed countries in comparison to developed countries. The current global emphasis for change in the care of disabled children is not to consider them as simple recipients of charity but to integrate them into the society through inclusive means of education and care. India having ratified the UNCRPD (United Nations Convention on Rights of Persons with Disability) in 2007 much before any other developing country shares the same vision but much work needs to be done still.

According to the Indian Census 2011 data, there are approximately 27 million persons with disability and 2.7 million of these are children below 19 years of age who suffer from one or the other disability, which is 10 % of the total disabled population. Of these how many reside in Child care institutions is not known but given the fact that it takes decades for paradigm shifts to get exacted in societal development, from the historical custodial care and charity model of care for the disabled to humanistic and rights based care model involving integrated care; the number is expected to be huge and hence the need for the Counsellors to rapidly evolve their strategies and bring the disabled children into the integrated system of care at the earliest.

It is alarming to know that in spite of advanced laws for the disabled population such as the PWD Act, 1995, National Trust Act, 1999 and the proposed Bill of Right of Persons with Disability Act, 2014 which was recently cleared by the Rajya Sabha on 14th December, 2016; only 5-10% of the disabled children in the age group of 6-14% avail benefits of government sponsored schemes. The role of the Counsellors in the care of children with disabilities is not simply restricted to assessment and management of their behavioral problems but also in education of other caretakers in changing their outlook towards disability, advocacy and ensuring that the disabled get their rights and benefits.

Children with disabilities are a heterogeneous group of children with varied needs. Children may have difficulty in seeing, hearing, movement, thinking and perception and understanding. Children with psychosocial disabilities such as Autism, Intellectual impairment, Cerebral Palsy, Specific Learning Disorders are perhaps the most vulnerable amongst the disabled group along with those who have Mental Illness, for the simple reason being that the disability in their case in one way or

another is related to their mind and brain and not merely a disability due to loss of vision, hearing or speech capacity. It is for this reason that constant care and support is needed to assist them and develop the or mental faculty so that they can lead for themselves a fruitful and meaningful life as a Right as enshrined in Article 21 of the Constitution of India.

In any residential institution, it is likely that children will also vary in the degree of impairment that they have from the very mild to the severe. We may also see children with multiple disabilities ie those having more than one disability. In India we often separate children with disabilities and have separate residential homes for children with different impairments. Some children are also included in homes for all children in need for care and protection.

In 2007 India ratified the UN Convention on the Rights of Persons with Disabilities which marks the big paradigm shift in understanding disability. The UNCRPD identifies children, women and girls with disabilities as a vulnerable groups requiring special attention in the formulation of rights. Apart from a separate article on children, the **Preamble**, as well as, the General **Principles** of the concern for children runs through the Convention. While advocating a twin track approach the Convention continues to focus on the inclusion of children with disabilities in all services and situations affecting children.

Recognizing the vulnerability of children with disabilities, the UNCRPD has a separate article, **Article 7** on Children with Disabilities. The article stresses that children with disabilities have **all human rights and fundamental freedoms on an equal basis with other children. It also talks about the right of this child to express their views on all matters affecting them. Children requiring disability and age related supports are to be given that assistance to realize their right.**

Article 7: Children with Disabilities (UN Convention on the Rights of Persons with Disabilities)

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them. Their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that

Article 16 of the Convention recognizes the existence of high levels of violence and abuse against children and urges states to put forth effective policies and legislation that would ensure the identification and investigation of violence and abuse against children.

It is well known that children with disabilities are extremely vulnerable to violence and abuse. Amongst children with disabilities there are some who may not communicate in conventional ways and this often becomes a barrier in our understanding of what has happened to the child and communicating with them.

Also very often, as professionals working with children we tend to focus on their impairment and feel that we have to deal with the impairment. Counsellors and caretakers may feel that working with this child is too specialized and that they do not know what to do. However, it is always important to

remember that first and foremost all children with disabilities (however severely disabled) are children first. They have all the needs that all children have and we can start with just looking at the child and not only the impairment.

In keeping with the rights of all children and the UN Convention on the Rights of Persons with Disabilities it becomes extremely important for counsellors to try very hard to communicate with the child and know the will of the child, Very often with children with disabilities, particularly children with intellectual disabilities and children who communicate differently, our tendency as professionals to make all the decisions for the child. However, the voice of the child is extremely important for their well- being.

In getting to understand the needs of children with disabilities counsellors can use all their learning as they would with other children. However for some children who may communicate differently, there will be a need to actively observe the child and understand their patterns of communication.

Counsellors should remember that it may take more time to establish a rapport with some children with disabilities. For example children with high support needs and multiple disabilities may appear not to be communicating and need to be given time to respond. Playing with the child is one of the best ways of getting to know them.

Some children with disabilities may appear extremely hyperactive and may behave in ways that are strange to other children and to the counselor. They may hit out at other children. It is important for counsellors to remember that there could be a range of reasons behind such behaviors and as with other children it would be important to understand this and not put it down to merely the impairment of the child. For example, Saurabh, who has Downs syndrome came to a special center with this mother for the first time. When the special educator tried to speak to him he spit at her. On further investigation it was found that Saurabh who could not speak, was distressed and worried every time he met strangers. His way of showing this distress was by spitting at the person. It is very easy for us to put down Saurabh's behavior to his intellectual impairment. However, that is only part of the truth and must be understood as such.

One of the best ways to promote well being of children with disabilities inside any residential space is to include them in all activities for all children and to have expectation from them. Very often, we do not include children with disabilities in activities for all children because we feel that they cannot do it and will get nothing out of it. This is perhaps the most exclusionary and traumatic experience for the child and counsellors and caretakers must work actively against such practices. Even the most severely

disabled child will learn and enjoy participating in activities with other children. Each child is different. A lot of problem solving can be done by counsellors and even children. For some children you may require specialized help and support. For example, some children with disabilities may not be able to sit on their own. Imagine a child who is lying down day in and day out. What does she see? Only a roof and perhaps a fan! This does not mean that they have to be lying down all the time. Instead, a therapist who knows about positions will be able to tell the team about how to seat the child with support. This will change the world for the child and for other children and the counselor who can then communicate in a different way.

It would be important for counsellors to be aware that children with disabilities may be more vulnerable to being bullied and hit within the home. It would be important to set up systems to prevent this and to look out for such happenings and deal with them.

Sensitization of peers and the support of peers is often crucial in the equal participation and well-being of the child with disabilities. However, it is also extremely important as to how this is done. Peers must not be taught to interact with children with disabilities on the basis of charity but rather as individual who are worth knowing and learning from.

Finally it is true that children with disabilities do have specific needs and requirements. The support of a multi-disciplinary team of professionals will go a long way in enabling counsellors and caretakers to improve the well-being of children with disabilities.

Interventions for Children with Disabilities

This section attempts to chiefly enlist and summarize universal, targeted and specific interventions for children with special needs. Attempts have been made to focus on Non-pharmacological modes of intervention only, as this is mostly missed and goes a long way in the overall development of the child and adolescent. Needless to say, if the child is receiving medication then the counsellors should co-ordinate with the locally available medical practioner or mental health expert. Non-pharmacological measures need to be given much greater emphasis as compared to pharmacological means as medications have their own limitations when it comes to treatment of behavioral syndromes in children and adolescents.

Box 5: Interventions in Children with Disabilities (Conway C, Kanic I et al 2015, AOTA)

Tier 1: Universal Promotion of physical and Mental well being

1. Ensure that child has access to all quality play experiences such as playground, recreational activities
2. Collaboration with caregivers and other agencies for physical and mental well being
3. Evaluate formally, informally and intervene to reduce barriers to participation in group activities
4. Collaborate with educators for effective learning (eg. Special education strategies for learning, reducing distraction for children with co-morbid ADHD
5. Creating positive learning areas such as quiet rooms for those who are easily distracted, sensory friendly classrooms, buddy system on playground
6. Recommended modification of playgrounds to promote social participation
7. Sensitization and Advocacy of inclusive education and disability rights amongst school teachers and community
8. Teach self regulation techniques such as putting head down, sitting in a quiet room, yoga, music. Ensure adequate and regular sleep and rest time and good nutrition for all children in the developing years.

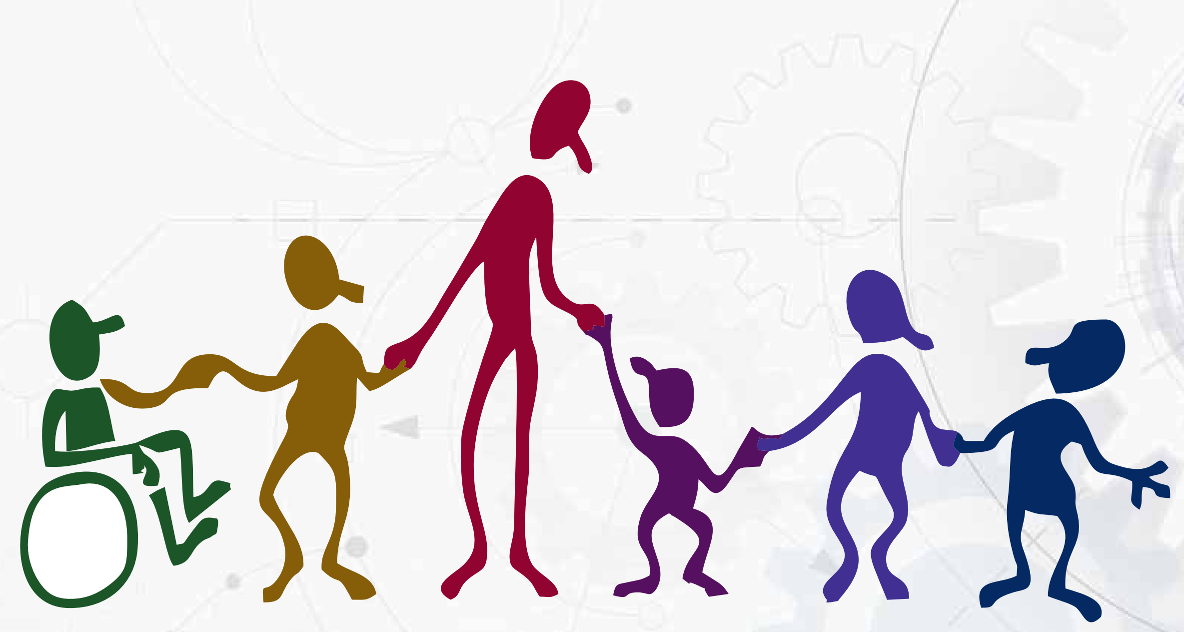
Tier 2: Targeted prevention

1. To include activities that enhance fine motor and gross motor skill development such as drawing, painting, rides and swings to assist those children with coordination difficulties
2. Relaxation strategies such as music, yoga and simple breathing to be included in daily routine.

Box 5: Interventions in Children with Disabilities (Conway C, Kanic I et al 2015, AOTA)	
3.	Coordination with technical experts to include computers in teaching and recreation
4.	Life skills training to be conducted
Tier 3:	**Intensive and Individualized services**
1.	Help in implementation of the individualized sensory integration program
2.	Self regulation techniques to be used on a daily basis
3.	Focus on art, music, physical education in all cases and especially in severe cases.
4.	To do structured and unstructured play activities
5.	Ensure safety in all programs e.g. to preventing children with intellectual impairment, autism from wandering
6.	Modelling of positive mental health behaviours for all staff.

Box 6: Take home message

1. Children with disabilities are children first and have all rights and entitlements that all children have.
2. Children with disabilities have special needs. The society needs to adapt to their needs for e.g. a child who cannot see may have difficulty walking on the road, but if the road is designed in a way to assist him in walking then no longer will he be restricted in his movements.
3. Children with disabilities should be included in all activities as much as possible like all other children.
4. Co-ordination with rehabilitation psychologist, special educators, occupational therapists, physiotherapists is a must if so the child requires throughout the developmental period.
5. Ensure the disabled child gets disability benefits through disability certification at a government hospital.



6.2: Children with Substance use

Statement of the problem-Also scope/definition

Substance use along with other behavioral and/or emotional problems is more common among vulnerable children such as those in Child Care Institutions. It often results in self-injurious behavior, immediate health consequences like injuries, sexual risk taking, medical conditions such as asthma, depression and anxiety and impaired brain function and long-term consequences like poor academic performance and delinquency. Substance use also causes high mortality among children and youth and is a major contributor to three leading causes of death among adolescents-accidents, homicides, and suicides. The younger the age of first use, the greater the chance of developing dependence and complications in later life.

Global Scenario

Large-scale studies on the extent of substance use among inmates of CCIs and other disadvantaged children are limited. Most studies have reported increased prevalence of substance use across all ages among children in CCIs compared to general population. Among older adolescents, higher prevalence of ever use of tobacco is reported in foster care vs. those living with families. The difference is found to be more prominent in young adolescents. Even the prevalence of harder drugs is more prevalent among those in child welfare care compared to similar aged in general population. Those in child-care were also found to have younger age of onset, more frequent use, continuing substance use after initiation, use related to stressful situations, having a substance-using peer, poor academic performance and feeling of loneliness, and low self-confidence as compared to those living in families. Factors like age, ethnic background, and family situation, partly explained the differences in substance use between the two groups. While caregiver connectedness and avoiding placement in foster care had a protective role in mitigating substance use, history of delinquency was a risk factor.

The high rate of delinquency among substance user and vice-versa is prevalent globally. For example, in U.S. in 2002, the substance use disorder rate between 12-17 year olds in detention was 23.8% vs. 8% among never jailed [Office of Applied Studies, 2004]. Thus, it is clearly evident that the substance-related problems and substance use disorder among these sub-group of children is quite high compared to those in the general population and so, substance use prevention and treatment services should be incorporated into child welfare interventions.

Indian Scenario

Currently, there are very few Indian studies on the extent and severity of the substance use problem and the risk factors associated among children in CCI. However, some inference about the magnitude of the problem and challenges associated can be estimated from studies conducted in the general population and among other vulnerable child groups like street children. The magnitude of the substance use problem in CCIs will be similar to those among other vulnerable groups as they often constitute major chunk of children in these institutions.

The magnitude of substance use problem among children is significantly high, considering their total population in the country. As of year 2007, the self-reported prevalence of tobacco use among

males and females in the age group of 15-19 years was 28.6% and 3.5% respectively [NFHS-3; International Institute for Population Sciences (IIPS) and Macro International, 2007]. There is also a significant increase in rate of substance use in this age group. For example, the prevalence of alcohol use from NFHS-2 to NFHS-3 among males has increased from 2.4% in 1998 to 11% and that among females has increased from 0.6% to 1% [National Family Health Survey 1998-99]. A large percentage of adolescents who have used a substance ever in his life continue to use daily (8.3-19% for tobacco and3.4-6.8% for alcohol). This is more common among females [GYTS, 2009]. Besides tobacco and alcohol, the rate of use of illicit substances like cannabis (3%) and opiates (0.1%) is also high among adolescents [Ray et al., 2004].

A large scale, multi-site survey in India also reported high rate of both licit and illicit substance use among substance-using children population [Tikoo, Dhawan, Pattanayak & Chopra, 2013]. The prevalence of various substance use in substance-using children were - tobacco (83.2%), alcohol (67.7%), cannabis (35.4%), inhalants (34.7%), pharmaceutical opioids (18.1%), sedatives (7.9%) and heroin/smack (7.9%). A significant proportion of the children also reported use of injectable substances (12.6%).Most of the children who had ever used any drugs were also likely to be current users. The street children initiated substances 1-1.5 years earlier compared to those living at home.

Studies have also assessed various variables related to initiation and continuation of substance use among children. These include curiosity about the substance, peer pressure, low moods and stress of daily life. Maintenance factors for substance use include parental substance use, domestic violence, physical abuse, broken family, poor parental supervision and care, poor academic performance, normalization of substance use among peers and society, deviant peer group, easy availability of substance, conduct traits, ADHD and learning disabilities. The number and severity of these risk factors are found to be more among street children, delinquents etc., as compared to those in general population. This explains higher prevalence of substance use among them. On the other hand the services for management of substance use problem available to them are often inadequate or unavailable due to inadequate staff and administrative unwillingness, lack of focus, insufficient resources, and lack of training for staff are major issues are responsible for poor response.

Intervention for substance use in the context of CCI

Screening for substance use

Some basic points related to screening are:

1. **Purpose -** to identify children who need a more comprehensive assessment for substance use disorders and substance-related problems.

2. **Aim -** to reveal the various areas in a child's life that are affected by substance use, with/ without making an involved diagnosis.

3. **On whom to apply -** all children in CCI who exhibit any signs of substance use

4. **Prompt application -** to identify use of substances known to cause intoxication/withdrawal symptoms and physical and/or psychiatric complication(s)

Substance use involvement can be assessed by assessing the following aspects-

- Lifetime use question - In your whole life, how many days did you use any substance?
- Current use question - In the last 30 days, on how many days did you use a substance?
- Frequency and quantity of substance use as well as last dose
- Complications related to substance use in terms of psychological and physical domains, academic, family, legal, financial, social domains
- Previous periods of abstinence
- Any symptoms of psychiatric co morbidity

Basic principles of intervention

Adolescents must be approached differently because of their unique developmental processes, physical differences, and differences in belief and value systems. Individual, family, peer, school, neighborhood/community, and societal factors can influence substance use and its management and these factors also reinforce each other. Higher the number of risk factors, greater the chance of severity of drug problem. Thus, a multi-dimensional treatment strategy to address the risk factors is needed in these children.

Intervention strategies for children substance use

Various approaches have been advocated for intervention among the children with substance use problem. Some of the approaches which have been proved effective through multiple studies include-

- Brief Intervention
- Relapse prevention a form of Cognitive Behavioural Therapy
- Contingency Management

Brief Intervention (BI)

Why brief intervention

Most of the adolescent substance users come under the category of non-dependent harmful/hazardous substance user. Even though they are not yet dependent on the substance, whenever they face difficulties, they may intensify substance use rather than learn healthy coping skills. BI helps in reducing the symptoms of substance abuse or dependence and thereby, reducing the harm due to the substance.

Principle

It utilizes the principles of motivational interviewing (MI). It induces thoughts about change in the child but the responsibility for change remains with the client. It gives direction to the adolescent's interests, goals, and motivation level by discussing and fixing realistic goals for their immediate future. Many possible options or strategies for accomplishing the target goals are explored and offered. However, complicated process of achieving goals with many steps and setting very distant goals are avoided.

Technique

No of sessions in Brief Intervention varies from 2-4, the usual length of the sessions are 1 hour.

Essential Elements of Brief Intervention

Step I. Assessment and Direct Feedback

- **Focus -** to elicit information about substance use and related consequences and give feedback
- **Assessment -** screening for the type and pattern of substance use (described above).
- **Purpose -** to give objective feedback (based on assessment results) about the patient's condition (to increase his willingness to change).

Step II. Negotiation and Goal Setting

- **Focus -** Goal setting (simple, specific, objective, short-term goals)
- **Assessment -** patient's view on drug consumption pattern and its consequences. Discuss pros and cons of substance use are evaluated through decisional balance exercise. Arrive at consensus by discussion that the harms due to the substance use are more than the benefit and that some steps need to be taken to decrease those harms.
- **Purpose -** Setting achievable goals to decrease substance use and associated harm after negotiating with the patient.

Step III. Behavioral Modification Techniques

- **Focus -** avoid triggers and cope with consequence of the substance use behaviour.
- **Assessment -** primary triggers and high risk situations are identified. Triggers causing substance use behaviour/act and the immediate consequence after the use is assessed.
- **Purpose -** Find ways to avoid antecedent triggers as well as ways to cope with the consequences. Sometimes caregivers who can help the patient are involved

Attitude of the counselor during therapy must be non-judgmental, non-labeling, and non-confrontational. The key points to note are:

1. **Expressing empathy -** able to understand the child's point of view by keeping oneself in his place.
   a. **Non-judgmental** attitude of the counsellor creates a context that encourages the child to feel comfortable talking about personal matters.
   b. **Using reflective listening skills** like using statements such as "I understand what you are saying" or "What do you see as the next step for yourself?" communicates empathy.
   c. **Summarising and seeking approval** of what is said by the child conveys the message that the counsellor is showing interest and is able to understand him.

E.g., "If I understood correctly, you want to say that ...... is the main reason why you are not able to stop the use, is it?"

2. **Personalized feedback -** Feedback is to be given not to "prove" that the child has a drug use problem; rather, to assist the young person to "recognize" that change is in needed. The feedback should be related to the actual problems faced by the child.

3. **Allocating Responsibility:** Emphasizing that changing his attitude and behaviour is the child's responsibility. The child is ultimately responsible for choosing what to do about his or her substance-use behaviour. Thus, the counsellor's goals are not forced upon the child. The therapist seeks a commitment from the child about what changes he or she will make. The therapist only offers information, provides guidance and suggestions to bring about the change.

4. **Encouraging self-efficacy:** Encourage self-efficacy or optimism in the child. Self-efficacy is encouraged when the counsellor acknowledges positive change-no matter how small-and reminds the child that the behaviour change goals are the child's responsibility.

Advantages

1. The main advantage of BI is the brevity of the intervention. This helps in keeping the attention span of the adolescents.
2. It can also be provided to a large number of adolescent clients, especially in a setting like CCI where a large number of clients need to be addressed.
3. It is a process in which there is simultaneous assessment and intervention. Besides identification of the level of substance use problem, it also helps in identification of other issues and problems which potentially modulates the substance use problem.
4. The stress on empathetic and encouraging rather than confrontational attitude by the counsellor avoids conflict between the need for independence of the adolescent with the "advice" of the adults.
5. BI does not require any special setting, training or qualification on the part of the counsellor to administer it. Therefore, it can be applied equally effectively in a low-resource setting.
6. It can be good initial intervention for those who need specialized treatment for substance use disorders by engaging and preparing the child for the same.

Preventing Relapse of Substance Use

The principle

Relapse prevention therapy for use in order to prevent relapse in those who are trying to quit substances or have already quit (as may often be the case in children in institutional settings). It is designed to teach individuals how to anticipate and cope with relapse. It follows the basic principle that relapse is less likely to occur when an individual possesses effective coping mechanisms to deal with high-risk situations.

