Continuing Professional Development (CPD) of Counselors working in Child Care Institutions

A Report BY

NATIONAL COMMISSION FOR PROTECTION OF CHILD RIGHTS

&

INSTITUTE OF HUMAN BEHAVIOUR AND ALLIED SCIENCES (IHBAS)
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ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<tr>
<td>IHBAS</td>
<td>Institute of Human Behaviour and Allied Sciences</td>
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<tr>
<td>NCPCR</td>
<td>National Commission for Protection of Child Rights</td>
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<td>ICPS</td>
<td>Integrated Child Protection Scheme</td>
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<tr>
<td>POCSO Act</td>
<td>Protection of Children from Sexual Offences Act</td>
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<td>JJ Act</td>
<td>Juvenile Justice (Care and Protection of Children) Act</td>
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<tr>
<td>DCPCR</td>
<td>Delhi Commission for Protection of Child Rights</td>
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<td>WCD</td>
<td>Women &amp; Child Development</td>
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<td>TISS</td>
<td>Tata Institute of Social Sciences</td>
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<td>NIMHANS</td>
<td>National Institute of Mental Health and Neurosciences</td>
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<tr>
<td>IQ</td>
<td>Intelligence Quotient</td>
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<td>CNCP</td>
<td>Child in need of Care and Protection</td>
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<td>NACO</td>
<td>National AIDS Control Organization</td>
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EXECUTIVE SUMMARY

No Child Care Institution can run effectively without a well trained staff, mainly counselor, therefore, the three workshop (CPDs) series was intended to understand the ground realities faced by the Counselors and Social workers working in various Child Care homes across India and to enhance their skills as a counselor. It is a well known fact that children residing in Child care homes face immense difficulties leading to physical, social, emotional and cognitive deprivation.

Counselors dealing with children living in child care homes need to have the basic knowledge of counseling skills and should be able to focus on overall development of a child. These three workshops focused on the processes involved in delivering psychosocial care to children in difficult circumstances and the difficulties faced by the Counselors in proving holistic care and its solutions. Further, the workshops also intended to focus on the needs and requirements of the Counselors 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 principles of counseling 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 counseling.

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 endeavors and Continuous programme for development of skills of Counselors working in Child Care homes.

All the experts during the three workshops gave the participants theoretical knowledge and also practical knowledge by sharing case studies, role plays.
Background: Why CPD of Counselors?

The hon'ble High Court of Delhi vide W.P.(crl) 694 of 2012 dated 01-06-2012, gave direction to NCPCR, a national statutory body under the Protection of Child Rights Act, 2005 to inspect all such shelter or care homes and prepare a comprehensive report as to the functioning of each such institution to point out deficiencies and shortcomings. In compliance 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.

The IHBAS team involved Psychiatrists, Clinical Psychologists and Psychiatric Social workers and was lead by the Director of IHBAS, Dr Nimesh Desai. The constitution of the teams was done in such a way so as to ensure gender sensitivity for inspection & assessment of both the Boys and the Girls Home. The visits were made between 14th to 16th June, 18th to 20th June and on 26th June 2012. Seven homes were inspected by IHBAS and a comprehensive report was submitted to NCPCR along with the reports of other mental health and human rights agencies. (Report annexed).

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 recording.
8. Problem behaviours such as restlessness, bed-wetting, stealing, lying, anger outbursts, bullying, verbal and physical aggression, indecent behaviour were commonly reported in all homes. Children also reported having sadness of mood, having crying spells and some reported fearfulness at night especially during their initial days at the home.
9. 10%-40% of the children were in need of some form of psychological intervention. However, the same could only be provided in homes with an attached mental health facility.

10. Corporal punishment and verbal abuses inflicted on the children by the caregivers suggested “burn-out” of the caregivers and the need for caregiver counseling, support and guidance.

From the observations and inferences drawn from the visit 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.

The Commission and a team comprising of experts had carried out inspections of children homes in Delhi in compliance of the order of the Hon’ble High Court and found many gaps in psycho social care and well being of the children living in these homes. The Commission feels that there is an urgent need to address these gaps especially in view of the influential role that counselors/social workers working in Child Care Institutions play in the psychological development of the child. The National Commission for Protection of Child Rights (NCPCR) in collaboration with the Institute of Human Behaviour and Allied Sciences, IHBAS, New Delhi proposes to hold three workshops in Delhi during the months of July and August 2014 for Continuing Professional Development (CPD) of Counselors/Social Workers working in Children Homes with focus on “Mental Health issues of children and role of counselors/social workers

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 (counselors, management staff) to identify, manage and rehabilitate and restore children with emotional and behavioral 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 counselors in screening children who are victims of trauma, neglect, abuse, and specific psychological disorder, their care and rehabilitation.