Goals of RP

- Understand relapse as a process, not an event.
- Identify and cope with high-risk situations.
- Coping effectively with urges and cravings.
- Learning to cope with lapses within the abstinence phase.
- Create a more balanced lifestyle

Technique

1. **Detecting High Risk Situations -** Encompasses all situations in which chances of taking substance is more than other situations. The high risk situations can be related to a specific place, time, emotion, person etc. Patients are encouraged to self-monitor their substance use - for example, by maintaining an ongoing record of the situations, emotions, and interpersonal factors in which he had restarted substance use in the past. It also includes the situations in which urges are more prevalent. Often adolescents abuse substances out of an impulse or in anger and it is imperative for the counsellor to identify such situations and teach new coping strategies.

2. **Learning New Coping Skill**
   After detecting the high risk situations two types of coping strategies are taught:

   A. Avoiding high-risk situations - by recognizing the warning signals associated with imminent danger i.e., the cues indicating that the patient is about to enter a high-risk situation. The patients are taught to avoid or escape those high risk situations by behavioural techniques.

   B. Dealing with the high-risk situations - involves learning more effective coping skills. Relevant coping skills can be behavioural or cognitive or include both. Common strategies are:

   a. Assertiveness Training: ability to decline substance use assertively. The cognitions due to which the child is not able to assert himself are evaluated (e.g People will stop liking me if I say no, I will have no friends) and cognitive biases are addressed through Socratic questioning (Will a friend who genuinely likes you stop befriending you just because you will no longer smoke with him?). Assertive communications are taught through modelling and role playing.

   b. Anger Management and dealing with extremes of emotions: Behavioural techniques like avoiding anger, sadness triggering situations, delaying response, deep breathing, and distracting self are taught. Through ABC charting the antecedents and consequences are evaluated and managed accordingly.

   c. Positive Self Talk

   d. Meditation and other relaxation therapies

To increase the likelihood that a patient can and will utilize his or her skills when the need arises, the therapist can use approaches such as role plays and the development and modelling of specific coping plans for managing potential high-risk situations.

3. **Increasing Self Efficacy**

Increase patient's sense of mastery of being able to handle difficult situations without lapsing. The child is encouraged to adapt the role of co-therapist and objectively view his/her substance taking behaviour and then asked what is wrong and steps that the child thinks he can take to stop the substance-taking behaviour. It is emphasised that changing a habit is a process of skill acquisition rather than a test of one's willpower. The other technique is to break the end goal in small reachable sub-goals, like climbing stairs one-by-one to reach the destination. When patient manages to reach small reachable goal it automatically increases his/her feeling of self-efficacy.

4. **Managing Outcome Expectancies**

Some people focuses on the short-term positive outcome due to the substance and continue substance use due to that, e.g. alcohol helping to deal with grief and stress, excessive smoking before exam to deal with stress. Those people who focus on the positive short term gain and discount the negative long term effects are more prone to relapse. The related expectations are managed in RPT and focus is set on bigger perspective of life. The therapist addresses each expectancy one-by-one, and dispels myths and encourages abstinence by using cognitive restructuring and education about research findings. The therapist also can use examples from the patient's own experience. E.g., "you started taking ganja to increase appetite and put-on weight but has it actually increased your weight or muscle mass since you started?"

5. **Managing Lapse and Relapse**

People who attribute the lapse to their own personal failure are likely to experience guilt and negative emotions that can, in turn, lead to increased use as a further attempt to avoid or escape the feelings of guilt or failure. Furthermore, people who attribute the lapse to stable, global, internal factors beyond their control (e.g., "I have no willpower and will never be able to stop drinking") are more likely to abandon the abstinence attempt (and experience a full-blown relapse). In the therapy session, the difference between lapse and relapse is taught. Patients are taught to see lapse as one individual episode rather than complete failure. Lapse management includes contracting with the patient to limit the extent of use, to contact the therapist as soon as possible after the lapse, and to evaluate the situation for clues to the factors that triggered the lapse.

6. **Life-style Modification**

It involves self-monitoring of daily activities by the child, identifying each activity as a "Pleasurable" "Necessary" or combination of both. Striking a balance between pleasurable and necessary activities are important and modifications are done in accordance to that.

Contingency Management

Principle

It is a type of behavior therapy where immediate and tangible reinforcements for positive behaviours are used to modify problem behaviors like substance abuse. It provides adolescents an opportunity to earn low-cost incentives such as in exchange for participating in drug treatment, achieving important goals of treatment, and not using drugs. The goal of CM is to weaken the influence of reinforcement derived from using drugs and to substitute it with reinforcement derived from healthier activities and drug abstinence. This therapy is often used in combination with other psychosocial treatment or a medication.

Technique

In this the children are given a list of target behaviours. Each desired behaviour is divided into multiple simple tasks which lead to the desired behaviour. The tasks are simple, pre-defined and unambiguous. For each task a reward in form of the token (worth fixed amount of cash or kind) is given. The reward should not be too small or too large but just enough to sustain the behaviour. E.g., if a child is able to follow his daily activity schedule, participates in the physical exercise sessions, attends group sessions etc., a fixed reward is given for completion. In case, they are not able to do that activity the child either does not get the token or a token may be taken away from his account. The child can exchange the collected token for money or for kind, depending upon the rule of the institution. The frequency, nature or the reward on the various tasks can be changed after discussion with the child in order to sustain his motivation and to make the child learn new activity.

Interface with other sections/chapters

Co morbidity psychiatric illness and substance use

Substance use problem and mental health disorders often co-exist with each other. Whatever be the underlying association, it is essential to evaluate and manage each disorder concurrently. Thus, screening for mental health disorder must be done in children with substance use disorder. Some of the situations in which thorough assessment for co morbid mental illness must be done are:

- Very early age of onset of substance use
- Family history of mental illness.
- Chaotic pattern and sudden excessive increase in substance use, including repeated overdose of substances
- History of exposure to excessive an unbearable trauma and stress, that which may be considered excess for most of the people in community.
- Any abnormal behaviour not explained by substance intoxication and/or withdrawals
- History of repeated self-injurious behaviour with/without high lethality
- History of suicidal/ homicidal attempt
- History of repeated harm to others, animals, younger children, gang activity, fire-setting not related to substance use

- History of engaging in repeated impulsive acts which may or have actually put the life of self/ others in danger

- History of delay in achieving developing milestone, poor academic performance, truancy, excessive hyperactivity which started before the onset of substance use

- History of poor relation with family and peers, introversion, and social anxiety or disturbed sleep and appetite (biological function) which either started before substance use or not accountable due to the use of drugs.

If any of the above conditions are present, a comprehensive assessment is necessary. Therefore it is advisable that in such cases the child may be referred to a mental health specialist who is also capable of managing substance use problem. In co morbid conditions, concurrent therapy of both the conditions bring better results. Both pharmacological and behavioral therapies have a role in the management which are delivered by the therapist trained in the same.

Suicide and substance use

Both adolescent substance use and suicidal behaviour, independently, are public health problem. In addition, substance abuse in adolescents appears to be associated with a greater frequency and repetitiveness of suicide attempts, more medically lethal attempts, an increased seriousness of intention, and greater suicidal ideation. Irrespective of the presence or absence of the risk factors, any adolescent substance user who expresses suicidal ideation, plan, or has a current or past history of suicidal attempt belongs to a high-risk group. Detailed assessment of substance use problem, assessment of co-morbid illness, stressors and risk assessment of suicide must be done. The child must be kept under vigil and must be kept away from any such object or situation which can cause grievous injury in case the child makes an attempt. Service of a trained mental health professional must be availed to manage such a child.

Promotion of Positive Mental Health & Well-Being among Children and Adolescents in CCIs as a preventive strategy (including addressing protective factors and reducing risk factors). Also see Tier 1 Universal Promotion of Physical and Mental health well being in Section 6.1 and section 7.

Not all children in CCIs are substance user. However most of the children are at high risk of substance use and associated problems because of the higher prevalence of risk factors among them. Therefore, preventive strategies play a major role. Also, preventive strategies work best at impressionable age. Some of the general principles for prevention programs for children in CCIs are:

1. Should address all forms of drugs of abuse, alone or in combination, both legal and illegal

2. They should enhance protective factors and reverse or reduce risk factors - the intervention should be specific and individualized to the target population, must specifically target the most important and modifiable risk factors first.

3. Family-based prevention programs should be an important component considering it is one the most important modifiable factors for substance use and most of the children in CCIs have some degree of dysfunction in the family.

4. The programs should not only specifically target the substance use problem in isolation but also address other domain of life like positive thinking, control of impulsivity and emotions, positive relation with family and peers, management of day-to-day affairs like money, relations, psychoeducation about other high risk behaviours.

5. Must be applied in interactive manner such as peer group discussion, role-playing, etc.

6. The programs must promote regularity, i.e., they should be consistent, unconditionally positive and predictive. They should be held regularly, for fixed duration and at fixed frequency. This provides a supportive and stable environments for the children at CCIs. Offering the same message and in multiple different but interesting ways - individual counselling, group counselling, role-play, to-do activities etc. This is because every child learns things in their own way.

7. **Constant evaluation** of the program by various non-intrusive means like, essay writing, story-telling, drawing on issues related to drug refusal, harms related to drugs, disapproval evaluation, positive living etc.

8. Ensuring continuity of such service to the child even after discharge by contacting local school authorities, parents, NGOs, local businessmen who employ such child, or even by allowing the child to visit the CCI as a volunteer.

9. **Understand family dynamics and involvement of the family.** The child in CCI may have varying strong feeling towards the family members which may range from anger, fear, shame, guilt, indifference, or even confusion about their feelings. This depends on the type of role the family has played as perceived by the child. Understanding the dynamics is important as the child may display similar reaction to counsellors in CCI which may affect the service delivery. Second, this also helps in developing appropriate intervention for the family.

10. **Avoid stigmas and labelling -** children often feel stigmatized for being part of the child care system and try to deny- and conceal the fact. This may also result in refusal of the services at the institution including refusal to reveal any experimentation with drugs or any risk factors for substance use. Therefore, special attention must be given to the needs without the identification of the child in a way that perpetuates stigma. Some of the ways are - review all printed materials and messaging to ensure that it is not stigmatizing, outreach strategies should be neutral as for the general population outside, respecting confidentiality of information revealed, avoid publicly identifying the child as being in the institution involved. Thus, both anonymity and confidentiality of the child must be respected.

Thus, the prevention program need to focus on integrated mental and behavioral health programs which includes skill building, strengthening family ties and stability in life in terms of living, relations, income etc. the preventive programs can be grouped in to some basic categories [Basca & North, 2009]:

1. Family based - family skills training program designed to increase resilience and reduce risk factors for behavioural, emotional, academic, and social problems in children. In some of the programs the parents or the guardians are also taught parenting skills component.

2. Primarily substance use based - it focuses on substance use prevention. Knowledge about various drugs, their ill-effects and risks associated with use, saying 'no' to drug use and drug-using peers, engagement with non-drug using peers and in alternate pleasurable activities are the primary focus of these programs.

3. One-to-One Mentoring Programs - match volunteers and counsellors with youth. These programs are more intensive and focus on range of issues including substance use.

Issues related to staff: training, support and burnout

Children in CCIs are often reluctant to let down their guard and reveal information related to substance use or other issues. One of the reason is they often feel stigmatized for being in child welfare system, being labeled as an 'addict' or being 'deviant'. Thus, they desperately seek to remain 'hidden' which hinders their full participation in intervention programs planned for them. In order to prevent that and increase the child's inherent resiliency, staff and volunteers must be well trained, supervised, and supported to work with such children. Also, staff may also need training and support to network and reach out to other organizations, professional and for referrals.

Referral Criteria for specialized centre/services (Also see section 11)

Various situations in which a child in CCI must be referred to a specialist in substance abuse:

1. Severity of drug use - if a child fulfils the criteria of dependence for any substance and needs pharmacological intervention along with psychological treatment

2. High dose of drug use, multiple drug use and engagement in other high-risk behaviours along with drug use

3. Withdrawals due to substance - presence of withdrawal symptoms in absence of the drug requires medical intervention and referral

4. Adolescents who report more serious problems, such as use of injection drugs, or reports serious physical or psychological complications due to substance use or co-morbid with substance use should be should be referred to a substance abuse specialist.

5. Current or past history of any co-morbid physical or psychiatric condition

CASE STUDIES

Amit (name changed) was a 14 year old boy, belonging to a lower socio-economic status. His father used to work as labour in a shoe manufacturing factory and his monthly wage was Rs 3000/ month. His father used to drink alcohol daily and often beat him as well as his mother after coming home in an intoxicated state. Unable to bear daily domestic violence, one day, when Amit was just 7 years old, his mother left the home along with his three sisters but left Amit with his father due to father's insistence. Amit had difficulty adjusting in home environment and he started remaining outside with his friends. He used to come home only in the night time and rarely used to show up at school. He also used to get involved in regular fights with schoolmates

over minor issues. At the age of 11 years, Amit started taking eraser fluid (volatile solvent) along with his friends and subsequently left school. He would feel relieved of his daily stressors at home, hunger and pain due to beatings by his father in the intoxicated state. Gradually his use of the substance increased and so the money required to maintain his substance use. Due to this, he started working in a cycle shop as a helper. However, after 2-3 months of working, he became irregular and have regular arguments with his customers. He was also thrown out of work as he was often found intoxicated and not work up to customer's satisfaction. Gradually his requirement for money increased to sustain his substance use and so, started stealing money from home. Initially those amounts used to be small and insignificant but gradually it became a regular pattern and was frequently beaten by his father. Amit became desperate to arrange money and he with his peer group started stealing from mobile shops, but was once caught while stealing. He was detained by police and the next morning and was taken to juvenile court. His father was informed. In the court he pleaded guilty and was asked to remain in an observation home for 1 month period.

Initially in the observation home he started having regular fights. He used to go to the classes in the juvenile home but never used to take interest. He used to have intense urge to take eraser fluid. He would often remain irritable and not take interest in counselling sessions or daily activities. He would however remain concerned about his appearance and weight loss and often adored film stars for their figure and appearance. The counsellor took this as an opportunity and gave him the feedback that the deterioration is due to prolonged use of inhalants. Initially he dismissed their suggestion but gradually became more approachable and amenable towards counselling. He revealed how he was often adored by his mother and neighbours as a child and how it deteriorated with time. Gradually the frequency and the duration of the sessions increased. He started recognizing the ill-effects of inhalants but still complained of intense urge to take them occasionally. However he started interest in daily activities especially in the drawing class and discovered his ability for drawing. As people in observation home used to praise him for his creative ability he started developing different opinion for self. In subsequent sessions he reported decrease in urge for the inhalants. The counsellor pointed out that it was because he could divert his mind from inhalants to drawing which gave him as much pleasure as taking inhalants. Also, the fact that he no longer meets substance-using peers, had no access to money and that he was following a fixed routine throughout the day which kept him busy. All these were responsible for decrease in urge and improvement in his health and appearance. The counsellor would never argue with him during sessions even if he would find some of the ideas and inferences of Amit to be wrong or irrational but would allow Amit himself to reason out his own ideas and allow him to correct himself. Counsellor took a non-judgmental attitude and tried to assist him in recognizing the need for changes. The pros of substance taking and the cons of substance taking behaviour were discussed. His motivation level was also checked and was motivated further to change his lifestyle. Rapport was established to the extent that Amit also started opening up about his personal life, his aggression towards his father and hatred for mother. He was explained how he is externalizing his aggression towards people less powerful than him and by taking inhalants. Aggression management techniques were discussed. After a month he left the observation home but used to come back to work there on voluntary basis. He had two lapses related substance taking behaviour but he did not get involved in any anti-social activities and started working regularly in a garment manufacturing unit.

6.3: Suicidal Behaviour in Children

Introduction

Suicidal behavior is any behavior that is performed deliberately, and has the potential to harm oneself. It includes suicidal ideation, suicide attempts, and completed suicide. Suicidal ideation is thoughts and plans about suicide. Suicide attempts are acts of self-harm that could result in death, such as drowning or hanging. It was once thought to be less common amongst children, with rates gradually increasing towards late adolescence and peaking in mid-life. However, suicide rates in this population have shown a remarkable upward trend over the past few decades, including in India.

Staffs at child care institutions have an important role to play, in the management of suicide and self-harm amongst young persons in institutional care. These staffs are frequently "gatekeepers" as they are the first point of contact for children with problems; they are the first responders in a crisis. Extensive researches into the roles of gatekeepers have established that institutional care staffs can be effective in the initial screening, assessment and referral of patients with suicidal behaviour, including the modification of risk.

Risk Factors

Over the past few decades, youth suicidality (both fatal and non-fatal) has been showing a steady increase. A diagnosis of mental illness increases this risk: a diagnosis of affective disorder is particularly associated. The presence of risk factors other psychiatric disorders additively adds to the risk. Many studies have shown that suicidality is the outcome of the interaction of earlier familial and environmental distress, with the child's own psychological distress.,

These factors are found by researchers and practitioners to be associated with suicidal behaviours in children. They can be broadly grouped into four categories: biological, psychological, cognitive and environmental risk factors. The examples below, though not all inclusive, are found in suicide literature.

Biological risk factors	Cognitive risk factors
■ Mental illness ■ Depression/anxiety ■ Genetic factors ■ Puberty ■ Hormonal changes ■ Physical illness and chronic pain	■ Rigidity of thoughts ■ Over-generalization ■ Egocentrism ■ Immature views of death e.g. see death as an act of revenge, a test of immortality, a means to end pain and a romantic act ■ Fascination with death, violence ■ Idealistic thinking, extreme perfectionism ■ Lack coping skills to manage decision making, conflict, anger, problem solving, etc.

Psychological risk factors	Environmental risk factors (family-related)
■ Low self esteem ■ Feelings of hopelessness/powerlessness/ helplessness ■ Feelings of inferiority ■ Loss (or perceived loss) of identity ■ Confusion/conflict about sexual identity ■ Poor impulse control ■ High levels of stress; pressure to succeed e.g. disappointment with school academic results and failure in studies, high stress about examination and tests ■ Fear of humiliation	■ Depressed, suicidal parents ■ Changes in family structure through death, divorce, re-marriage, etc. ■ Low socio-economic status and educational level, loss of employment ■ Lack of strong bonding/attachment within the family, withdrawal of support ■ Unrealistic parental expectations ■ Violent, destructive parent-child interactions ■ Inconsistent, unpredictable parental behaviour ■ Physical, emotional or sexual abuse

Environmental risk factors (in general)	
■ Bullying and victimization ■ Drug or alcohol abuse ■ Exposure to suicide of a peer ■ Social isolation/alienation or turmoil ■ Poor peer relationships ■ Loss of significant relationships e.g. separation from girl or boy friends, death of a loved one	■ Frequent mobility ■ Anniversary of someone else's suicide ■ Access to lethal means ■ Disciplinary problems ■ Unwanted pregnancy or abortion

Suicide risk assessment and management

When to assess?

A routine assessment of risk should be part of the assessment of children, and particularly adolescents who are placed in childcare institutions. Throughout the period in which a child or adolescent is placed in such a setting, staff must be mindful of the possibility of suicide or self-harm, and be equipped to manage these situations.

In most cases, this assessment may take place informally, through the course of regular interactions. Here, the obligation upon staff members is to maintain an index of suspicion, and to watch out for warning signs such as a recent change in interaction, behaviour or performance; withdrawal from relationships; a recent change in life circumstances or stressors; disappointments that may occur during the course of peer interactions, achievement of life goals, in romantic relationships. In this population, depression is often missed, as it may present with 'atypical' signs such as a new onset of aggressive, disruptive or defiant behaviour; engagement in high-risk behaviors such as substance use or promiscuity; and a change in performance (e.g. in school). Some warning signs are presented in box 1.

Box 7: Warning Signs for Suicidality

- Unexpected reduction in grades or academic performance
- Apathy in class
- Failure to complete assignments
- Inability to concentrate on routine tasks and school work
- Increased absences or truancy
- Increased aggression, frequent trouble-making in school

Where staff suspects that such signs are present, a formal assessment of suicide risk must be done. In addition, staff must also be aware of other situations in which a formal suicide risk assessment is indicated even in the absence of such signs. This includes children or adolescents who have an established diagnosis of a mental disorder such as depression or psychosis; children and adolescents who have a history of substance use; children with a previous history of self-harm or suicide; those who have been exposed to significant traumatic experiences in the past; and those who have expressed ideas of self-harm or suicide either to their friends, relatives, teachers, or caregivers. In these cases, a systematic assessment of suicide risk must be performed, as detailed below.

How to assess

A systematic assessment of suicide risk includes the following components:

1. An assessment of the young person's current mental state in terms of their predominant thoughts and emotions, outlook and self-assessment of themselves and their situation
2. Specific enquiry about any current thoughts of suicide or self-harm
3. An assessment of the young person's history, accounting for temperament, previous experiences, exposure to suicide in the family
4. A specific enquiry about past suicidal plans or acts
5. Assessment of the young person's ability to access means by which they could commit an act of suicide or self-harm, for example access to dangerous chemicals or medication (including household chemicals and over-the-counter medication), or any object that might be used as a weapon (for example knives or other sharp instruments in the institution).

In assessing the young person's mental state, experiences of previous interactions may be valuable. This examination must be undertaken in a sensitive manner, as the person may be in significant emotional turmoil, and maintaining an open and non-judgmental attitude may promote disclosure of thoughts and current emotional states and stressors. For skills of assessment, refer box 2.

In the mental state, psychological symptoms that are particularly associated with suicide risk include a prominent negative view of oneself ("I am no good"; "I can't do anything right"; "I am a failure"), negative view of the future ("I will never succeed"; "Nothing good can ever happen to me") and

negative view of their own circumstances ("I can't get myself out of this mess"; "Things will always be as bad as they are right now"). Other symptoms such as fearfulness or suspiciousness must also be assessed. Emotional states such as persisting sadness, irritability, anger or anxiety, may also contribute, and must be assessed.

When such symptoms are found or suspected, counsellors must proceed to ask the person about any current suicidal thoughts or behavior. This is an oft-misunderstood component of the assessment. Multiple studies have shown that direct questioning about suicide risk is not harmful and does not lead to an increase in suicide risk, especially when it is done in a sensitive or empathetic fashion. Often, persons who are contemplating suicide feel unable to express their views for fear of provoking an unpleasant response of ridicule, anger, displeasure or invalidation from those around them. Counsellors who are able to express warmth and understanding, remain non-judgmental, and are willing to discuss the issues surrounding suicidality openly, are often able to establish a relationship with the young person that may even be protective against suicide and self-harm in the future.

While enquiring about suicidal thoughts, particular care must be taken to find out whether the person has thoughts that are persistent and troublesome; whether they have made any preparations to perform the task (such as collecting medications, identifying any item that may be used as a poison or weapon), or even attempted an act in the recent past. Protective factors (factors that prevent the person from going through with suicidal acts despite the presence of thoughts of self-harm) must also be enquired for.

One of the most consistent risk factors for elevated suicide risk is the presence of any previous suicidal behaviour in the past. For this reason, past suicidal attempts must be enquired for. The presence of previous mental disorders is also associated with a multi-fold increase in the risk of future self-harm. In addition, the presence of significant stressors or traumatic events (either recently or even in the past) including experiences of physical and sexual assault, bullying or punishment, must be enquired for.

Throughout the interview, the counsellor must be aware of the child's perception of power dynamics and potential negative consequences of disclosure. Where possible, the child should be assured directly that any information would be kept confidential, and disclosed only where it is mandated e.g. to facilitate medical management, or during legal proceedings. The rights of the child, and their legal status as a minor, may have implications.

Box 8: Basic Skills in Assessment

- Recognizing risk
- Developing rapport and cultivate trust
- Active, non-judgmental listening and support
- Empathy
- Asking the question, "Are you considering suicide?"
- Asking specific follow up questions to better understand risk levels
- Working collaboratively on a safety plan
- Knowing who and how to access additional support

Management

Staff at CCIs must be aware of what to do in situations where a significant risk of suicide exists, Suicide risk can be mitigated or even eliminated by appropriate management, which is delivered in a manner that takes into account the specific needs of the young person, and involves mental health professionals and all other persons involved in care giving.

The first and most important part of this is to clarify the best mode of action. In case of severe and acute suicidality, urgent referral to a psychiatrist, preferably one who has experience in managing children and adolescents, is clearly indicated. In this situation, the juvenile may require in-patient or out-patient care, and staff may be involved predominantly in the role of a guardian who acts in their best interests. Such a decision would also be indicated in any juvenile with a previous significant history of suicidal behavior (especially in the recent past), or those with multiple coexisting problems (e.g. diagnosed depression with previous history of trauma or assault), where psychological difficulties are likely to persist, and may require ongoing management.

In certain other situations, urgent referral may not be possible, or the staff member may feel that the situation can be managed for a time within the setting of the institution. In such situations, the first priority of all staff engaged in the care of the child should be to ensure their safety on an ongoing basis. A level of supervision and monitoring must be devised, with a single person being made responsible for supervision at any given time, and this responsibility being transferred formally if this person is unavailable for even brief periods. This level of supervision may range from frequent reassessments of suicide risk (in those who are deemed to be not at a moderate to high risk of immediate self-harm) to continuous monitoring by a staff member who stays with the person throughout the day and night (for those who are at high risk and need referral). Care must be taken to prevent the person from restricting

access to themselves in a bath area or otherwise, and access to chemicals, sharp instruments and other weapons, or any other object that could be used for suicide, must be restricted.

In a substantial minority of cases, it may be difficult to determine a risk level, in spite of careful assessment. In such situations, the best course might be to assume that the risk if towards the higher end, and act accordingly. Although such an action might lead to unnecessary referrals or increased load upon staff, it has less potential to lead to the missing of significant suicidality, which may be acted upon.

Staffs at CCIs also have an ongoing role in the aftercare of children and adolescents after the acute management of their suicidality. This is best done in collaboration with psychiatry services. Other children who would require ongoing support are a group with chronic ideas or acts of self-harm, even if not amounting to suicide. In such patients, psychiatry services must be involved as the management will require careful long-term planning. Such patients frequently have other psychological and behavioral disturbances that would place a significant burden of care upon staff.

Counselling skills

A number of research studies have shown that persons who are involved in the care of children can be highly effective in supporting them through a crisis. One approach that has been shown to be useful is one that is based on the principles of motivational interviewing. Such an approach is collaborative- it allows the child to participate in setting the agenda of discussion, and recognizes that the child can contribute; it is based on encouraging the child to discuss their problems, by means of active, empathetic listening; and it respects the child's autonomy.

Rapport must be established in order to create a situation in which the child feels comfortable discussing their problems. Counsellors must recognize that rapport is dynamic, and is strengthened or weakened by a number of verbal and non-verbal behaviours. Barriers to rapport may be due to the client (in this case, the young person in need of assistance); due to the circumstances that have led up to the interview; and also the behavior of the therapist. Although it impossible to establish rapport in all cases, certain barriers can be avoided: therapists must be careful not to sound as if they are dismissing the young person's concerns as "non-serious"; they should avoid giving advice that does not correctly address the person's specific concerns; they should try to recognize their own biases (particularly about coexisting behaviours such as crime, promiscuity or substance use) in their clients, and not allow these to get in the way of addressing other concerns. A few practical steps to establish rapport are provided below:

- ✓ Try to come out the reason to involve in this area
- ✓ Having clients explore solutions for their own dilemma
- ✓ Keeping the therapists agendas under wraps
- ✓ Reflecting what the child says
- ✓ Using YOU and WE vs I
- ✓ Asking permission before informing

In terms of counselling, a general approach is one that combines approaches from life-skills training and problem-solving approaches (Box 3 & box 4). In a crisis, the aims of counselling are to strengthen the client's own feelings of autonomy, and counter any feelings of powerlessness that often coexist. This may be done by helping the client, to see their own resilience and strength. This may be done by expressing positive regard, and by specifically pointing out and praising positive actions that the person takes.

An approach that emphasizes critical thinking and reasoning through one's problems may be useful in the medium term. Such an approach usually helps the child not to feel overwhelmed by problems—this is a common experience amongst young people and adults who are suicidal. In these situations, children should be encouraged to break their problems out, to rehearse solutions, and to adopt an approach where appraisal of failures leads to a gradual improvement in approach. A number of domains may be addressed by a variety of approaches, including role-plays, expressive writings, group activities and team-work, communication skills.

Box 9: Essential components of Life skills training

Self-awareness and self-esteem: Drawing and writing about oneself; taking responsibility for various activities.

Assertiveness: Role play, mime and drama are very helpful. Group rules are useful for group participation as well as to argue one's point of view.

Coping with stress and emotion: Drawing to express emotions, helping each other in distress, writing poems and stories of 'I feel'

Interpersonal relationships: Doing group work or in pairs such as on joint projects or pictures or stories, helping each other, participating in committees.

Communication: Opportunities to express, speak – verbal and non-verbal; role play, art.

Critical Thinking: Review the work done, ask questions – what happened, why, who, how.

Creative Thinking: Write or finish stories, think of hypothetical situations and solutions, role play.

Decision making: Games in groups, discussion based on real, hypothetical or role play situations, providing opportunities to take decisions

Box 10: Essential components of Problem solving training

- Orientation to the problems: recognize problems and to realize that one can deal with problems in appropriate ways.
- Problem list: helps to find out the, what the problem situations.
- Definition of the problem: clearly define the problem and any factors related to it.
- Generation of alternatives: think of many solutions
- Pros and cons: considering pros and cons of each solution
- Decision making: considering alternatives & choosing a solution and devising a plan to implement
- Verification: implement the plan and monitor the results.

6.4: Victims of Child Abuse

Child Abuse: Global & Indian Scenario

According to WHO (1999) "Child maltreatment, referred to as child abuse and neglect, includes all forms of physical and emotional ill treatment, sexual abuse, neglect and exploitation that results in actual or potential harm to child's health, development and dignity. With this five subtypes of abuse can be distinguished- Physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse and exploitation."

Child Abuse is a global malaise and is rampant across both developed and developing countries. Societies and countries have evolved in the last century; from the Geneva Declaration of the Rights of the Child adopted in 1924 to United Nations Convention on the Rights of the Child 1990, laws have become stricter and more effectively enforced across the globe. However, much needs to be done before each and every child gets the right to life and lead it without fear and persecution.

According to a global study on violence against children conducted across 137 countries by the United Nations, young children are at greatest risk of physical violence, while sexual violence predominantly affects those who have reached puberty or adolescence. Boys appear to be at greater risk of physical violence than girls, while girls face greater risk of neglect and sexual violence. Specifically for sexual violence, WHO in 2002, estimated that 73 million boys and 150 million girls under the age of 18 years had experienced various forms of sexual violence. A recent meta-analysis conducted in the year 2009 analyzed 65 studies in 22 countries and estimated 7.9% of males and 19.7% of females universally faced sexual abuse before the age of 18 years. The highest prevalence rate of Child Sex Abuse was seen in Africa (34.4%). Europe, America, and Asia had prevalence rate of 9.2%, 10.1%, and 23.9%, respectively.

The Indian saga is no different from most of the developing world, perhaps only a shade better. According to The Study of Child Abuse in India by the Ministry of Women and Child Development in 2007, every second child suffers emotional neglect, 2 out of every 3 children suffer physical abuse and more than half suffer sexual violence. If only every case of abuse were to be reported would we get the actual figures, but unfortunately child abuse for myriad cultural factors is shrouded in secrecy.

There is dearth of systematic information on child abuse in child care organizations in India. The growing number of media reports in the last decade is only a minute reflection of the enormity of the problem that is rampant in child care institutions. In the absence of family, children living in CCI's suffer all forms of abuse, more than what has been observed in the home and community settings. It is estimated that 40% of India's children are susceptible to threats like homelessness, trafficking, drug abuse, forced labour, and crime..

The issue of Child Abuse is still a taboo in India. Even today, people still do not want to disclose/report Child Abuse. The prevalence of CSA is alarming and calls for stringent measures for prevention and control.

Child Abuse in Child Care Institutions (CCI)

Children often don't realize that it is something wrong in the manner of interaction with the caretaker & needs to be reported, however uncomfortable it may be. Moreover, disclosure tends to be a process rather than a single reporting and is often initiated by careful history & interview following a physical complaint or a change in behaviour. The disclosure becomes more difficult in institutional settings because of insecurity of safety in psychological and/or physical terms. It has been often seen that at times perpetuators in these settings are one of the care takers themselves. Hence, prevention and eliciting detailed information becomes a challenging task.

Children in CCI are often isolated. Some are orphaned and some have left home due to neglect, poverty or abuse. In such cases, they are usually not equipped with the skills, knowledge, facilities or knowledge of their rights to defend themselves in high risk situations of abuse within the child care home..

Recognizing Child Abuse

Counsellors need to be aware of subtle signs that the child may display which may be indicators of abuse. The counsellors should watch for any change in the behavior of the child from previous behaviours, injury marks, oddities in behaviours, alterations in sleep and appetite, inappropriate dressing for seasons, spontaneous comments, paintings and drawings made by the child during the interview. A description of some of the indicators for physical abuse, neglect, emotional abuse and sexual abuse has been enlisted below made in Box 11.

Physical abuse is a non-accidental injury caused by the caretaker and can be distinguished from normal childhood injuries by it's location and shape as the latter are mostly over bony prominences and not on unusual areas such as abdomen and genitals. A print of a hand on the cheek is clearly an indicator of physical violence towards the child. Intent could be present or absent in these cases (eg Extreme disciplining, age inappropriate punishment or recurrent loss of self control because of stress, immaturity or drug use by the caretaker). **Neglect** comprises caregivers inattention to the basic needs of the child such as food, clothing, shelter, medical care and supervision. Neglect is chronic unlike physical abuse which is episodic. It Leaves no visible scars and is likely to go undetected. **Emotional Abuse** amounts to blaming, belittling or rejecting a child. It is important to be able to differentiate an emotionally disturbed child from an emotionally maltreated child as the in the former, the caretaker would himself be aware and concerned about the emotional disturbance in the child and would seek help, whereas in the latter the caretaker would either be unaware or minimize the gravity of the situation. Inappropriate adolescent or adult sexual behaviour with a child amounts to **sexual abuse**. The child may have physical symptoms in urogenital region, behavioural and emotional disturbances and/or precocious or otherwise inappropriate sexual behaviour. Child Abuse may have acute and long term health consequences for the briefly enlisted in Box 11.

1. **Recognizing Physical Abuse**

   Injury marks on inappropriate/ unusual places on the body

   Behavioural Indicators of Physical abuse:

   Wanting to spend more time in school

Demonstrating fear of adults
Act out, display aggression or disruptive behaviour
Self destructive
Poor scholastic performance
Poor peer relationships
Wearing season inappropriate clothes to cover injured body parts
Regressive behaviour
Dislike even 'good' physical contact such as a pat on the back or a gentle touch on the head
Subtle comments made by the child

2. Recognizing Neglect

Failing to provide a safe environment by not protecting them from unsanitary or hazardous living conditions
Leaving young children alone
More subtle such as malnutrition or wearing inappropriate clothing (eg No sweaters in winter)

3. Emotional Abuse

Treating one child from another unequally
Persistent lack of concern by the caretaker for child's welfare

4. Recognizing Sexual Abuse

- **Physical Indicators**
  - Lack of sleep
  - Lack of appetite
  - Aches & pains (somatic complaints)
  - Urinary tract infections
  - Skin infections

- **Fear or Anxiety Reactions**
  - Fear reactions towards opposite sex/same sex/ peers/ strangers/concept of going home.
  - Anxiety or fear without any reason or out of proportion to the present reason.
  - Childlike clinginess and clinging to adults.
  - Sudden onset of childlike behaviors like thumb sucking, nail biting.
  - Sudden onset of soiling and wetting clothes when these were not formerly a problem.
  - Decreased interaction with teachers and peers.
  - Excessive interaction with teachers and peers.
  - Excessive approval seeking from teachers and peers.

- **Depressive symptoms**
  - Sadness, low mood
  - Decreased interest in pleasurable activities, T.V, games etc
- **Aggressive reactions**
  - Anger outbursts, irritability, frequent fights with peers, back answering teachers.
  - Sudden mood swings: rage, fear, insecurity or withdrawal.
  - Self harming behavior like cutting hand, slashing threatening to slash wrists, banging head etc. So any sign of cut marks on hands, bruises in hands, head needs further exploration.
- **Behavioral problems**

  A. Fire setting (more characteristic of boy victims)

  B. Cruelty to animals (more characteristic of boy victims)

  C. Aggression toward more vulnerable individuals (younger, smaller, more naive, retarded individuals)

  D. Delinquent behaviors (characteristic of older victims)
     1. Running away (may be an adaptive response to avoid the offender)
     2. Criminal activity

  E. Substance abuse

  F. Self-destructive behaviors (characteristic of adolescent girl victims)
     1. Suicidal gestures, attempts, and successes
     2. Suicidal thoughts
     3. Self-mutilation

  G. School problems
     1. Inattention
     2. Sudden decline in school performance
     3. School runaway
- **Age inappropriate Sexualized Behavior**
  - Writings, drawing or play having sexual themes.
  - Mimics adult-like sexual behaviors with toys or stuffed animal
  - Asks other children to behave sexually or play sexual games
  - Has new words for private body parts
  - Sexual promiscuity.
  - Adult like knowledge regarding sexual matters.

- **Changes in Dressing Style**
  - Deterioration in personal hygiene.
  - Extra interest in dressing such as using accessories hairstyles, earings, histrionic tendencies.
  - Wearing clothes which cover body more than usual. Children with CSA sometimes show reluctance to expose any part of the body.
- **Changes in Biological functions**
  - Signs which indicate lack of sleep like dark circles, redness of eyes etc.
  - Loss /Increase in appetite.
  - An older child behaving like a younger child (such as bed-wetting or thumb sucking)
  - Wetting and soiling accidents unrelated to toilet training
- **Changes in performance**
  - Sudden drop in grades, lack of interest in studies, incomplete class work and homework can also indicate presence of trauma.
  - Lack of interest in sports and other hobbies can become important indicators.

Clues to Sexual Abuse via Internet

Prevents others from viewing the computer screen

Has disks that he/she will not allow for others to view

Takes significant time away from schoolwork to use computer

Exhibits secretive behaviour when using the internet

Box 11: Acute and Long term health consequences of child abuse

A. Physical

Abdominal/thoracic injuries
Brain injuries
Bruises and welts
Burns and scalds
Central nervous system injuries
Disability
Fractures Lacerations and abrasions
Ocular damage

B. Sexual and reproductive Reproductive health problems

Sexual dysfunction
Sexually transmitted diseases, including HIV/AIDS
Unwanted pregnancy

Box 11: Acute and Long term health consequences of child abuse

C. Psychological and behavioural

Alcohol and drug abuse
Cognitive impairment
Delinquent, violent and other risk-taking behaviours
Depression and anxiety
Developmental delays
Eating and sleep disorders
Feelings of shame and guilt
Hyperactivity
Poor relationships
Poor school performance
Poor self-esteem
Post-traumatic stress disorder
Psychosomatic disorders
Suicidal behaviour and self-harm

D. Other longer-term health consequences

Cancer
Chronic lung disease
Fibromyalgia
Irritable bowel syndrome
Ischaemic heart disease
Liver disease
Reproductive health problems

Source: Runyan D et al. (2002). Child Abuse and Neglect by Parents and Other Caregivers

Assessment and Intervention in Child Abuse

A. Interviewing a child who is a potential victim of abuse:

Child abuse has serious physical and psycho-social consequences which adversely affect the health and overall well-being of a child. Child abuse is an outcome of a set of inter-related familial, social, psychological and economic factors. The problem of child abuse and human rights violations is one of the most critical matters on the international human rights agenda. **Most Counsellors face difficulty in initiating a dialogue with a child who is a potential victim of abuse. Some general principles as mentioned in the Box below need to be born in mind before doing so. Also refer to section 5**.

- Open-ended questions tend to elicit more information. No direct or leading questions should be asked
- Consider other children (boys as well as girls) that may have had contact with the alleged perpetrator.
- Establish ground rules for the interview, including permission for the child to say he/she doesn't know, permission to correct the interviewer, and the difference between truth and lies.

- The child should be approached with extreme sensitivity
- Ensure gender neutrality and interview child along with someone whom he trusts.
- Establish a neutral environment and form a good rapport
- Try to establish the child's developmental level/cognitive understanding/maturity level
- Identify yourself as a helping person
- Confidentiality should be assured
- The child may be encouraged to narrate the experience at his/her own pace
- Explore-Prior history of trauma, sexual or otherwise, Prior mental health issues, Relationship of the offender to the victim, Victim appraisal of the circumstances, victim's coping mechanisms, Positive social support, Cultural background: perceived & actual response of society, to disclosure of sexual violence
- While exploring, don't be judgmental in expression and words. Don't criticize the child or get angry with her/ him.
- Be empathetic, understanding and supportive throughout the interview.
- Explain to the child that your duty is to report
- The authority should inform parents/guardians (If available) that the CCI has made a report of suspected child abuse.
- Do not communicate directly with the perpetrator (If an employee in the home) regarding alleged maltreatment. Remember your duty is to listen to both sides objectively and inform the appropriate law enforcement agency for probe into the substance of the complaint.
- Listen to the perpetrator (If an employee of the home) and remain objective
- Respond in a professional, direct and honest manner without displaying anger, shock or guilt
- Inform about the limitations of confidentiality and the professional obligation to inform
- Reassure the child of all possible help and that information will not reach peers

In cases of sex abuse specifically, WHO has listed following guidelines during assessment for CSA

- The evaluation of children requires special skills and techniques in history taking, forensicinterviewing and examination; the examiner may also need to address specific issues related to consent and reporting of child sexual abuse.
- Definitive signs of genital trauma may be seen in cases of child sexual abuse, as physical force is commonly involved. The accurate interpretation of genital findings in children requires specialist training and wherever possible, experts in this field should be consulted.
- Decisions about STI testing in children should be made on a case-by-case basis. If testing is warranted, age-appropriate diagnostic tests should be used. Presumptive treatment of children for STIs is not generally recommended.

- A follow-up consultation is strongly recommended. Although a physical examination may not be necessary, a follow-up consultation provides an opportunity to assess any psychological problems that may have since arisen and to ensure that the child and his/her caregiver are receiving adequate social support and counselling.

B. Intervention

The management of the trauma is the trickiest part. The care-taker should be supportive without being too intrusive. Following measures should be taken care of by the person who is handing the child.

Counselling for Abuse in general

1. First and foremost developing the trust with the child so he/she can disclose trauma is important. For that, talking to the child on regular basis, communicating support verbally and non-verbally is important. Never show and try to be in hurry.
2. It is important not to ask personal questions till the child is ready to answer. So till child himself/herself is not disclosing the trauma, sensitive questions should not be asked. Always begin with open-ended questions. Avoid the use of leading questions.
3. Child also goes through lot of self blame, shame and self doubt in these phases and needs unconditional support. Hence, the child should be provided with the support and explained that he/she is not responsible for what happened.
4. Art forms like drawing, writing can be used to bring out disclosure in a child. Getting the child involved in coloring/painting can have therapeutic effects too.
5. At the time of disclosure, it is important to listen to the child. It is preferable not to disturb the child when he/she is disclosing the trauma. It is important for them to express emotions like: anger, sadness, fear. If a child is crying or shouting let him/her do that. Don't use sentences like: Don't cry, don't feel like this, try to feel better.
6. Don't panic or overreact, with your help and support, the child can make it through this difficult time.
7. After disclosure, safety and security of the child needs to be ensured before going to the family members or if he continues to stay in CCI. In most of the CSA cases, family members/care takers are the perpetrators and any wrong actions can endanger the child.
8. It is important for care-takers to be acquainted with all the laws related to child sexual abuse. They can psycho-educate child regarding all their basic rights. It is important also not to make false promises. Also refer to section 3
9. Most of the time, the family/care-takers are unwilling to seek professional help and the psychological trauma experienced by the child remains undealt with. The counselor may need to work with the family or caretakers as well.
10. Child under-going abuse are also at risk of psychiatric disorders like: Depression including suicidal ideas, Anxiety, post traumatic stress disorder, and sometimes psychosis.

Care-takers need to understand the risk and an effort may be made for formal evaluation by the mental health professional so as to evaluate for psychiatric assessment, treatment and professional counselling.

Counselling for Sex Abuse

Children with sexual abuse undergo sequel of adverse physical, behavioral and mental health consequences which profoundly affect their overall development. Factors such as developmental age of the child, severity of abuse, closeness to the perpetrator, availability of medico-legal-social support network and family care, gender stereotypes in the community complicate the psychological trauma and hence need to be addressed.

Treatment of a child and familial system after sexual abuse is multifaceted and generally requires a bio psychosocial approach. Depending on the presence and extent of physical injury, medical professionals may be involved in treatment.

The basic counselling skill and techniques have been discussed elsewhere in this manual. The key components in any psychotherapeutic approach used with CSA should start with rapport building, Perhaps establishing rapport with the child holds maximum importance, in the absence of which the child will not open up to the counselor. The counselor needs to be prepared to deal with silence and accept it rather than fight with it and interject time and again out of apprehension. This seriously jeopardizes therapeutic relationship. Often the child may not say anything for many sessions together. The Counsellors work is not to be interrogative and ask questions relating to the abuse, unless the child himself wants to talk about it. The counselor needs to be available for the child if the child wants to talk about his trauma but at the same time be watchful not to scrape old wounds when the child does not want to talk about the abuse. The counselor needs to remember at all stages that it the child that guides the interview and his role is only to support the healthy aspect of his ego function.

Individual therapy or in groups (after due consent process) to teach children new skills of managing their affective, cognitive, and behavioral responses to the traumatic events. Key components would be to teach the child the basics of touch to prevent further abuse. This is also part of basic sex and safety education programmes which the counselor may conduct as part of a preventive programme in the CCI. The child needs to be told about 'Good' touch, such as a pat on the head or the back which may be gentle and has a positive influence on the child in the form of motivation or giving the child a sense of security. 'Bad' touch is what is uncomfortable or inappropriate, such as touching on the private parts. The child through simple language or diagrams needs to be made aware of his body and then tought abuse response skills such as moving away, shouting out loud in case he/she experiences a bad touch.

During the therapy process the child may experience post abuse distress and PTSD symptoms, dealing with self-blame/stigmatization, betrayal feelings, traumatic sexualization, and powerlessness. The child can be taught simple deep breathing exercises to relax himself. Enhancing coping skills to boost the moral and self esteem goes immensely into working with such children and helping them deal with their feelings. The ultimate goal of the therapy process is for the child to

overcome the pain and trauma that he/she has gone through, to develop the child's personality and make him capable of dealing with the vicissitudes of life.

Play therapy:
The child may be experiencing intense negative emotions and play being a natural medium of expression among children may allow the victim to find an outlet for her trauma. It helps the child to gain insight into their own behavior; increasing children's ability to observe and appreciate own and other people's feelings, needs, and rights; and increases ability to meet their needs in socially appropriate ways. The treatment components include : reflection to increase child's self understanding (insight), acceptance to convey positive regard for the child and improve the child's self-esteem; Interpretation to assist children in identifying and expressing feelings, Facilitating group interaction to improve peer relationships, Caregiver participation in collateral group treatment that uses acceptance, reflection, and interpretation to process problems presented by the caregivers.

Supportive Psychotherapy:
This is the least the therapist posted in the CCI can and should be able to do with the child if not in depth individual therapy for which the child may be referred to a higher centre. It includes comforting, advising, encouraging, reassuring, and mostly listening, attentively and sympathetically. The therapist provides an emotional outlet, the chance for patients to express themselves and be themselves.

The therapy can be augmented with sessions with caregivers on child behavior management skills, supporting them enough and working on building bonding and communication skills between them. The average number of sessions to complete the recovery program can range from 11 to 13 sessions.

Prevention Programs
Prevention programs and early identification can decrease the extent of sexual abuse and ameliorate its impact. Therefore, preventive interventions in these institutions can have far-reaching impacts.

The prevention programs include five components:

1 Screening for potential paedophiles;
2 Prevention material that is delivered to children in these institutions;
3 Educational material provided to adults in the institutions;
4 Rules that reduce risk; and
5 Procedures for investigating complaints.

C. Responsibilities of CCI Staff

An individual -centered approach presents an incomplete picture of the problem because institutional factors also play a role in sexual abuse, which occur in all institutionalized environments, where children and adolescents reside. Though in India, the pattern of abuse in residential setting

has not been systematically studied, but western reports have highlighted the importance of better training of childcare workers, more rigorous code of conduct, improve security within building etc.

- The staff should be affectionate, caring and understanding of the requirements and needs of the child.
- The staff should be responsive in case any special need of the child arises such as health issues or emotional support.
- The staff should have a sense of accountability, in order to deter any poor practice or potentially abusive behaviour.
- The child should be encouraged to talk to the Welfare Officers and/or the Superintendent, or the supervisors in their Home/Institution without any apprehension.
- Immediately report any suspicious behavior/suspected occurrence of abuse to the Management
- Record keeping, file work of case history, assessment and treatment provided should be maintained.

6.5: Mental Health Issues of survivors of Disaster and Conflict

Mental Health Issues of survivors of Disaster and Conflict: Indian Scenario

Disasters, whether natural or human-made, often leave today's families facing difficult times due to loss of parental employment, relocation, death of family members and other catastrophic events that create stress for all members of the family as well as in children of the family.

Most of the researches in India clearly establish that the Child and Adolescent population is a vulnerable group in disaster situations prone to adverse psychological sequelae. One year after the Orissa super cyclone in 1999, one-fourth of the adolescent population suffered from Post traumatic Stress disorder (PTSD) and around one-fifth had had depression and GAD. Proportion of Adolescents with any diagnosis was around 38% . Prolonged periods of helplessness and lack of adequate psychological support was cited as the reason for severity of psychological morbidity in the Child and Adolescent population. Although studies are lacking in this regard, but it is expected that for those children who are displaced from their homes, lose their family members and sent to Child care homes, the psychological morbidity and its impact on their lives would be much greater.

The psychological morbidity in Children and Adolescents is no less in conflict and war zone areas and stories are heart wrenching. According to one study conducted in the State of Jammu & Kashmir, 0.2 million children have been orphaned due to years of conflict in the region and most of these children do not even get economic compensation leave aside psychological support. In a study conducted on 400 children (200 Juveniles in conflict with law and 200 children in need of care and protection) in J&K one third of the total number of juveniles were victims of armed conflict with frequent crackdowns, beating of the family members, imprisonment of family members, house being burnt down and death of parents leading to them being subjected to poverty, constant fear and anxiety, Normlessness in the absence of family and a nomadic life.

In yet other regions of India the psychological morbidity in conflict zones is high. Even after four years of the Gujarat riots, 9.4% of the adolescent population had Major Depression and 4.7% continued to have PTSD. A phenomenon, perhaps less studied in India but a clear and potential danger of rendering adolescents in Conflict zones to religious extremism and radicalization and counsellors need to be aware of the management strategies to prevent the same.

The government systems and disaster response teams need to take into account the exigencies imposed on this vulnerable population of Child and Adolescents as a result of disaster and conflict situations tearing apart their lives and the need to rebuild it with the essential services including above all, psychosocial care and support.

There are five primary responses seen in children resulting from loss, exposure to trauma and disruption of routine: (The American Academy of Paediatrics Work Group on Disasters (1995).

1 Increased dependency on parents or guardians
2 Nightmares
3 Regression in developmental achievements

4 Specific fears about reminders of the disasters, and
5 Demonstration of the disaster via posttraumatic play and re-enactments.

Impact of Disaster on Children

Through the disaster children are likely to experience some of the following aspects of the event;

1 Loss of familiar environment
2 Fear and insecurity
3 Struggle for food, shelter and other amenities
4 Witnessing death
5 Witnessing rapes and other forms of violence, and
6 Continued threat to their sense of well-being.

Psychosocial Recovery of Children from Disaster

As adults in a caregiver's role (parents, relatives or members of outsides agencies, or teachers) must understand how you can help them recover. Diagram-1 captures the recovery process after a disaster and what you can do to hasten the recovery.

Understand the Emotional Reactions

It is important that we do not neglect the child. We need to accept and acknowledge change in the child. See it as a reaction to the event and then interact with the child keeping this information in mind. Accept and acknowledge the changes (Apetekar & Boore, 1990) by;

- Developing a warm friendly relationship
- Accepting them totally
- Not giving advice rather accept their views and feelings
- Respecting the child's views and emotions
- Being there both time and attention.

The process recommended for helping children and families often starts with "crisis intervention," which trained and supervised paraprofessionals and volunteers can provide. The primary goal in crisis intervention is to identify, respond to, and relieve the stresses resulting from the crisis (disaster) and to re-establish normal functioning as quickly as possible. Sometimes the reaction is mild, but other times it is severe. Also, the workers must be trained to recognize when the condition is mild and can be handled by the families (with guidance), when referral to a helper, such as a school counselor is warranted, and when it is severe and requires intervention by a mental health professional. Often counsellors feel that they have had no exposure in dealing with victims of a disaster situations. Such doubts are common and perhaps valid too but what needs to be remembered that in such situations 'Anyone who has a human touch' can be a counsellor, as it is the warm, emotional connect that becomes the need of the hour in a disaster situation.

Box- 12 below enumerates the steps in dealing with victims of disaster

Box 12: The steps in the dealing with victims of disaster are (Source: Speier 2000)

1. **Establishing Rapport**
   - Let the children know you are interested in them and want to help.
   - Check with the children to make sure that they understand what you are saying and that you understand them.
   - Display genuine respect and regard for the children and their families.
   - Communicate trust and promise only what you can do.
   - Convey acceptance of the children and their families.
   - Communicate to the children and their families that you are an informed authority.

2. **Identifying, Defining and Focusing on the Problem**
   - Identify and prioritize specific problems with the children, parents, and family.
   - Select a specific problem, define its characteristics, and focus on solving it first.
   - Achieve a quick resolution to the problem so that the members of the family experience a sense of success and control.
   - Evaluate the seriousness of each of the identified problems and the capacity of the family to deal with them.

3. **Understanding Feelings**
   - Demonstrate your ability to see and feel as others do.
   - Display patience in trying to understand children's feelings, for children are frequently unable to express their fears.
   - Respond to the children's stories frequently by commenting on the events and affirming their feelings.
   - Express a nurturing positive regard for the children, to convey an appreciation for the kind and intensity of their feelings.

4. **Listening Carefully**
   - Understand the disaster concerns from the point of view of the children.
   - Listen to the children's account of the disaster many times, in order to help children "work through" their feelings associated with the disaster.
   - Refrain from interrupting the children as they tell their stories.
   - Affirm children's feelings by giving them time to express themselves.

5. **Communicating Clearly**
   - Communicate in a language children understand.
   - Talk with children in groups or with siblings or other family members.
   - Seek the presence of family members to interpret code words used by the children.
   - Communicate with children in their dominant language.

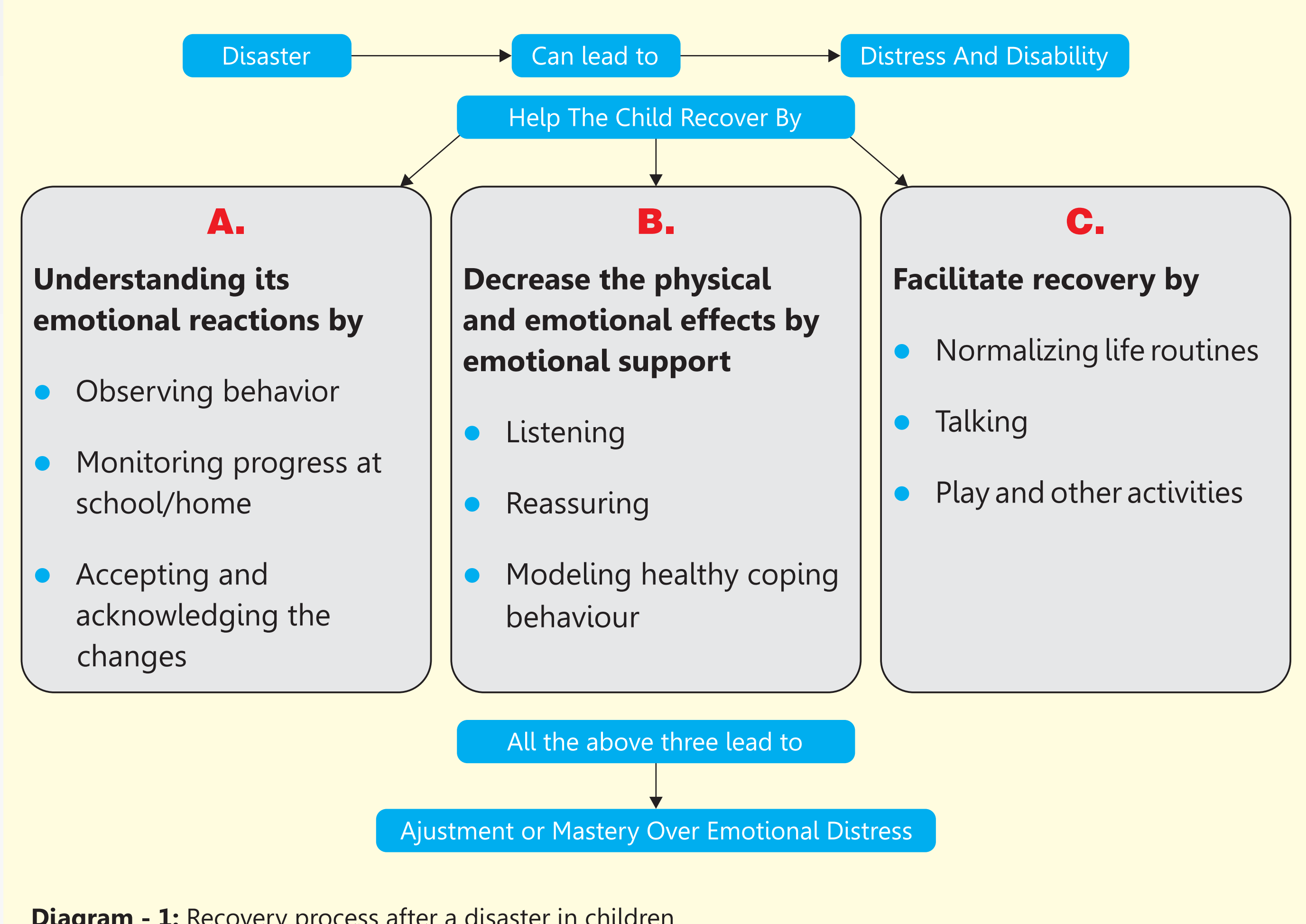


Diagram - 1: Recovery process after a disaster in children

Source: NIMHANS Training Of Trainers Information Manual-1Psychosocial Care in Disaster Management (2005)

Radicalization - A New age reality in the aftermath of constant conflict in sensitive geographical areas

Radicalization is a process by which an individual or group adopts extreme political, social or religious ideals and aspiration rejecting the contemporary ideologies. The risk of radicalization is extremely high in disaster and conflict zones

Risk Factors for Radicalization

1. Child going missing in conflict and war zones
2. Spending time with people already involved in radical activities
3. Lack of family support, home and guidance
4. In constant search for identity, faith and belonging in a conflict zone
5. Identifying with a radical group or ideologies
6. Identifying another group as threatening and using derogatory names for them

Strategies to deal with potentially radicalized children/adolescents

1. Provide a home like environment at the CCI's
2. Talk to the child always in a warm, comforting manner
3. Assess the developmental stage of the child and understand his reasons for identifying with one

particular radical group. Do not confront the child at the outset. Often, this may just be a passing developmental phase.

4. Engage child in positive constructive activities to boost moral and self esteem
5. Build on the resilience of the child
6. The counsellor should not allow ethnic, religious bias to develop and influence psychosocial intervention and maintain a neutral, non-judgemental psychological position for one's own sake and the larger context.

Building Resilience in Children who are victims of Disaster/Conflict prone geographical areas

When children in disaster/conflict prone areas are brought to the CCI's, it is important to know how long back the traumatic disaster event has happened prior to initiating counselling. Often, the

child has recovered from the acute disaster event, in such cases the focus should be on the development of resilience in the child.

A combination of factors like having caring and supportive relationships within and outside the family contributes to resilience. Relationships that create love and trust, provide role models and offer encouragement and reassurance help bolster a person's resilience. Children in CCIs unfortunately are not privileged enough to have such kind of relationships and hence all the more important the the counsellor establishes with the child a good working relationship.

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress- such as family and relationship problems, serious health problems or workplace and financial stressors. It means "bouncing back" from difficult experiences.

Being resilient does not mean that a person doesn't experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress.

Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that can be learned and developed in anyone.

An effective plan to develop resiliency for the children in CCIs can include many areas that can be worked upon. Some of them are highlighted as below in Box:

Box 12: Developing resilience in children

a. Building self-esteem
b. Overcoming past trauma
c. Developing positive attitude towards life
d. Re-building the confidence
e. Developing skills in communications
f. Gain control over feelings
g. Preparing the child for the future

In CCI, Developing resiliency differs from child to child because every child does not react in the same manner to traumatic and stressful events for example, whether and how a child connects with significant others, including extended family members and community resources. Following points can be considered while making resiliency plan for the children.

a. Encouraging child to make connections
b. Motivating the child to avoid seeing crises as insurmountable problems
c. Preparing the child to accept the changes of the life.
d. Setting goals and motivate the child to focus on them.
e. Motivating child to look for new opportunities for self- discovery
f. Helping child to nurture a positive view about himself

Other basic components:

Point 1: Help the child to Identify and then address the Problem.
Point 2: Help the child to avoid stress when possible.
Point 3: Bring Exercise in the daily routine.
Point 4: Make a healthy diet plan.
Point 5: Make sure that child has sufficient hours of sleep.

Also equal focus should be made to develop the inner strength of the child the key areas of focus in that aspect can be:

a. self-control
b. thinking skills
c. confidence
d. positive outlook
e. responsibility and participation

Also read and refer to section 3 and 7 of the handbook

Box 13: Role and responsibilities of CCI staff (Do's)
Do's a. Provide a Family like environment for the child to grow freely. b. Help child in making new relations in the institution. c. Motivate the child to believe in himself d. Develop an informal bonding with the child e. Gain trust of the child and motivate the child to share his feelings, ideas, views with them f. Motivate the child to participate in group activities

g. Tell inspirational stories which can include stories related to spirituality, national leaders, famous personality etc.

h. Motivate children with the success stories of the other children who have left the CCI.

I. Provide all the necessary information to the counsellor, mentor or any other expert who is assigned for this kind of job.

j. Helping children in setting up goals for the life and to stay focus towards those goals

k. Under take all such measure, to make the children of the CCI emotionally, mentally and physically strong.

l. Ensure a healthy diet plan for every child.

m. Make sure that the child has sufficient hours of sleep.

n. Provide emotional support to the child during the examination time or any other important event.

o. Ensure privacy for each child.

Box 14: Role and responsibilities of CCI staff (Don'ts)

Don'ts

a. Do not leak the information which the child has shared.

b. Do not force the child to share his feelings.

c. Do not discuss about the present or the past problems of the child while sitting in a group.

d. Do not de-motivate the child by using words such as 'you are not capable of doing it'.

e. Do not stop the child from trying any new skills, unless it is not in the best interest of the child.

f. Do not discuss the stories related to the past trauma of the child.

g. Do not disclose any confidential information with the counsellor, mentor or any other person assigned with the child, unless required.

h. Do not interfere in the privacy of the child.

I. Do not break the trust of the child.

6.6: Convergence and Prioritization

Often Counsellors working in CCI's come across situations where multiple issues related to the health and safety of the child may need to be addressed. The child may have an underlying psychological /psychiatric disorder complicated by disability and suicidal tendencies requiring urgent attention. Although, it is difficult to get exact estimates of psychiatric co morbidities in physically disabled children especially those living in CCI's but it is indeed very common.

According to the IHBAS assessment report of Home for Mentally retarded Asha Kiran done first in 2010, 10% of the total residents required admission at various medical facilities on an urgent basis. These residents had primarily Intellectual disability and suffered from co-morbid medical conditions which ranged from Tuberculosis and Acute respiratory infections, Gastroenteritis, skin infections, nutritional deficiencies. Neuropsychiatric conditions in decreasing order ranged from Seizure disorder, cerebral palsy, genetic and endocrine disorders and movement disorders. Orthopaedic deformities complicated the case in some of the residents. These conditions in combination not only contribute to physical disability but psychosocial disability as well.

In this category of patients with co-morbid medical and neuropsychiatric disorders, acute behavioral problems such as aggression, suicidality and psychosis often pose difficulty in assessment as the observer will find it difficult to delineate the acute psychiatric condition from the usual behaviour of the child wherein the child may be helpless to speak out his/her troubles because of intellectual impairment, speech and hearing impairment, pain due to contractures and physical disability. This group of children are also more vulnerable to sex abuse especially from the caretakers and may not be able to voice it, such situations are always difficult and unsettling for the counsellor often to the extent of Therapeutic nihilism. In such perplexing times, the counsellor needs to maintain objectivity and neutrality. All attempts must be made by the counsellor to provide safety and security to the victim from the perpetrator and report to the concerned authorities immediately, even on slightest suspicion.

It is suggested to the counsellors to follow the protocol mentioned in Diagram-2 in the subsection of the Handbook entitled 'Framework for developing a locally available referral network and referral criteria for specialized centers/services' and refer to the Flowchart for the seven essential management strategies for children with multiple co morbidities and/or disabilities as they are highly vulnerable of the vulnerable group. The role of the counsellor in such cases goes much beyond what may have been learnt in the clinic. From a holistic bio-psychosocial perspective the counsellor may have to make astute observations in delineating acute behavioral changes as part of a recent onset neuropsychiatric or metabolic condition from the behaviour that may be ascribed to the physical disability. Further, the counsellor needs to co-ordinate with other professionals for continued care and advocate for the rights of the client by pursuing for disability benefits after certification which oft happens in residential care facilities. Thus the counsellor needs to be do psychosocial intervention and not merely assessment and behavioural intervention.

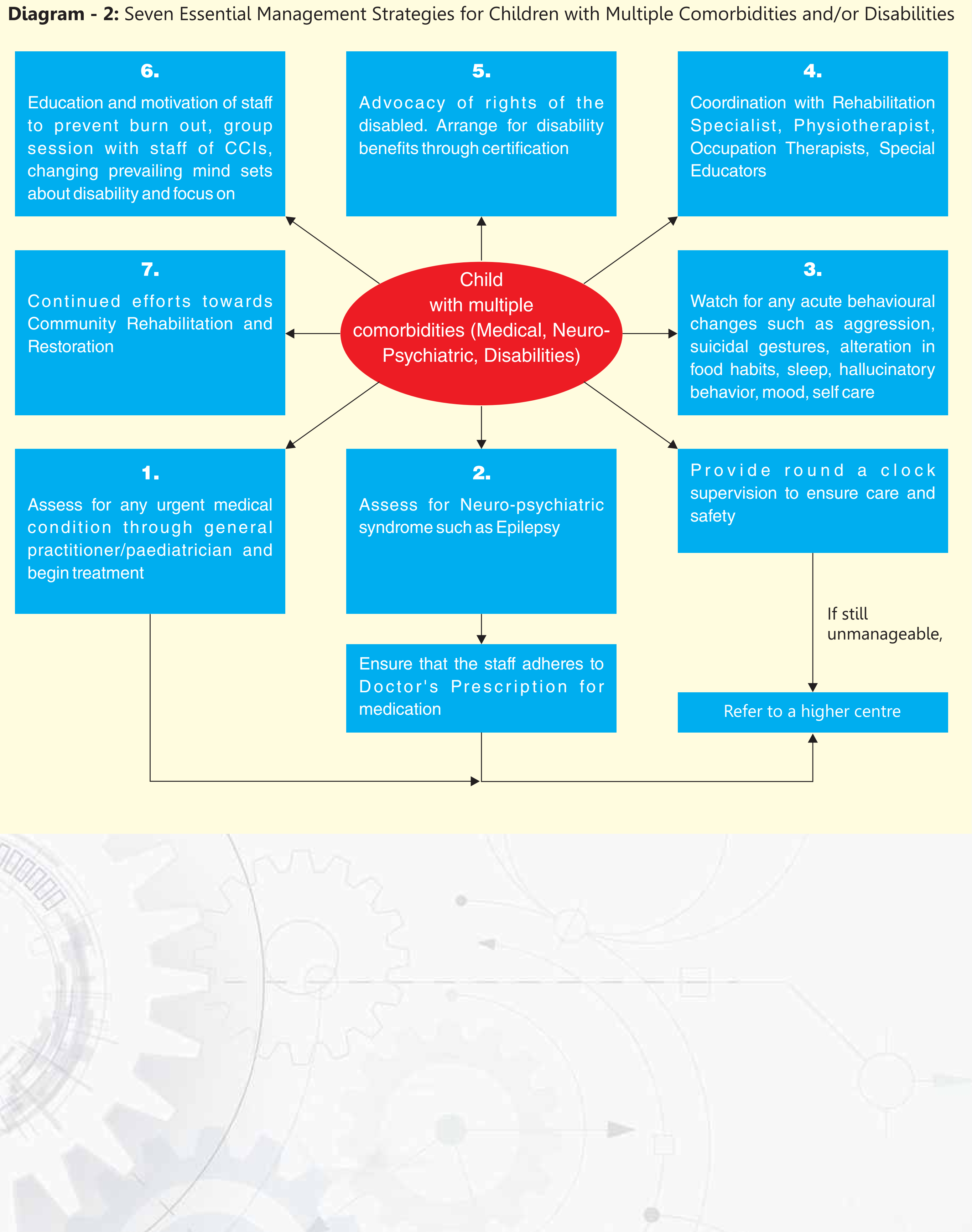


Diagram - 2: Seven Essential Management Strategies for Children with Multiple Comorbidities and/or Disabilities
6.
Education and motivation of staff to prevent burn out, group session with staff of CCIs, changing prevailing mind sets about disability and focus on
5.
Advocacy of rights of the disabled. Arrange for disability benefits through certification
4.
Coordination with Rehabilitation Specialist, Physiotherapist, Occupation Therapists, Special Educators
7.
Continued efforts towards Community Rehabilitation and Restoration
Child with multiple comorbidities (Medical, Neuro-Psychiatric, Disabilities)
3.
Watch for any acute behavioural changes such as aggression, suicidal gestures, alteration in food habits, sleep, hallucinatory behavior, mood, self care
1.
Assess for any urgent medical condition through general practitioner/paediatrician and begin treatment
2.
Assess for Neuro-psychiatric syndrome such as Epilepsy
Provide round a clock supervision to ensure care and safety
If still unmanageable,
Ensure that the staff adheres to Doctor's Prescription for medication
Refer to a higher centre

Section 7:

Promotion of Positive Mental Health & Well being among children in CCIs

7.1: Identification of Positive and Protective factors in children:

How we nurture our children into healthy and mentally balanced individuals? What is the formula for it? There is essentially no particular formula to it but certainly there are a few directions which can be also called as "Protective" and "Positive" factors for child development. In context of the right to Protection as per the National Policy for Children, 2013, our focus in this chapter will be on the responsibility of care homes for children in protecting children. In order to understand how to protect children in general, we first must understand about what to protect them from and what are the risk factors.

In order to develop a child into a healthy individual, we need to protect them from child maltreatment which includes the following four types of maltreatment namely: Physical abuse, Child neglect, Emotional abuse and Sexual abuse.

In order to understand the protective factors, we must first know the risk factors and their likely outcomes. They can be understood as follows:

1 Risk factors refer to stressful conditions, events or circumstances that increase a family's chances to poor outcomes making the children more vulnerable to maltreatment of any form.

1.a The maltreatment whether in any form causes immense amount of stress for children that can hinder the normal early brain development and chronic stress can affect the children's immune system and nervous system.

1. b Maltreated children are more likely to develop health problems such as depression, alcoholism, drug abuse, eating disorders, obesity, smoking, suicide, high risk sexual behaviours etc. in their adult lives. In order to mitigate the effects of such adverse circumstances on the children, the role of protective factors comes into play.

2 Protective factors refer to those factors, conditions or attributes of individuals, families, communities or the larger societies that lessen the vulnerability and the impact caused by the risk factors thereby promoting healthy development and positive wellbeing in children. As these factors are instrumental in protecting the child against the effects of risk factors thus focusing their positive wellbeing they are also called as positive factors.

However, it is important to note for care givers that few studies have also shown that not all children who have suffered with sexual abuse develop psychiatric sequelae. Finkelhor and Berliner (1995) showed that approximately 40% of the sexually abused children present with very few or no

symptoms at all. In contradiction to this line of thought, few studies have also referred a phenomenon called as "sleeper effect" which means that such asymptomatic children may initially remain asymptomatic due to various individual factors such as good coping skills or resilience but gradually they tend to deteriorate over a period of 10 to 12 months. Mannarino et al.,1991 and Finkelhor and Berliner(1995) have estimated this population of children to be 10% to 20%. Thus, for such cases the study of positive factors becomes even more relevant and caregivers need to be extra cautious.

Affectionate and trustworthy relationships seem to be important protective factors in the care of maltreated children. On these lines, the Centre for Disease Control and Prevention's Division for Violence Prevention in United States of America (2014) enlisted three essential and critical qualities of relationships that make a difference for children as they grow and develop. The three essentials are as follows:

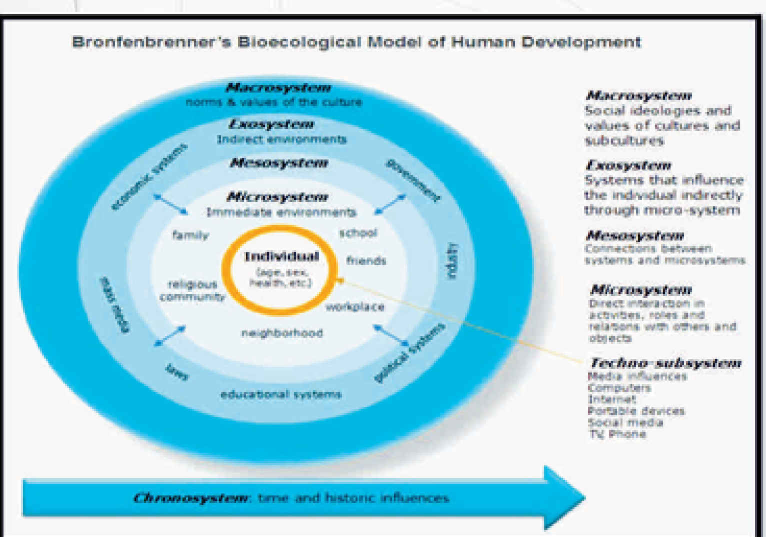
1 **Safety:** it refers to the extent to which the child is free from fear and perceives his /her relationships as a secure bonding and free from any physical and psychological harm in their social and physical environment.

2 **Stability:** the degree of predictability and consistency in a child's social, emotional and physical environment. Changes in relationships, people, social milieu is contraindicative

3 **Nurturing:** this means the extent to which a parent or a caregiver is available and is able to sensitively and consistently respond to and meet the needs of their child.

Since the concept of child maltreatment is based on person- environment interaction and the role of particular environments is considered vital in nurturing human development and supporting freedom of expression of every individual, it is important to first analyse the levels at which various risk factors as well as protective factors can exist. To better comprehend this, we shall base it on Uri Bronfenbrenner's Social ecological model known as Ecological Framework for human development. This model focuses on child development within the contexts of the systems of relationships that form his/her environment.

Bronfenbrenner's Ecological Framework for Human Development



In this system Bronfenbrenner proposed that for effective development of an individual we need to take into account the entire ecological framework in which the individual is developing. This ecological system is bi-directional i.e. relationships have bi-directional influences both away from the individual and towards the individual. In simple terms, it means that human beings develop in relation to their environmental conditions and circumstances. Everything in a child's environment affects how a child grows and develops. He labelled the different levels of environment surrounding an individual as follows:

A **The Individual:** Various individual factors such as age, level of maturity, coping skills, resilience, intelligence etc. determine the risk and protective factors for children.

B **Micro-system:** It comprises of the institutions and groups of people that directly impact the child's development such as family, school, neighbourhood, religion and peers, in this case care-giver in institutions, counsellor, and therapist

C **Meso-system:** It refers to the interactions and inter-connections between micro-systems such as family and teachers, family and peers, therapist, care-giver etc.

D **Exo-system:** This refers to the links between the social setting in which the individual does not have an active role and the individual's immediate context.

E **Macro-system:** This refers to the cultural influences, attitudes and ideologies of culture and religion, socio economic status, ethnicity, impacts of poverty etc.

We shall discuss the positive and protective factors and associated risk factors along these layers particularly at the levels of the individual, micro-system excluding the family, meso-system and macro-system.

Since the individual is the central point of this cocoon of social systems we shall first start with various individual protective factors and the associated risk factors. The Administration on Children, Youth and Families wing of the US Department of Health and Human services in their review Youth Thrive and Strengthening Families presented with a factsheet in September, 2015 and professed the role of children's internal skills in promoting their wellbeing. This review came up with the following three main internal skills leading to positive outcomes:

a **Self-Regulation of emotions and action -** it refers to the child's ability to manage or control their emotions and redirect them. It is related to the child's resilience.

b **Good interpersonal skills -** a child's ability to form positive connections with others and effective communication of one's problems and assertiveness could be a useful skill to develop in children.

c **Ability to problem solving and facing challenges with fervor:** it refers to the child's ability to solve problems and good decision making and planning skills. The focus of the caregiver in the care institutions should be on inculcating positive and affectionate relationships with children

and empowering them with the motivation to adapt effectively in situations, good adjustment and task oriented coping skills. These are further seen to lead to improvements in academic performance.

Other than these three major sets of internal skills, there are many positive individual factors:

d **Involvement in positive activities -** such as involvement in extracurricular activities such as debates and games of children's choice, dancing, singing, drawing, painting, writing etc. Such activities could give a release to a child's frustrated pent up emotion and release of tension.

e **Good achievement in schools -** it could be a boosting and a positive factor for maltreated children, distracting them from their trauma and bringing their focus to a more neutral and age appropriate achievement for them.

f **Development of social-emotional competence -** it should be emphasized to teach children to be more receptive and mindful towards their own and others emotions, to nurture empathy and take other's perspective as well and use their emerging cognitive skills to think about appropriate and inappropriate ways of acting. Studies have focused on development of social and emotional competence of children. These studies have emphasized that social development and emotional competence are two distinct yet very connected domains. Emotional development has been linked to the development of linguistic and cognitive capacities in the child. For e.g. emotions of happiness and interest can help children to engage with and learn from cognitively stimulating objects and experiences such as building a block tower and reading a book. These studies have brought forward the following ways to develop social-emotional competence in children:

f.1 **Making friends and taking part in play:** caregivers should focus on helping children to make friends and take part in play. The ability to socialize encourages the child's self-worth, self-competence and fosters a positive overall view of the world. Ice breaking sessions and participative games are required.

f.2 **Development of positive attachment patterns:** Shonkoff and Philips (2000) have shown that emotional development is considered to be the base for children's psychosocial wellbeing and mental health. They have further reported that the quality of a child's primary relationships has a critical influence on the child's view of self and others. Thus, the caregivers of the children in care institutions should try to establish positive attachment patterns with these children as this can develop a sense of positive self-competence in children.

Other common individual protective and positive factors suggested for maltreated children are as follows:

g **Above average Intelligence -** High intellectual ability could provide a child with resources to deal with a traumatic memory of an experience, to rationalize the agony associated with it and to learn to move on making use of coping skills. The use of cognitive skills in resolving trauma is important and high logical skills will help rationalize the trauma to a large extent.

h **Interests and hobbies -** having hobbies could prove to be potentially useful for a child as engaging in his/her hobbies could again prove to be distracting for the child and pleasurable since the child is pursuing in his/her hobbies. It will also make the child feel useful and wanted. It's a rewarding self reinforcing and self achieving experience for the child and

I **Good Peer Relationships -** Caregivers should encourage the children to make friends and engage in play, on similar lines having pre-existing good peer relationships could also act as a strong buffer for maltreated children and in helping them deal with the negative emotions associated with the maltreatment. A supportive peer group will help the child deal with the negative experience in a more rational and pragmatic way and will help the child to get over it by providing the child with a sense of belongingness and affiliation thereby reducing the child's feelings of isolation, shame and dejection. The ability to socialise with others could be an effective skill for distracting the child's attention from distressing thoughts and memories. Being in the company of others, social participation could enhance the child's wellbeing. It has indicated in a study that early social development tends to set children on a path towards either social competency or deviance in middle childhood or adolescence (Shonkoff and Phillips, 2000). Good social and relational skills when seen are an indication of positivity.

j **Good health and history of adequate development -** A child who is physically healthy and has a history of normal milestones and has no physical or learning disabilities, will be equipped with a better self-confidence to handle the maltreatment associated trauma.

k **Easy temperament and positive disposition -** an easy going and adaptable child will cope better with the maltreatment associated trauma as compared to a slow to warm up or difficult temperament child.

Since a child with easy going and adaptable temperament will be more sociable and will not prefer to remain aloof and isolated, it will provide the child with better resilience.

l **Positive Self Esteem -** Valuing one's own self and being aware of one's own strengths could prove to be a boon for the child who has suffered a maltreatment episode as it will keep up the child's self-esteem despite having suffered a big traumatic blow. Having a high self-esteem can act as a great catalyst in building up the child's coping mechanisms in the face of the maltreatment.

m **Active coping styles -** if the child is equipped with effective coping styles, it will act as a positive and protective factor for the child. Efficient coping styles such as finding humour in a situation, using emotion focused coping strategies such as distracting one's self, releasing pent up feelings by talking about them, disclaiming, avoidance of traumatic thoughts and positive reappraisal of the situation, seeking support etc. could be helpful.

n **Internal Locus of Control and self-efficacy -** having a positive internal locus of control is and self-efficacy could act as pivotal buffers against maltreatment. Self-efficacy could be understood as the one's own positive beliefs about one's capabilities. It could promote the child's wellbeing as that ways child would feel motivated to get over with his/her distress

assuming it to be his/her own responsibility. It further improves the child's resilience and leads to improvements in internalizing behaviours such as anxiety, depression, social withdrawal and somatic symptoms.

The corresponding individual risk factors that need to be explored for and paid attention to are the child's age as younger the child's age lesser is the maturity to handle the effects of the traumatic experience, anti-social peer group, childhood trauma, attention deficits, aggression and behavioural problems, physical, cognitive or emotional disability, difficult and slow to warm up temperament.

Further, we shall discuss the protective and positive factors pertaining to Brofenbrenner's micro-system and exo-system such as school, neighbourhood, peers, and factors associated with the caregiver etc.

o **Caregiver's well-being -** The importance of caregiver's well-being as a protective factor for maltreated children particularly sexually abused or neglected children. The caregiver with better emotional skills, low stress levels and adequate social support are perceived more positively by sexually abused children.

p **Positive peers -** also act as protective factors in the lives of the sexually abused children and foster reduced levels of substance abuse, less anti-social behaviour, less suicide rates and better focus on academic performance.

It is further reiterated in the review about the role of community in providing positive environment to the children who have suffered sexual abuse. It has put forth the importance of the following:

q **Stable school / institution environment -** which can be measured by effective teacher student interaction is a vital protective factor for children. Koplow (1996) has coined a term "therapeutic classroom" which is referred to as a place where troubled children are helped to sort out their complicated experiences so that development can proceed. In addition to the primary factor of positive child student relationship, a therapeutic classroom facilitates a child in providing an educationally rich physical environment in terms of teaching using models, diagrams etc., a consistent daily schedule and routine, long periods of open ended playtime, clear rules and limits and a curriculum integrating conceptual and emotional themes. Rich environment, interested care givers, dedicated staff will contribute positively to ameliorate the trauma.

r **Positive community environment -** which can be ascertained from cordial relationships with the para-professionals, visiting staff, surrounding cohesion, and positive community norms working towards encouraging the children could be important community factors.

s **Stable living environment -** whether it is at home or a care institution, it can be ascertained by healthy attachment dynamics with a caregiver, consistent care-giving patterns, discord and disagreement free understanding and unconditional positive regard from the caregiver could help in bringing the maltreated child's level of anxiety down and thus act as positive and protective factors.

7.2: Strategies for Prevention and Promotion of Mental Health in Children living in Child Care Institutions

Introduction

Worldwide, an estimated 102 million children are orphaned, abandoned, or otherwise separated from their parents. Many of these children are placed in Child Care Institutions (CCI). In addition, child offenders are placed in correctional institutions as mandated by the law, and other residential facilities exist for children with special needs, whose parents are unable to provide for them. The reasons for placement of a child in such a facility may show marked variations; they may be regulated differently; their administration and expected outcome may vary; and the profile of the residents may be markedly different. But Child Care Institutions also share a number of features:

1. They are residential facilities with provision of round-the-clock care
2. They are managed by professional staffs who are remunerated for their services.

By and large, children placed in such facilities spend a considerable amount of time in them. Depending on the institution and jurisdiction, a number of possible outcomes may be expected for boys and girls who enter such an institution, such as:

1. Foster care or adopting parents
2. Voluntary departure on attaining majority
3. Transfer to an adult facility that caters to the same population (in the case of children with special needs)
4. Completion of a mandated period (in the case of correctional facilities)

Worldwide, reasons for placement in such a facility have been described, although systematic studies are infrequent. In the civil setting, the major reasons for placement have been either being orphaned or abandoned by parents, runaways where identification of guardians has not been possible, and separation from adult guardians due to conflict or natural disasters. In the juvenile justice setting, delinquency and crimes have been major reasons for placement.

These children have been shown to be at a markedly elevated risk for psychosocial problems. This is due to the complex interaction of a number of biological, psychological, familial and broader social factors. It is important to understand these, as many of them have a role to play while planning interventions. These are: social disadvantage and adverse experiences in early childhood, that have been repeatedly shown to be associated with increased rates of psychological and behavioural symptoms; traumatic experiences that immediately led to the placement, which frequently have long-lasting sequelae; unusual socialization, which may be influenced by early separation from parents, by the child's own

predispositions, and the absence of prosocial role models; and personality features in the children themselves. The relationship between these factors is multi-directional, and a number of these may be modified by intervention. In the absence of intervention, they may place these children at an elevated risk of depression and anxiety, substance use, personality disorders, suicide, apart from a range of other mental and behavioural disorders.

In this context, the importance of preventive and promotive strategies cannot be over-emphasized. In this chapter, we will attempt to define what is meant by mental health prevention and promotion; describe strategies at an institutional level that may be useful in preventing mental disorders and promoting mental health; techniques to deal with high-risk children that may be implemented by staff while dealing with individual high-risk children. While doing so, we shall try to frame these approaches within the Indian context, while also taking into account the international perspective on child rights, and the special problems inherent in dealing with children in an institutional setting.

Preventive and Promotive approaches in mental health

Preventive and promotive approaches in mental health include a number of public health strategies whose primary aim is the prevention of mental disorder, and the promotion of overall mental health. As may be expected, preventive approaches must be broad-based and available to a large number of persons. At the same time, individual approaches may be more suitable to any one person or setting.

Preventive approaches are traditionally classified as universal strategies, which may be applied to all individuals in a population (in this case, all the children in the Child Care Institution). These approaches include promotive aspects that aim to enhance mental health, such as the teaching of social skills or coping skills that may be useful to all children; or other interventions that aim to remove problems that might exist in these institutions, which are known to adversely impact mental health-for example the provision of adequate infrastructure, staffing and facilities for education and general health. These approaches must be appropriate to the developmental stage of the individual, but their effects are general and not disorder-specific.

Another set of interventions are also required, that are targeted at persons who are at particular risk within the population, and these include the identification of such children; the description and understanding of factors that contribute to their elevated risk, and the design and delivery of interventions that may be best suited to them, either at a group or individual level. The relative advantages and disadvantages of universal and targeted approaches are detailed in table 1.

It is important to point out that an approach that is universal in one setting may be better thought of as a targeted intervention in another setting. For example, children with disruptive behaviors, delinquency or substance use may form a small group of high-risk subjects in a children's' home that caters to orphaned and abandoned children; on the other hand, they may be much more frequent in child offenders residing in juvenile justice homes.

Table 1: Advantages and disadvantages of universal and targeted approaches

	Target	Advantages	Disadvantages
Universal	Population	No labeling Single intervention for multiple problems	Inefficient - high risk children are the minority Insufficient duration/intensity
Targeted	High risk groups (Selective) or Sub syndromal (Indicated)	Increased efficiency Early identification and intervention More control over duration/intensity	Labeling and stigmatization Failure to target accurately to highest risk group Unstable risk status Predictive validity problems

Childhood mental illness known to be associated with multiple long-term adverse outcomes, such as:

- Lower educational attainment
- Lower wages
- Lower likelihood of employment
- More crime

It has also been consistently shown that prevention (that includes the early identification and intervention in the case of diagnosable mental illness) can significantly alter the course of mental disorders, and may be able to reduce or even eliminate disability in adult years (Figure 1).

Figure 1: Targets for intervention

Child Rights and Mental Health

The current international standard as regards child rights is the United Nations Convention on the Rights of the Child (UNCRC). This convention, ratified by the United National General assembly in 1989, and ratified by 196 member countries (all eligible nations except the United States of America) defines the rights of all children (defined as those under the age of 18, unless national legislation defines majority at a later age).

With respect to Child Care Institutions, the convention specifies child-specific needs and rights that prescribe certain obligations upon member nations, including in the realms of child custody and guardianship. Basic rights that must be assured to all children irrespective of setting include the right to life, the right to having one's own name and identity, the right to be raised by his or her parents within a family or cultural grouping. Children have the right to be protected from abuse or exploitation, to have their privacy protected.

As a country that has ratified this convention overall, India is obliged to provide these rights to children, including those who have been placed in child care institutions.

The institution receiving the child and becoming his/her new home has the duty to respect all the rights of all the children, delivering the services it is meant to provide without compromising on

standards. The fundamental rights and needs of institutionalized children and some important principles to be followed in the daily management of an institution. Also focus on monitoring mechanisms to prevent and

promptly counter against violence and abuse when they occur and the debate's emphasis on the importance of valuing caregivers and staff working in residential facilities.

Promoting a child's mental health means helping a child feel secure, relate well with others and foster their growth at child care institutions. We do this by helping to build a child's confidence and competence- the foundation of strong self-esteem. This can be achieved by providing a child with a safe and secure home; warmth and love; respect; caring and trusting relationship with the person who are living with them, friends and adults in the community; opportunity to talk about experience and feelings; time to play, learn, and succeed; encouragement and praise; and consistent and fair expectation with clear consequences for misbehavior.

Preventive and Promotive Strategies

Targeted interventions

Screening

Numbers of risk factors have been identified, that contribute to mental health problems either in childhood or into adulthood. Some of these risk factors are listed in table 2 and protective factors in table 3. Staffs at Child Care Institutions are well-placed to identify these risk factors.

Table 2: Risk factors

Constitutional Handicaps	Perinatal complications, organic handicaps, sensory disabilities
Skill Development Delays	Low IQ, social incompetence, attentional deficits, reading disabilities, poor work skills & habits
Emotional Difficulties	Apathy/emotional blunting, immaturity, low self-esteem, emotional dysregulation
Family Circumstances	Mental illness, family size/organization, child abuse, SLEs, conflict, poor bonding
Interpersonal Problems	Peer rejection, alienation, isolation
School Problems	Scholastic performance
Ecological Risks	Deprivation, discrimination, unemployment

Table 2: Protective Factors

Individual Characteristics	Cognitive skills, social skills, temperament
Quality of Interaction	Secure attachment to parents and peers
Environmental Characteristics	School-home relations and regulatory activities

Counselling and Care within the Child Care Institution

One advantage of preventive and promotive care is that it can be made available to children by individuals who do not have very specialized training in mental health care. An added advantage is that by developing such skills within the institution, continuity of care would be maintained, and the setting is one which is familiar to the subject.

Preventive and promotive counselling includes a number of components that are outside the ambit of psychological counselling, for e.g. Vocational and career counselling.

Components:

1. Life skills: Life skills refer to psychosocial and interpersonal skills that promote mental wellbeing and that lead to a healthy and productive life. Life skills training develops competencies and promotes behavior change. They result in personal actions, actions directed to others and actions to change the surrounding environment in a healthy, safe way. Refer to Box 9 and Box 15 for details.

2. Sex education: Sex education refers to the process of acquiring information and forming attitudes and beliefs about sex, sexual identity, relationships and intimacy. It is also about developing young people's skills so that they make informed choices about their behaviour, feel confident and competent about acting on these choices.

3. Stress management and coping skills: Stress management and coping skills training are techniques to reduce to a person's stress and how to cope with stressful situation and especially for the purpose of improve everyday functioning like.

4. Social skills: Social skill is any skill facilitating interaction and communication with others. Both verbal and non-verbal through gestures, body language and our personal appearances. It is also social rules and relations which develop socialization in human life.

5. Substance use counselling: It is refers to the services and programs that provide to advantage and disadvantage of substance use. In the process counsellor should be develop some of the key skills to work at an individual level with children who have substance use problem.

6. Problem solving: It is refers to the process of solutions to difficult or complex issues of the children's internal or external behaviour.

7. Counselling towards eventual deinstitutionalization: In this process counsellor refers to the technique and services how to reforming child care system and moving the children out of institutional care and finding new placement for children., The aim of this intervention is to prevent psychological difficulties that may arise from having to adjust to this new environment, and the consequent stress.

   In general, counselling that would be most helpful to these children would be one that includes establishing a trusting relationship in which the child feels comfortable discussing their

problems. In order to do so, staff would have to cultivate an attitude that is non-judgmental, warm and supportive, without sacrificing objectivity. In counselling children from a history of disadvantage, rapport may be particularly difficult unless counsellors are able to overcome the child's suspiciousness. It is important to define the desired long-term outcome, and work steadily towards this. Ideally, such an outcome would be defined by the child and the counsellor together, and staff must be aware that the expectations and needs of the child are best achieved by encouraging the child to participate and define the outcomes themselves.

Staff involved in counselling may find it useful to rely on the trans theoretical model developed by Prochaska and diClemente which defines stages in behavioural change. In the first step of "pre-contemplation", the client does not recognize the existence of a problem. In the second step, "contemplation", the client is consciously aware of the problem, and can make "preparations" to alter their behaviour. After the behavioural change itself, a period of "maintenance" of the new behaviour ensues, which may be sustained. In other cases, the client relapses to former patterns of behaviour, and must be motivated to resume their activity. Any given child may be at a different stage of this cycle, and would require intervention that either provides knowledge or changes attitudes towards a behaviour, or strengthens their ability to act for behavioural change.

Appropriate referral

It must be understood that preventive and promotive care is only one component in a comprehensive mental health care package to be implemented in these institutions. Although preventive and promotive strategies may be very effective in the management of subsyndromal symptoms of anxiety and depression, additional care may be required by a number of children with problems such as prominent anxiety, depression, post-traumatic stress-related symptoms, moderate to severe suicidality, psychotic symptoms. Children with symptoms in multiple domains, or those with difficult personality traits, may also require care in a specialized setting, at least for planning management. In this scenario, staff at the childcare institution could function as the initial point of referral, as case managers who support the child through formal healthcare services, as the primary caregivers, and in the provision of care during the follow-up period.

Institutional approaches

While planning for preventive and promotive strategies in this setting, one important consideration is that many aspects deal with factors outside the individual child {Rutter, 1982}. Mental health in this population is dependent on a number of factors, e.g. nutrition and general health, the availability of a nurturing family environment, education and appropriate stimulation, peers and role-models, and so on.

This places, a responsibility upon the staff and administration of Child Care Institutions to deal with these environmental factors. In our survey of Child Care Institutions in Delhi, we found that infrastructural problems were frequently present.

Another part of the institutional approach is the sensitization and training of staff at Child Care Institutions. Worldwide, the initial identification of psychological and behavioural problems in

children is by educators, counsellors and parents (or other legal guardians). Staff at institutions, particularly those dealing with large groups of high-risk individuals, are particularly in need of formal training that would convey knowledge, as well as develop their skills in screening and intervention.

The institution would also have to work towards developing a referral and linkage network with other services involved in the care of children. In particular, systematic linkages with general practitioners and pediatricians; educational facilities and special education facilities where required; child welfare services, would be essential for the successful functioning of these institutions.

Ongoing linkage with mental health institutions would also be required. This may be achieved either by the creation of a referral system that takes care of the children's ongoing mental health needs; a liaison model, where mental health professionals regularly visit the institution to manage mental health problems, and interact with the staff to take care of the day-to-day management. The specific model adopted would depend on the morbidity the particular institution, as also the availability of mental healthcare.

Box 16: Life skills Training

Many of the strategies for preventive and promotive mental health well being fall under what is called as 'Life skills training' which are skills that the child needs to stear his/her own ship through the waters of life

1. Self care skills: This involves teaching the child skills to brushing, toileting, bathing, wearing clothes, eating food properly and table manners. This may be done through role modelling, active guidance and support. In case the child has not learnt these skills at the time of entering the residential facility then the staff would need to be patient and caring enough for the child to learn and master the skills.

2. Physical education: Children develop and improve not only their motor and sensory skills through play but also their social skills. It provides the child an important platform to learn and develop and hence the CCI should have and make arrangements for adequate play facilities for the health and well being of the resident children. Further, outdoor and indoor activities in still good habits in the child preventing them from lifestyle disorders in the future.

3. Schooling to normalize routine: The adverse psychosocial reasons resulting in the child being brought to the residential facility causes disruption in the normal school life and routine. It is the duty of the counsellor, superintendants, child protection agencies and the State to ensure that the child receives schooling at the earliest without delay as per provisions of the Right to Education Act, 2009. Schooling ensures continued learning, socialization and setting of a routine which is so very essential during developmental years.

4. Ensure leisure and entertainment time: During this time the child should be allowed to do what he/she wants to do. Some children may enjoy painting, some playing music, dancing and the same should be actively supported by the staff. During this time the child can

express freely and is a window of opportunity for observation of any behavioural change that the counsellor may suspect to indicate a mental health problem.

5. Externalizing the interests of the child: By cultivating a hobby in the child as a means of learning and healthy coping. The organizations need to tide over problems related to time and human resource, finances etc and impart skills to the children residing in CCI's which will have both short term and long term impact on the developmental trajectory of the child. It takes the attention and mind away from troubled personal lives and allows for positive changes through hobbies.

6. Teaching child cooking and preparing meals for self, money handling so that the child can manage his/her own finances later in life are essential skills which are often overlooked.

7. Sex education and Menstrual hygiene: Sex education for both boys and girls should begin when the child is ready for it and the counsellor needs to be prepared to deliver it without any undue hesitation. It involves teaching the child about good touch, bad touch and confusing touch, assertiveness training etc. If required, special workshops on sex education may be arranged which are managed by professionals. Imparting sex education becomes even more important as this group (ie children in CCI's) is vulnerable and susceptible to abuse; and earlier the child learns to protect himself from abuse and keep away or seeks help from prying individuals, the better. Girls need to be taught how to maintain menstrual hygiene for a healthier and happier life. Most girls often during the menstrual period end up getting neglected by the caretakers whereas they need to be more sensitive to the concerns and anxieties of the child during this phase. Effectively dealing with the transition during adolescence will not only generate feelings of well being in the child and develop a health self construct but also accept and welcome womanhood.

8. Effective communication, social skills and problem solving skills: Individual/group sessions may be taken by the counsellor in-cooperating certain play material/board games to improve communication and problem solving skills in children permitting them to be in touch with their feelings and be able to express them clearly and permitting them to be in touch with their feelings and be able to express them clearly and coherently.

9. Emotional Regulation: Teaching the child to talk about his feelings and emotions, find out ways of dealing with anger and frustration differently.

10. Vocational training: Specialized skills can be imparted to children living in CCI's which can become a source of livelihood in the future. Electronic repairing, woodwork, welding, mechanical repairing, plumbing, travel and tourism training which are taught to many adolescents in some observation homes in Delhi have helped in rehabilitation and securing the future of many of these children. Those children with special needs benefit immensely form vocational training.

11. Supporting higher education through state funding and resources: This improves the quality of life and makes the individual more resourceful for the society at large.

12. Preparing the child for healthy relationships: Especially for children in CCI's who have no parental guidance and are old enough and on the verge of entering adulthood to effectively decide for themselves; need to be educated by the counsellor about the concept of marriage and togetherness, the pros and cons of each, the right time to take such decision so that the young adult can make a conscious, well thought over decision for himself/herself.

13. Provide continued moral support and provide constructive feedback.

14. Emphasize on 'Self Reliance' at all steps and stages of intervention so as to develop the child into a healthy, responsible adult.

stresses
anxiety disorders
emotional problems
central nervous system
health
emotions
behavioural problems
symptoms
sensory
psychological
depression
psychological
personality
mental disorder
mental health
dopamine
drugs
philosophies
social
expression
cope
degenerative disorder
wellness

Section 8:

Mental Health well being of the Counsellor (Care for Carers)

Perhaps the most potent force in therapy is the counsellors own ability to model 'aliveness' and 'realness' and hence the counsellor needs to take care of himself/herself to remain alive in his/her profession. The counsellor needs to be aware and work with his/her own feelings and thought process that is disturbing him/her and hindering him/her from delivering effectively. The factors that contribute to sapping the vitality of a person and professional needs to be paid attention to, thereby preventing 'Professional Burnout'.

Stress at workplace including Burnout among health care professionals has become a common and critical problem affecting staff, the agencies for which they work, and the clients they serve. Working constantly with people who are in pain, feeling suicidal, grieving over the loss of loved ones, or those severely traumatized, takes a heavy toll on practitioners. Further, most ethical and risk management instructions fuel unrealistic fears and worries about?? board investigations and law suit. Unlike carpenters, gardeners, or surgeons, psychotherapists rarely see immediate, profound, or tangible results from their efforts. The work is often (though not always) slow.

Box 17: Common feelings and thinking as indicators of Professional Burnout

1. "Just going through the rut of life'
2. Feeling whatever one is doing makes no difference at all
3. Convincing oneself that such feeling are inevitable and an occupational hazard which has to be dealt with
4. There is nothing much to revitalize oneself

Manifestations of Burnout

There are many ways that the symptoms of occupational stress and burnout can manifest. Physical symptoms such as headaches, gastrointestinal disturbances, chronic colds, changes in appetite, and sleep difficulties can appear or become worse. Emotional manifestations can include feelings of depression, helplessness, anxiety, nervousness, guilt, irritability, and emotional depletion. Behavioural symptoms may show up as tardiness, absenteeism, poor performance, or participation in gossip at work, all of which can lead to low morale. As the experience of burnout continues, therapists may develop negative attitudes toward the work, themselves, their clients, or life in general. This can manifest in defensiveness, pessimism, cynicism, or intolerance toward clients or other people. They may then find it difficult to focus on others, choosing instead to withdraw from clients, friends, and family members.

Men and women working in the care services provide professional support to individuals experiencing emotional, mental and physical difficulties. Providing this level of constant care is demanding and stressful and can encroach upon the personal life of the professional counsellor or therapist if the updating of adequate support measures is ignored. Those working within the caring professions must understand the importance of self- honesty and be willing to seek support or help when workload and responsibilities become too demanding.

Research on the correlates and antecedents of burnout suggest that a number of organizational-environmental variables are related to burnout, including an excessive workload, time pressure, role conflict, role ambiguity, absence of job resources (especially supervisory and co-worker social support), limited job feedback, limited participation in decision-making in matters affecting the employee, lack of autonomy, unfairness or inequity in the workplace, and insufficient rewards (including social recognition)

Box 18: Manifestations of Burnout

- Feeling tired, drained and without enthusiasm.
- Feeling pulled by many projects/tasks, most of which seem to have lost meaning.
- Feeling that what they do have to offer is either not wanted or not received.
- Feeling unappreciated, unrecognized and unimportant and going about their jobs in a mechanical and routine way.
- Tendency to not see any concrete results or fruits from their efforts
- Feeling oppressed by the "system" and by institutional demands which are contended as stifling any sense of personal initiative.
- In its increased form, burnout makes the professionals/counsellors feel more and more isolated, making them fail to reach out to one another and to develop a support system and rob us of the vitality we need personally and professionally.

Box 19: Causes of Burnout

A combination of individual, interpersonal and organizational factors contribute to burnout.

- Doing the same type of work with little variation, especially if this work seems meaningless.
- Giving a great deal personally and not getting back much in the way of appreciation or other positive responses.
- Lacking a sense of accomplishment and meaning in work.
- Being under constant and strong pressure to produce, perform, and meet deadlines, many of which may be unrealistic

- Working with a difficult population, such as those who are highly resistant, who are involuntary clients, or who show very little progress
- Conflict and tension among a staff; an absence of support from colleagues and an abundance of criticism
- Lack of trust between supervisors and mental-health workers, leading to a condition in which they are working against each other instead of toward commonly valued goals
- Not having opportunities for personal expression or for taking the initiative in trying new approaches, a situation in which experimentation, change, and innovation are not only unrewarded but also actively discouraged
- Facing unrealistic demands on one's time and energy.
- Having a job that is both personally and professionally taxing without much opportunity for supervision, continuing education, or other forms of in-service training.
- Unresolved personal conflicts beyond the job situation, such as marital tensions, chronic health problems, financial problems and so on.

Box 20: Remedies of Burnout

- There is a need for acceptance of 'personal responsibility'.

  It should be remembered that blaming the system or external factors for one's condition and placing more responsibility outside of oneself and believing that someone else or some impersonal factors is making oneself ineffective, often contributes to general feelings of hopelessness and powerlessness. By this, professionals surrender their own personal power and assume the position of a victim. This lends itself to the development of cynicism.
- Counsellors have to become active and stop blaming the system. Instead, they should focus on what they 'can' do to bring about 'some' changes and to create a climate in which they can do work that has meaning for them.

Box 21: Preventing burnout from happening

- Evaluate your goals, priorities, and expectations to see if they are realistic and if they are getting you what you want.
- Recognize that you can be an active agent in your life.
- Find other interests besides work, especially if your work is not meeting your most important needs.
- Think of ways to bring variety into work.
- Take the initiative to start new projects that have personal meaning, and do not wait for the system to sanction this initiative.

Box 21: Preventing burnout from happening

- Learn to monitor the impact of stress, on the job and at home.
- Attend to your health through adequate sleep, an exercise program, proper diet, and meditation or relaxation.
- Develop a few friendships that are characterized by a mutuality of giving and receiving.
- Learn how to ask for what you want, though don't expect always to get it.
- Learn how to work for self-confirmation and for self-rewards, as opposed to looking externally for validation.
- Find meaning through play, travel, or new experiences.
- Take the time to evaluate the meaningfulness of your projects/tasks to determine whether you should continue to invest time and energy.
- Avoid assuming burdens that are clearly the responsibility of others. If you worry more about your clients than they do about themselves, for example, it would be well for you to reconsider this investment.??
- Take classes and workshops, attend conferences, and read to gain new perspectives on old issues.
- Rearrange your schedule to reduce stress.
- Learn your limits, and learn to set limits with others.
- Learn to accept yourself with your imperfections, including being able to forgive yourself when you make a mistake or do not live up to your ideals.
- Exchange jobs with a colleague for a short period, or ask a colleague to join forces in a common work project.
- Consider forming a support group with colleagues to share feelings of frustration and to find better ways of approaching the reality of difficult job situations.
- Cultivate some hobbies that bring pleasure.
- Make time for your spiritual growth.
- Become more active in your professional organization.
- Seek counselling as an avenue of personal development.

Role of Organization in managing Burnout in staff

Work organizations can play an indispensable role in the prevention of occupational burnout. Increased autonomy, effective supervision, ongoing training, realistic work demands, appropriate vacation and sick time and supportive contact with colleagues are some of the ways that agencies can assist their workers to reduce the potential for burn out.

It is unrealistic to think that burnout can be completely eliminated. Internal and external stressors will always affect people from time to time. However, when we are aware of occupational stress and its causes and manifestations, we can develop and implement preventative strategies that will greatly decrease unnecessary burnout among health care professionals.

Box 22: A number of possible changes in organizational practices that may help decrease or prevent burnout, include the following –

1. Increasing social support for employees,
2. Teaching communication and social skills to supervisors thereby increasing individual employee autonomy
3. Involvement in decision-making
4. Reducing role ambiguity and conflicts for employees
5. Providing regular supervision, including peer supervision
6. Provision for two way feedback between staff and the organization
7. Decreasing workloads and promoting self-care as a value within the organizational culture
8. Provisions for re arranging schedules
9. Periodic rotation of staff into different sections of the organization to reduce stress
10. Providing benefits for attending workshops/conference for continued professional developments
11. Periodic health checkups for staff
12. Recognizing work and rewarding for the same
13. Providing professional support to individual employees experiencing psychological fatigue.

Section 9:

Child and Adolescent Mental Health Assessment Tools

(Brief and simple screening tools)

Statement of Problem (including scope & Definition)

This Chapter deals with the screening and assessment of various mental health and behavioural problems in children and adolescents, emphasizing the importance of their early identification. Children with underlying mental health problems show changes in their behaviour or have alterations in their social and academic functioning, which if timely identified by significant caregivers, can be corrected by means of counselling and/or medication. The screening tools mentioned are brief and simple ones and are meant to empower the staff of Child Care Institutions (CCIs).

Relevance and Context of Child Rights and Mental Health

Indian Scenario (including data sets & Reports)

In the recent times, with the growing urbanization, stressful lifestyles, etc, the mental health problems in child and adolescent age groups have been reported to be on the rise. Children comprise 40% of the total population of India. According to Census 2011, the state of Delhi has a population of approximately 20 million of which 2 million are below 6 years. Most studies report a prevalence of Mental illness of 20% in the Child and Adolescent population. Given such a high burden of illness, it becomes important for the authorities concerned to identify and if required treat the mental and behavioral problems in the children and adolescent age group. Early identification and treatment will not only improve the quality of life but also would prevent the problem from becoming more serious and prevent any long term sequale which may happen in the natural course of the illness.

Subject as applicable to CCIs

Child welfare agencies are increasingly being encouraged and/or required to screen all children for mental health concerns. This chapter is intended to highlight the process of identification and management of mental health problems in Children and adolescents residing in Child Care Institutions (CCIs) in the light of the current and standard practices of Mental Health across the globe.

What can be done about it? (in CCIs)

- When a child develops a common medical problem such as fever, sports injury, bleeding etc it is not difficult for the caretaker of a residential home to recognize it as a medical problem and seek help for the same. The same does not hold true for emotional/behavioral or psychological

problems which by itself may be complex, masquerading in different forms and easily missed by an untrained eye.

- The commonest reason the problem may be overlooked is that it may be considered part of the 'normal' behaviour and may go un-noticed. On many occasions, the 'problem' behavior cannot be dissected out properly from 'normal' behavior because of the ignorance of the caretaker and the child may continue to suffer. What is important and expected of the caretaker is to know and gauge the extent of impairment in social functioning, school performance and observe for any odd behaviour that may be an indicator of an underlying mental illness and inform higher authorities and /or seek help from a qualified mental health professional. The process of early identification of mental and behavioral problems in the child and adolescent population holds immense importance as it offers the opportunity to intervene when the problem is still developing and prevent it from escalating any further. Early identification is the key to effective management because with age any behavioral problem can get consolidated in a child's personality/temperament thereby making it all the more difficult to correct it.

- Any person who is directly or indirectly related to the care of a child, whether it be a parent or a guardian, or someone involved in the education of the child such as a teacher, school counselor, or school principalal, caretakers and staff of residential and foster care homes, skilled workers engaged in health care programs for children such as Anganwadi workers, social workers, nurses and other basic health care providers, medical and paramedical professionals such as general physicians, paediatricians etc, should be aware of and be able to recognize certain manifestations which could be indicators of an underlying mental health/psychological problems. This module intends to empower all the care providers with the basic knowhow of the identifying symptoms of mental health problems in Children and adolescents by helping them with appropriate and timely course of action/intervention .

- **How to do it?(Techniques, expected benefits and precautions)**

The first and foremost principle to remember before even attempting to identify 'abnormal' behavior and making an appropriate referral is 'Do No Harm' by labeling, stigmatizing the child or use of pejorative comments. Identification and subsequent assessment for presence or absence of a mental health problem can have many ramifications. The child may feel stigmatized and isolated, and the caretakers of CCIs may jump to conclusions that the child be given special classes or be transferred to special education unit, while on the other hand the authority figures in the organization where the child is residing may have a change of attitude towards him/her. Such attitudinal changes run the risk of disrespecting the child knowingly or unknowingly which may further ostracize the child.

To prevent this, it is imperative on the part of the organization concerned to clearly state that the process of identification is only to help out children with possible underlying mental health problem. Words and the label of 'mental illness' can have a lot of impact on the psyche of the children and adolescents. The use of the words 'Mental stress' has a less stigmatizing impact than the words such as 'Mental illness' or 'psychological/psychiatric illness' while one is

screening for the presence of the same in an organization. As the identification is intended to be done at various organizational levels such as residential facilities, juvenile homes etc by non-mental health professionals, merely identifying a child with one or another problem behaviour, by no means is proof of a clinical diagnosis indicative of mental health problem requiring intervention . It is important that caretakers remember this tenet, as false positive diagnosis can have grave consequences.

Key points to remember during Identification
1. Do not use stigmatizing words and phrases
2. Communication with the child should be clear and coherent
3. Identifying a children with having one or another problem behavior by no means is proof of a clinical diagnosis
4. Process of identification is only to help out children with possible underlying mental health problem
5. The identification of mental health problem should not lead to 'labeling" a child or use of pejorative comments.

The mental Health Professionals namely Psychiatrists, Clinical Psychologists, Psychiatric Social Workers and Psychiatric Nurses either alone or within the framework of a "multidisciplinary" team can make a diagnosis of a mental illness. In view of shortage of mental health professionals, programs have been designed and initiated to train doctors and other health staff in identifying and treating common mental illnesses and refer whenever necessary to higher centers. Other than these professionals mentioned above, all other professionals whether it be teachers, school counsellors, psychologists without adequate training/expertise or qualification in Mental Health and social workers should not attempt to make a diagnosis of mental illness ,as it has far reaching implications. It is prudent to mention at this stage the gold standard of medical practice 'When in doubt, refer to a specialized center', in the best interest of the child.

- Many children and adolescents will exhibit some of the following characteristics and behaviors at various times during their childhood development as mentioned below.

Symptom patterns/Behavior in child needing attention by caretakers of CCIs
• Experiencing frequent mood swings
• Avoiding friends and family
• Anger and Rage attacks
• Spending excessive time in bathroom or room alone
• Not doing the things he or she used to enjoy

- Worrying constantly
- Lacking energy or motivation
- Poor appetite
- Having difficulty sleeping
- Getting low marks in school
- Rebelling against authority
- Hitting or bullying other children
- Damaging other people's property
- Not concerned with his or her appearance
- Obsessed with his or her weight
- Trying to use drugs and tobacco
- Attempting to injure him or herself or others

Although, the above mentioned behaviors may be indicative of an underlying mental disorder, it is important to keep in mind that the mere presence of these behaviors do not qualify for a diagnosis, unless they fulfill certain other necessary criteria as mentioned below. It is emphasized that it is not uncommon for a child to exhibit one or more of these behaviors at some point of time, while growing up, which is normal for that age group, since these behaviors may be transitory, most children stop exhibiting them.

How does the staff recognize the ' pathological' nature of behavior / symptom pattern

- Occur more commonly than usual
- inappropriate for the child's age;
- Are of reasonable intensity;
- persists for reasonable length of time;
- Interferes with the child's life.

- Children with the most severe mental health problems (e.g., psychosis or schizophrenia) may exhibit symptoms like Distorted thinking, Excessive anxiety, Abnormal mood swings, Acting overly suspicious of others, Seeing or hearing things that others don't see or hear (hallucinations),Talking or smiling to self, Poor self care, Odd body movements/postures etc.
- In case the child is unmanageable or exhibits any of the symptoms mentioned below, he/she should be referred to a specialist or to a higher centre for further management.

	Indicators for Referral to Specialized mental health centers/teams
1	If the child is suicidal
2	If the child exhibits verbal, physical or sexual aggression
3	If the child is suspected of using drugs
4	If the child has made attempts in the past to harm himself / herself and continues to do so.
5	If the child exhibits behavior, which is difficult to control
6	If the child has a medical problem such as seizures.
7	If the child fails to respond to the routine counselling provided

- The goal of early identification is to further take up the child for a detailed assessment and if required, provide treatment as well. Even though the treatment of these disorders is done by specialists in the field of Mental Health, the role of caretakers cannot be undermined. The caretakers of Juvenile homes must remember that a supportive environment can always be provided to such children. They are aptly placed and in a position to provide support and reassurance to the child that he/she will be well. The initial stages of developing a mental illness can be very unnerving to the child and the process of identification, assessment, diagnosis and treatment in itself can be anxiety provoking for the child. It is at this stage that the least all the concerned caregivers can do is to provide a listening ear to the child. Caretakers need to be empathetic, supportive and easily available to the child. A neglectful, cold attitude will only worsen the problem. Often, out of genuine concern, the staff members of CCIs start 'counselling' the child and start giving many suggestions. One needs to be watchful of these suggestions as they may not be having a scientific rationale and may cause more harm to the child than good. An understanding attitude towards the child by the caretaker will help greatly in not only reducing the child's emotional burden but also understanding the details of the behaviour which would go a long way in modifying it with the help of a mental health professional.

- It is important to remember and emphasize that not all children and adolescents with behavioral and emotional problems require medication, but where medication is needed it should be given. Most people wrongly believe that Psychotropic medications cause 'dependence', make a child 'dull', arrest normal brain development, and will continue lifelong. It is for these reasons that family members never seek Psychiatric help for the child when perhaps treatment may genuinely help the child and improve his overall functioning. Not all Behavioural and Emotional problems in children require medication and not all such problems may respond to medication.

- Often, children with such problems require Psychotherapy. Psychotherapy which in common parlance is called 'talk therapy', can help a child understand and manage his illness better with the use of simple behavioral techniques, in some cases by changing unhealthy thoughts and dealing with stress. The Therapist works with the child and with the family and in some cases

even the teachers and other significant caregivers. If the severity of the illness is mild to moderate, then Psychotherapy may be considered without adding any medication. However, if despite on therapy if there are clear indications of worsening of symptoms then administration of psychotropic medication may be necessary.

Child and Adolescent Mental Health Screening Questions

Historical factors

1. Parent has a history of a mental disorder (including substance abuse/dependence)
2. Family has a history of suicide
3. Youth has a childhood diagnosis of a mental disorder, learning difficulty, developmental disability, behavioural disturbance or school failure
4. There has been a marked change in usual emotions, behaviour, cognition or functioning (based on either youth or parent report)

One or more of the above answered as YES, puts child or youth into a high risk group. The more YES answers, the higher the risk.

Current situation

A. Over the past few weeks have you been having difficulties with your feelings, such as feeling sad, or down most of the time?

B. Over the past few weeks have you been feeling anxious, worried, very upset or are you having panic attacks?

C. Overall, do you have problems concentrating, keeping your mind on things or do you forget things easily (to the point of others noticing and commenting)?

D. Do you or others have significant difficulty managing your child's behaviour (e.g., temper tantrums, acting out, disobedience, unprovoked outbursts, physical or verbal aggression, being destructive, impulsivity, inability to sit still or focus)?

If the answer to **question A** is YES - for adolescents, consider a depressive disorder

If the answer to **question B** is YES - consider an anxiety disorder

If the answer to **question C** is YES - consider ADHD

If the answer to **question D** is YES, probe further to determine whether the difficulties are on-going or transitory. Problem behaviours that occur erratically typically do not warrant treatment. Consistent behaviour problems at home and/or school may warrant referral.

Substance Use Assessment

Adolescence is the time during which most individuals first experience exposure to alcohol or other substances. Based on the scientific evidence, we know that the brain continues to develop throughout adolescence and into young adulthood, and insults to it during this period may result in

unwanted, negative impacts both short and long-term. Substance misuse and substance abuse then become important issues for the health of young people.

Screening for substances use should be part of general health assessments for adolescents. Although every adolescent should be screened for substance use, there are some red flags that should trigger a more comprehensive assessment. These are:

- **Adolescents who present with substantial behavioural changes**
- **Adolescents who present to emergency medical services for trauma**
- **Adolescents who present medical problems such as accidents, injury, or gastrointestinal disturbance**
- **Adolescents with significant decline in school grades and a high number of school absences.**

Screening for substance use/misuse/abuse provides an opportunity for psycho-education about the risks of substance use (i.e., alcohol related car accidents are the number one cause of death in adolescents, psychosis risk with marijuana smoking) and an approach to safe and moderate use of alcohol.

For those youth whose substance use is harmful or putting them at risk for negative health or social outcomes, screening opens an opportunity for referral to specialized treatment programs that can provide them with the comprehensive evaluation and interventions that they require. While waiting for the teenager to get the specialized attention: monitor for self harm and suicidal behaviours; educate about the possible negative outcomes of substance misuse; provide support to family members and be available in crisis situation.

A parsimonious approach to substance use screening in adolescent is the application of the CRAFFT screening tool (CRAFFT = mnemonic acronym of first letters of key words in the six screening questions). The CRAFFT is a valid, reliable, and developmentally appropriate tool.

When using the CRAFFT, begin by asking the adolescent to answer the following questions honestly and reassure him/her that the answers will be kept confidential within the reasonable limits to confidentiality addressed

Commonly used mental health screening tools

For the purposes of this module "screening tools" are defined as instruments that are designed to identify children and adolescents who are at-risk of having mental health problems or concerns and/or those who would most benefit from more in-depth assessment. "Assessment tools" are instruments that provide a thorough assessment of mental health and/or social-emotional functioning.

1. Achenbach Child Behavior Checklist (CBCL)

There are sets of forms for preschool age (18 months to 5 years) and school-age children (6-18 years). There is Child Behaviour Checklists (CBCL) for each age group. The preschool set includes a caregiver teacher report form; the school-age set includes a teacher report form and a self-report form for ages 11-18. Incorporates the Language Development Survey (LDS) for ages 18-35 months. The forms are long; for example, the parent and teacher report forms for 18 months to 5 years contains 99 items.

Time: 20-30 minutes to administer

2. Conners Rating Scales-Revised (CRS-R)

Norm-referenced screening and assessment forms to identify symptoms of attention deficit hyperactivity disorder and other problem behavior. Written at 6th to 9th grade level depending on version. The long forms correspond to the DSM-IV diagnostic criteria for ADHD.

Time: Available in long (15-20 minutes to complete) and short (5-10 minutes to complete) versions Assessment of ADHD with subscales useful for assessment of conduct problems, cognitive problems, family problems, emotional, anger control and anxiety problems 36 months -17 years for caregiver and teacher report,12 years – 17 years for self-report Parent Report, Teacher Report.

Take Home Messages/Points to remember-theory and Practice

Mental health problems in children are treatable. This requires coordinated and complementary efforts of the family, school, mental health professionals and local agencies within the framework of a multi disciplinary team management. Early identification and treatment of mental and behavioral problems in children not only improves the quality of life of the child and the family but also helps in building a stronger society for the future.

Section 10:

Framework for developing an Individualized Care Plan

Individual Care Plan for a child or adolescent in Child Care Institution

Chapter VII, section 39 of the Juvenile Justice (Care and Protection of children) Act, 2015 states that 'the process of rehabilitation and social integration of children under this Act shall be undertaken, based on the **individual care plan of the child,** preferably through family based care such as by restoration to family or guardian with or without supervision or sponsorship, or adoption or foster care'. Neither the previous act nor the current act mention the strategies to develop an individual care plan but it is obvious and goes without saying that it has to be prepared by the experts involved in child care who are available in the child care institutions taking into consideration all possible information available and organizing it within a bio-psychosocial framework.

This mandatory provision of the law emphasizing rehabilitation and social restoration through and an individual care plan underscores the fact that each child is different and will have varying needs for care and protection depending on his/her circumstances. More importantly, it has and will continue to push the state machinery in developing, harnessing and providing the necessary human resource required for the care of this vulnerable population across India and this includes medical professionals, mental health experts, vocational and occupational therapists, special educators and rehabilitation social workers etc.

The counsellors working in Child Care Institutions need to know the basics of preparing an individual care plan as it is not only important from a medical and psychosocial perspective but for legal correctness as well, as per the provisions of section 39 of the JJ Act, 2015. This section of the Handbook will detail the different aspects of an individual care plan that the Counsellor needs to be aware of, to make it realizable.

The individual care plan is to be made from the available information with the Counsellor. Counsellors would normally receive information from different sources, about the child in distress, such as the child protection agencies, caretakers and allied health professionals; they may also make certain observations regarding the behaviour and needs of the child which needs to be collated, analysed and

formulated into a comprehensive care plan for the child. Hence, the care plan includes socio-demographic details of the child, family history, details of the current psychosocial arrangement, medical status, psychiatric/psychological status, legal status, as well as care and safety needs of the child as per the developmental level.

The Counsellors may formulate the individual care plan according to the following illustration and may further enrich it with their years of experience.

General guide to an individual care plan

- Just like the Physical (medical) records, all attempts to prepare and maintain the mental health record of every juvenile or child staying in a home, in the form of an "Individual Mental Health Care Plan" should be made by the staff of the concerned institution.

- The child welfare officers are best placed to develop the mental healthcare plan in consultation with mental health experts/ Counsellors associated with the institution.

- The attempt should be to integrate the mental health care plan into the individual care plan of the concerned juvenile or child.

- Ideally, every institution should have the services of trained counsellors or collaboration with external agencies such as child guidance centres, psychology and psychiatry departments or similar government and non-governmental agencies, for specialized and regular individual therapy for every juvenile or child in the institution

- All persons involved in taking care of juveniles or children in an institution shall participate in facilitating an enabling environment and work in collaboration with the therapists.

- All attempts should be made so that the environment in an institution is free from abuse (of any kind), allowing juveniles or children to cope with their situation and regain confidence.

- It must be understood that interventions including milieu-based interventions, individual counselling and/or group work are must for every child and all attempts should be ensured by the staff that it is provided in the institution.

(Note: milieu-based intervention refers to a process of recovery, which starts through providing an enabling culture and environment in an institution so as to ensure that each child's abilities are discovered and they have choices and right to take the decision regarding their life and thus, they develop and identify beyond their negative experiences and such intervention has a critical emotional impact on the child.)

- Individual therapy or group work are specialized process and each institution should make provisions for it as a critical mental health intervention.

- All care plans, which are documented, should be produced before the Management Committee of the institution every month and before the Child Welfare Committee every quarter for the purpose of updating and reviewing.

- No juvenile or child should be administered medication for mental health problems without a psychological evaluation and diagnosis by appropriately trained mental health professionals.

- When a Juvenile or a child placed under the care of an institution is found to be suffering from a mental health problems requiring prolonged medical treatment, or is found addicted to a narcotic drug or psychotropic substance, the juvenile or the child may be sent (by an order of the competent authority) to an appropriate place for such period as may be certified by medical officer to be necessary for proper treatment of the juvenile or the child.

- When the juvenile or the child is cured of the mental health problem, the juvenile or the child is to be placed back in the care of the institution from where the juvenile or child was removed for treatment (by the order of the competent authority) and if the juvenile or the child is no longer · liable to be kept under the care of the institution, he/she may be discharged (by the order of the competent authority).

- The welfare officers and other ground level staff involved in mental health care and protection of the children in the homes/institutions should be sensitized to the special needs of such juveniles or children through mental health orientation & sensitization workshops conducted by administrators of the institutions. Such programmes are also likely to make the staff more empowered by sharpening their skills in identification and referral of common mental health problems. In the absence of such an orientation, the staff may see these as very technical, for which he/she has no expertise, and/or perceive lack of skills to deal with such problems and avoid its recognition & documentation.

- The Homes can recruit in-house counsellors who can provide periodic workshops for identification of psychological problems.

- While the care plan needs to be developed (tailor made/customized), but for it to be effective and implementable, there is need for the staff to overcome the attitudinal barriers in this regard.

- The staff must see this as an obligation, spelt out by the legal provisions.

- The staff must be ready to make efforts to reach out to different agencies, do the proactive coordination role and be willing to work with multiple agencies (including statutory bodies), as an integral part of the holistic care of the child.

Sample Individual Care Plan

(As an illustration)

Date: ________________

Name of the Institution:

Name of the Counsellor/Welfare Officer/Staff:

Concerned CWC/JJB:

Name of the Child/Juvenile:

Age: Gender:

Medical Illness (if any)

Physical impairments/disabilities (if any): Speech/Hearing/locomotor/others

History suggestive of (H/s/o) Poor Comprehension, Delay in milestones, Subnormal intelligence, Child requiring varying degree of supervision in activities of daily living : Yes/No

H/S/o Previous referral/consultations with Mental health professionals/counsellors:Yes/No (if yes, details thereof)

H/S/o Psychiatric Hospitalization: Yes/No

H/S/o Problematic Behaviour (eg. Conduct, aggression, running away tendencies, lying, stealing): Yes/No (details thereof)

H/S/o Emotional Problems: (eg. Anxiety, crying, remaining withdrawn, clinging behavior etc)

H/S/o Oddities of Behaviour: (eg. Hallucinatory behavior like gesturing in air, hoarding garbage & filth, laughing without reason, paranoid ideas, irrelevant talk, apathy)

H/S/o Drug Abuse: Yes/No (details thereof)

H/S/o Suicidal behaviour or acts of self harm: Yes/No

H/S/o Exploitation, Physical or Sexual Abuse: Yes/No

Sleep Pattern:

Appetite:

Mood (eg sad/irritable/cheerful):

Level of involvement in the Daily routine of the Home:

Play activity:

Self care/personal hygiene/grooming:

Relationship with peers:

School performance/academics:

IQ test report (if available):

Psychological assessment report (if available):

Behaviour report (if available):

Interventions already received by child:

Interventions planned: Individual therapy/ Group work/Milieu based intervention/others

Medications (after due consultative procedures medical/surgical/psychiatric illnesses)

Plan for Physical education (esp for children who are long stay)

Educational needs- Based on the current intellectual level assessed through interviews, observation and IQ score and ensure that the child's education is not hampered but continued

Legal assistance- in victims of abuse or where a case is already ongoing or where adoption and foster care issues are concerned co-ordination with the concerned agency and its details

Restoration Plan (including community resources available): Restoration efforts made in past (if failed, reasons thereof):

Strengths and Weakness of the Child with emphasis on positive promotive health care measures (eg physical education for a child who is good in sports) and appropriate interventions to reduce the impact of 'weakness' on the overall development (eg special education for reading difficulties etc)

Summary:

____

____

(Signature with stamp)

Section 11:

Framework for developing a local referral network and referral Criteria for specialized centre/services

What is the need to refer?

Inequitable distribution of human resource is a well known fact in mental health practice in the Indian subcontinent. According to an ICMR multi site study on the Urban Mental Health Services conducted in 2004, there is a human resource deficit of up to 80% in the field of Mental Health Professionals. If this is so for the urban settings one can imagine the dearth of these professionals in the rural areas.

The situation is even more dismal when it comes to allied mental health professionals who specifically deal with children and adolescents with mental health issues. According to the Rehabilitation Council of India (RCI), 16 professional fields are enlisted and recognized with approximately 500 professionals registered with the RCI till February 2016. Some of these include Audiologist and Speech Therapists, Special Teachers for Education and Training the handicapped, Vocational Counsellors, Employment Officers and Placement Officers dealing with handicapped, Multipurpose Rehabilitation Therapists, Rehabilitation Psychologists, Rehabilitation Social Workers, Rehabilitation Practitioners in Mental Retardation, Community Based Rehabilitation Professionals, Rehabilitation Counsellors/Administrators etc.

It is believed that in the Child Care Institutions (CCIs)/homes across India, it is mostly the allied mental health professionals who deal with children in difficult circumstances. In the absence of any higher training and professional guidance, often these counsellors have to face difficult situations in counselling, which are beyond the scope of their educational training and professional competence. It is imperative that such situations are dealt with effectively and appropriate referral to a higher centre is made in time to prevent subjecting the child/adolescent to any undue harm.

The Counsellors working in CCIs need to establish liaison and networking with local agencies and bodies that are offering services pertaining to children in their Child Care Institutions. A Directory of services available in their locality needs to be prepared by them which can be a beneficial tool for others who are new recruits or those handling jobs for a brief period in the absence of the regular counsellor.

A broad framework is provided below for the counsellors/new recruits to help them develop a network directory of various services available and operating in their community has been enlisted in Box 23.

Box 23: Framework for developing a locally available referral network
1. Identifying the nearest health centre/facility with details of address, phone no, contact person, services offered, out-patient, in-patient admission details etc.
2. Any Hospital nearby and details of it thereof.
3. Private Practitioners in the locality
4. Any Psychiatrists/ Mental Health Professionals in the locality
5. Any psychologists/counsellors/ Special educators working in the area
6. Local Police station, address & phone no, SHO in-charge etc
7. Educational facilities like Balvadis/ schools and their address and contact details, admission criteria etc
8. Vocational training Institutes/ Gender Resource Centres nearby
9. NGOs working in the area of health, mental health, Disability and Welfare
10. Colleges or departments of Social Work or Special education that are nearby to avail details of various NGOs or Organisations dealing with different issues of relevance
11. The nearby Court/ legal agency(State Legal Services Authority)
12. Community leaders of the area
13. Principal/Teachers of the nearby schools with names, contact nos and address
14. Lions Club/ Rotary Clubs nearby

In what circumstances should a counsellor refer?

The following are some of the most common situations in which counsellors need to refer children in distress residing in Child care facilities:

Table 2:

Absolute Indications for Referral to higher centre
1. Children with co-morbid medical disorder.
2. Children with suicidal ideation
3. Children with aggressive and violent behaviour or homicidal intent
4. Cases with medico-legal implications

Referral to higher centre after discussion within team members at CCI*
1. Children having reduced appetite or poor weight gain or height.
2. Children with an already diagnosed co-morbid Psychological/psychiatric disorder for reassessment.
3. Children requiring detailed assessment by a qualified mental health expert.
4. Children exhibiting symptoms of self withdrawal, self talking inappropriate for age, undue suspiciousness or fearfulness, anxiety or depressive symptoms, sleep disturbances
5. Children exhibiting symptoms of hyperactivity, inattention, poor scholastic performance.
6. Children with substance use and dependence
7. Extreme attention seeking behaviour and increased libido, abnormal moodiness
8. If the case demands expertise over and above the professional competence level of the Counsellor.

*The specifics of the referral to higher centre in these cases needs to be worked out for each child care institution separately depending upon the availability of trained staff and discussion between them.

In Child Care Institution (CCIs) where professionals from other allied mental health fields are available and unable to deal with the case, he/she should consult the available counsellor and subsequently the team may decide whether to refer the case to a higher centre or not.It is also suggested that each counsellor develops his own locally available referral network.

Considerations prior to a referral

A 'referral' forms an important part of the overall process of counselling. The child or adolescent may develop an attachment towards the counsellor and in such cases the referral can get even more difficult. The following are the considerations to keep in mind before a child or adolescent is being referred.

Table 3:

Absolute Indications for Referral to higher centre
1. To be aware that the specifics of the case are beyond the professional competence of the Counsellor
2. To be aware of the professional competence of the agency where the Counsellor is referring
3. To preferably have personal knowledge of the doctor/mental health professional where the child will be referred and communicate in advance to make the referral more useful.

4. In some cases, a personal visit with the child to referral centre may be warranted, this may help build trust in the child towards the newly introduced professional.
5. Often the child may need to be prepared before an attempt is made to refer.
6. Explore feelings of the child before the referral, it avoids making the child feel dejected
7. Be honest and explain to the child in simple words as to why you need to refer him/her and the benefit of it.
8. Explain to the child that he/she is not being abandoned and that the counsellor will remain in contact with the child and the referral doctor.
9. Take a feedback from the child after the referral.
10. The Counsellor may need to deal with the taboos associated with mental illness with the child or the family, in case the child is required to be referred to a mental health institution.
11. In case the counsellor develops positive or negative feelings towards the child or adolescent, a referral is indicated as feelings of 'transference/counter transference' can be detrimental to the process of counselling.

Whom to refer to?

The following table will broadly enumerate the list of professionals to whom referrals can be made to from Child Care Institutions. Before the referral is made, the CCI Counsellor must be reasonably informed about the technical facility and professionals available in the region and accordingly make the referral. Some of the referrals to medical centres may need to be made immediately and labelled as an Emergency. Those referrals that need to be seen preferably within a 24 hour time period should be labelled as 'Urgent' and all others cases as ' Routine'. This practice may assist the professional to whom the referral has been made to prioritize the referral.

Table 4:

Reason for Referral	Professionals
Medical/Surgical Co-morbidities	Paediatrician/Paediatric surgeons/ General Practitioners/Medicine specialists
Intellectual Impairment (Assessment)	Certified Clinical Psychologist
Intellectual Impairment (Behavioural Intervention)	Certified Clinical Psychologist/ Occupational Therapist
Speech and Hearing difficulties	Audiology and Speech Therapist/Special teachers for education and training the Handicapped
Learning Difficulties	Special Educators
Child and Adolescent psychological/ Psychiatric Issues	Psychiatrist/Clinical sychologist/Psychologist/ Counsellors
Rehabilitation and Restoration of Child into Community	Multipurpose Rehabilitation Therapists/ Rehabilitation Psychologists/Rehabilitation Social Workers/Rehabilitation Practitioners in Mental Retardation/Community Based Rehabilitation Professionals/Rehabilitation Counsellors/ Administrators/Social Workers or Psychiatric Social Workers
Mainstream/Vocational Education	School Principal/ School Counsellor/ Vocational Counsellor

Table 5:

Take home message
1. Deliver as much as you can within the CCI 2. Not to "under do" or "overdo" 3. Consult seniors available at the CCI 4. When in doubt, refer

*Referral Format/ Form

Name of the Child Age Sex

CCI Registration No:

Residing in CCI since: Address (If Known):

Nature of Referral: Immediate/Urgent/Routine

Purpose of Referral: Opinion for diagnosis/ Co-management/ Transfer/ Further treatment/ Others, please specify

Referral request made to (Specify name/ Department/ Unit):

Current Treatment (If any):

Recent Investigation reports (If any):

Type of Admission in CCI: By Family/ Court/ Jail case

Family Members with Child: Available/Not available

Risk of Harm to self or others: Present/ Absent

Child has escaping tendency: Yes/No

Name and designation of the accompanying person:

Brief Clinical/behavioural observation notes and the reason for referral:

Signature with date of the referring person

Name:

Designation: Name of Child Care Institution:

The above Format is an Adaptation of IHBAS patient referral/transfer request form IHBAS-MRF-1.8

Section 12:

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Annexures

A. Continuing Professional Development Programme Workshop Series July-August 2014

About Continuing Professional Development (CPD) programme for Counsellors working in Child care institutions:

It was decided to conduct a series of Continuous Development Programme's (CPD) of counsellors working in Child care Institutions (CCIs) to understand the prevailing circumstances in Child Care Institution's from the counsellors and caregivers themselves. This would not only help in developing and providing workable skills to the counsellors in the CCI to effectively and more importantly sensitively address the mental health concerns of children in CCI's. NCPCR had a meeting with IHBAS, the premier mental health institution in Delhi to collaborate in this endeavour of providing Continuous Professional Development (CPD) to counsellors of CCI's. Faculty members of IHBAS from the Department of Psychiatry, Department of Clinical Psychology and Department of Psychiatric Social Work along with few experts on Children with Disabilities, Juvenile Justice Act and POCSO Act, 2012 were resource persons for the programme.

The overarching goal was to further professional development of the counsellors and equip them to be able to promote and provide personalized psychosocial care and positive mental health for children in child care Institutions. Layout of the Trainings was designed by NCPCR and IHBAS. Three CPD programmes were held on 25th-26th July, 8th-9th August and 22nd-23rd August, 2014. The format of the 1½ day programme was interactive with **group activities, role play, knowledge and experience sharing between counsellors and experts.** It also involved pre-post assessment of the participant's knowledge, attitude and skills. The participants were expected to provide a feedback at the end of the programme. The Programme was designed to impart basic knowledge of skills involved in relating to a child, identifying psychological problems in children and their management in the homes. The sessions were also designed to promote active participation, sharing of experiences and provide feedback and inputs for the development of a manual for training of Counsellors in Child Care Institutes. The format and sessions for all three CPD's was similar and participants were called from various states across India.

Executive summary of the CPD Workshop

The three workshop series was intended to understand the ground realities faced by the Counsellors and Social workers working in various Child Care homes across India. It is a well know scientific fact that children residing in Child care homes face immense difficulties leading to physical, social, emotional and cognitive deprivation.

Counsellors dealing with such children need to have the basic knowledge of the essential requirements of a child and should be able to provide psychosocial support and advocate them amongst other caretakers in the parent organization. These workshops focused on the processes involved in delivering psychosocial care to children in difficult circumstances and the difficulties faced by the Counsellors in proving holistic care and its solutions. Further, the workshops also intended to focus on the needs and requirements of the Counsellors themselves and deliver self help tips and seek help whenever and wherever needed.

There appeared to be a significant gap between the knowledge and application of scientific principles of counselling by the participants in their respective Child care homes. At the end of the workshop participants felt more proficient in dealing with children in difficult circumstances and some reported feeling competent in training other staff in their respective child care homes with basic issues of counselling.

Most Participants felt that the workshop provided them a platform to share their experiences with other fellow colleagues and mental health experts which immensely benefitted them in getting acknowledgement and feedback for their efforts in ensuring that all children in their respective child care home receive adequate and holistic psychosocial care. It was heartening to learn that the workshop helped improve the confidence and awareness of the participants and this would definitely provide momentum for future endeavours and Continuous programme for development of skills of Counsellors working in Child Care homes.

B. Psychological Tests

Projective Techniques (For use of Counsellors only)

Projective techniques are used for inquiry and diagnosis, using vague or meaningless stimuli to elicit responses that are likely to reveal hidden personality strata in a subject through the projection of inner content onto the external stimulus. The various stimuli used in projective techniques are intentionally vague and open to different interpretations, in the expectation that the subject will give meaning to the stimuli, meaning that emerge from internal personality processes, the thus enable observation of these processes. Various experts believe that the greater freedom subjects have to choose their responses the more their responses will be charges with meaning for them, since they can "supplement" what the stimulus lacks and accord it meaning solely by means of their own internal content. Thus, there are no "right" or "wrong" responses to the stimuli, but whether the responses are normative or non-normative is of great importance. Projective techniques possess several clear advantages: they do not require subjects to have high reading ability or a particularly high level of articulation (compared to other personality tests), their results are very difficult to falsify, and they enable a wide variety of assumptions and a broad and comprehensive view of the subject's personality. Projective techniques have been developed specifically for use with adults as well as children.

Sentence completion test

Sentence completion tests are a class of semi-structured projective techniques. Sentence completion tests typically provide respondents with beginnings of sentences, referred to as "stems," and respondents then completes the sentences in ways that are meaningful to them. The responses are believed to provide indications of attitudes, beliefs, motivations, or other mental states. The uses of sentence completion tests include personality analysis, clinical applications, attitudes assessment, achievement motivation, and measurement of other constructs. The data collected from sentence completion tests can usually be analyzed either quantitatively or qualitatively.

Draw-A-Person Test

DAP is a projective test, that allow an examinee to respond to questions through drawings. The formal beginning of its use for psychological assessment is known to begin with Florence Good enough, a child psychologist, in 1926. Harris later revised the test including drawings of a woman and of themselves. Now considered the Good enough-Harris Test it has guidelines for assessing children from ages 6 to 17 (Scott, 1981). Projective tests can be applied in various settings from schools, corporate, and private practices to assess different psychological aspects include: personality, family background, intelligence, physical, emotional and sexual abuse, emotional disturbances, depression etc.

House Tree Person Drawings

The House-Tree-Person (H-T-P) projective technique developed by John Buck was originally an outgrowth of the Good enough scale utilized to assess intellectual functioning. Buck felt artistic creativity represented a stream of personality characteristics that flowed onto graphic art. He

believed that through drawings, subjects objectified unconscious difficulties by sketching the inner image of primary process.

Since it was assumed that the content and quality of the H-T-P was not attributable to the stimulus itself, he believed it had to be rooted in the individual's basic personality. Since the H-T-P was an outcropping of an intelligence test, Buck developed a quantitative scoring system to appraise gross classification levels of intelligence along with at qualitative interpretive analysis to appraise global personality characteristics.

Children Apperception Test

Children Apperception test has been devised by Bellaks and its Indian adaptation is given by Uma Chowdhury for use with young children of the age groups of 3 to 10 years. It was designed to facilitate the understanding of the various important problems of childhood, such as feeding problems specially and oral problems generally, sibling rivalry, toilet training and oedipal problems. It also helps in assessing the child's structure of personality, his dynamic mode of reacting to his problems and the manner he would handle his problems of development.

Thematic Apperception Test (TAT)

The Thematic Apperception Test (TAT) is a construction technique developed by Henry Murray and his student Christiana Morgan to assess reactions to ambiguous interpersonal stimuli. Murray chose the term "apperception" as opposed to perception to denote the fact that respondents actively interpret TAT stimuli in accord with their personality traits and life experiences. The TAT consists of 31 cards depicting ambiguous situations, most of them social in nature.

With regard to TAT administration, the respondent is asked to look at each card and construct a story. Each story should describe what (a) led up to the events depicted on the card, (b) events are occurring on the card, (c) events will occur in the future, and (d) the characters on the card are thinking and feeling (Murray, 1943). Murray assumed that the respondent typically identifies with the primary protagonist featured in each card (the "hero") and creates the story from the vantage point of the hero. The basic premise is that unconscious themes will begin to develop relating to specific types of cards or to the test in general. These themes can then be interpreted and used for further exploration of conflicts.

The test assesses the individual's needs, drives, emotions, sentiment, complexes and conflicts as well as their interaction among themselves and with the social environment. It also reveals the underlying inhibited tendencies of the person.

C. Screening Tools

Children's Mental Health Screening Questionnaire

Name: ______________________________ Age: ________ Gender: M / F Regn No: __________

Instruction:

Here some questions are given regarding the behavior and feelings of the child. Kindly think of the child's behavior in last few months or weeks and provide answer either in 'Yes' or in 'No' to all the questions. Remember this will help in the detection of possible emotional and behavioral problems in the child. Thanks for your co-operation.

1.	Has there been any problem in his/her behavior?	Yes / No
2.	Does he/she remain confused or lost?	Yes / No
3.	Does he/she appear sad or gloomy?	Yes / No
4.	Does he/she get angry easily?	Yes / No
5.	Does he/she have many complaints against other children?	Yes / No
6.	Does he/she have difficulty in concentrating in studies?	Yes / No
7.	Is he/she stubborn?	Yes / No
8.	Does he/she have various aches and pain?	Yes / No
9.	Does he/she have sleep problem?	Yes / No
10.	Does he/she have difficulty in sitting still at one place?	Yes / No
11.	Does he/she become violent or aggressive?	Yes / No
12.	Does he/she break rules frequently?	Yes / No
13.	Is he/she excessive fearful?	Yes / No
14.	Does he/she smoke or chew tobacco?	Yes / No
15.	Does he/she have difficulty in understanding?	Yes / No

****

Total Score (No. of Yes	

Examiner's Signature

Institute of Human Behaviour & Allied Sciences

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Department of Clinical Psychology

TEST OF VISUO- MOTOR SKILLS

Stimulus Figures	Reproduction/Copy

Examiner's Signature

Children's Behaviour Questionnaire

(By M. Rutter)

Name: ______________________________ Age: ______ Gender: _________ Date: __________

Response Option				
S.No.	Items	Doesn't apply	Applies Somewhat	Certainly applies
1.	Very restless, often running About or jumping up and down Hardly ever still	______	______	______
2.	Truants from school (leaves Home for school, does not attend)	______	______	______
3.	Squirmy, Fidgety child	______	______	______
4.	Often destroys own or other's belongings	______	______	______
5.	Frequently fights with other children	______	______	______
6.	Not much liked by other children	______	______	______
7.	Often worried, worries about anything	______	______	______
8.	Tends to do things on his own (rather solitary)	______	______	______
9.	Irritable. Is quick to 'fly off the Handle' (Gests angry very quickly)	______	______	______
10.	Often appears, miserable, Unhappy, tearful or	______	______	______
11.	Has twitches, mannerisms or tics of the face or body	______	______	______
12.	Frequently sucks thumb or fingers	______	______	______

13.	Frequently bites nails or fingers	______	______	______
14.	Tends to be absent from school for trivial reasons	______	______	______
15.	Is often disobedient	______	______	______
16.	Has poor concentration or short attention span	______	______	______
17.	Tends to be tearful or afraid of new things or new situations	______	______	______
18.	Fussy or over particular child	______	______	______
19.	Often tells lies	______	______	______
20.	Has stolen things on one or more occasions	______	______	______
21.	Has wet or soiled self at school this year	______	______	______
22.	Often complains of pains and aches	______	______	______
23.	Has had tears on arrival at school or has refused to come into the school building, this year	______	______	______
24.	Has had tears on arrival at school Building, this year	______	______	______
25.	Has s stutter or stammer	______	______	______
26.	Has other speech difficulty	______	______	______
27.	Bullies other children	______	______	______

Assessed by: ______________________

Supervised by: ______________________

D. Sample Individual Mental Health Care Plan

(only as an illustration)

Date : _______________

Name of the Child/Juvenile:____

Name of the Institution: ____

Name of the Welfare Officer/Staff: _________________________________

____

Concerned CWC/JJB :____

Age :____________ Gender: ________________

Medical Illness (if any):______________________________________

Physical impairments/disabilities (if any): Speech/Hearing/locomotor/others

History suggestive of (H/s/o) Poor Comprehension, Delay in milestones, Subnormal intelligence, Child requiring varying degree of supervision in activities of daily living : Yes/No

H/S/o Previous referral/consultations with Mental health professionals/counsellors: Yes/No (if yes, details thereof)

H/S/o Psychiatric Hospitalization : Yes/No

H/S/o Problematic Behaviour (e.g. Conduct, aggression, running away tendencies, lying, stealing): Yes/No (details thereof)

H/S/o Emotional Problems : (e.g. Anxiety, crying, remaining withdrawn, clinging behavior etc)

H/S/o Oddities of Behaviour : (e.g. Hallucinatory behavior like gesturing in air, hoarding garbage & filth, laughing without reason, paranoid ideas, irrelevant talk, apathy)

H/S/o Drug Abuse : Yes/No (details thereof)

H/S/o Suicidal Behaviour or acts of self harm :Yes/No

H/S/o Exploitation, Physical or Sexual Abuse : Yes/No

Sleep Pattern:____________

Appetite:_______________

Relationship with peers :____

Mood (e.g. sad/irritable/cheerful):_______________________________________

Level of involvement in the Daily routine of the Home: ______________________

Play activity :____

Self care/personal hygiene/grooming:____________________________________

Schoolperformance/academics:____

IQ test report (ifavailable):____

Psychological Assessment report(if available):____________________________

Behaviour Report (if available):____

Interventionsalreadyreceivedbychild:_____________________________________

Interventions planned: Individual therapy/ Group work/Milieu based intervention/others

Psychotropic medications (after Psychiatric consultation):___________________

Restoration Plan (including community resources available): ________________

Restoration efforts made in past (if failed, reasons there of):_______________

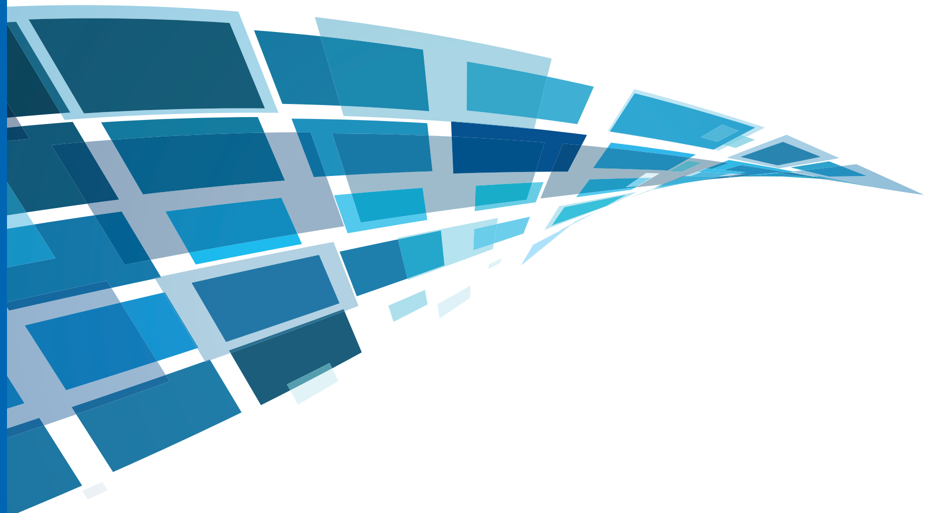
Summary:

____

____

____

(Signature with stamp)



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