• Training of counselors in planning interventions for psycho social care.

• Imparting skills to staff and counselors to manage their own concerns arising out of a high stress situation of the CCI’s
Process of Planning of CPD’s

It was decided to conduct a series of Continuous Development Programme’s (CPD) of counselors working in Child care Institutions (CCIs) to understand the prevailing circumstances in Child Care Institution’s from the counselors and caregivers themselves. This would not only help in developing and providing workable skills to the counselors 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 endeavor of providing Continuous Professional Development (CPD) to counselors 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 counselors 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 counselors and experts. It also involved pre-post assessment of the participant’s knowledge, attitude and skills. A Pre and Post Assessment form was designed by IHBAS and NCPCR in which questions related to Counseling skills, JJ Act and other psychological issues were asked before workshop and after workshop. 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 Counselors in Child Care Institutes.

The format and sessions for all three CPD’s was similar and participants were called from various states across India.
Structure of the CPD Programme:

Participants:

The programme was divided into three parts and a group of 30 participants was approved for each CPD programme. The participants were Counselors and Social workers working in various Child care homes across India and the structure of the CPD programme were as under:

<table>
<thead>
<tr>
<th></th>
<th>Date</th>
<th>Location</th>
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<tbody>
<tr>
<td>1</td>
<td>25th-26th July, 2014</td>
<td>Delhi, Haryana, Uttar Pradesh, Punjab</td>
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<td>2</td>
<td>8th-9th August, 2014</td>
<td>Maharashtra, MP, Goa, Gujarat, Bihar</td>
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<tr>
<td>3</td>
<td>22nd-23rd August, 2014</td>
<td>Assam, Manipur, Tamil Nadu, West Bengal</td>
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</table>

First CPD Programme 25th-26th July, 2014

Inaugural session:

The first day of the programme was inaugurated by Chief Guest Sh L.D.Mishra IAS (retd), who shared his experience with the participants of working in the field of Child Rights. The difficulties encountered in child care institutions were detailed and included problems of a safe and secure living environment, hygienic and nutritious food, love and care for the children brought in the homes and provisions for their education and occupational productivity. The unique position and role of Counselors was emphasized as they have the opportunity to intervene during childhood which is a tender, formative and impressionable part of a person’s life, highlighting tremendous scope for improvement.

Mr Asheem Srivastava, Member Secretary, NCPCR emphasized on the role of Child care institutes for correctional and reform purposes for those children who have moved away from the law. But there was a perceived sense of failure on behalf of the society in general in doing so. Hence, there was a felt need to gauge the reform measures for the children in CCI’s as these children would ultimately contribute to the progress of the nation. The participants were encouraged to bring forward their problems in the field area and their perceived needs which would be monumental in designing a course curriculum for the training of trainers.

An Overview of Continuous Professional Development (CPD) was given by Dr Nimesh G Desai, Director, IHBAS and a brief session of matching expectations was held with the participants.

It was emphasized to the group of Counselors that the rationale for using the term ‘Continuous Professional Development’ and not ‘training’ was to promote active participation with sharing of experiences from those who were already working in the Child Care Institutions (CCI).
# Brief Details of the Programme Conducted

## I - Round 1 of CPD

### Programme Outline for 25th-26th July, 2014

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<th>Topic</th>
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<tr>
<td><strong>Day 1</strong></td>
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<tr>
<td>9.00 am to 9.30 am</td>
<td>Registration</td>
<td></td>
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<tr>
<td>9.30 am to 9:45 am</td>
<td>Inaugural address by Chairperson NCPCR Overview of CPD by Director, IHBAS Guest of Honour Sh L.D.Mishra, IAS (retd.)</td>
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<tr>
<td>9.45 am to 10:45 am</td>
<td><strong>Session – I</strong> Psychosocial Needs of Institutionalized Children and Adolescents</td>
<td>Dr Vibha Sharma (IHBAS) &amp; Dr Amit Khanna (IHBAS)</td>
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<tr>
<td>10:45 am to 11:00 am</td>
<td>Tea break</td>
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<tr>
<td>11.00 am to 12.30 pm</td>
<td><strong>Session-II</strong> Mental Health related aspects of Institutionalized children &amp; Adolescents (Sharing of case studies by the counselors)</td>
<td>Dr Uday K Sinha (IHBAS)</td>
</tr>
<tr>
<td>12.30 pm to 1.30 pm</td>
<td><strong>Session – VI</strong> Psychosocial Disabilities and care issues</td>
<td>Dr Rachna Bhargava (AIIMS)</td>
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<tr>
<td>01.30 pm to 02.30 pm</td>
<td><strong>LUNCH</strong></td>
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<tr>
<td>02.30 pm to 4:00 pm</td>
<td><strong>Session-IV</strong>: Strategies for Promotion of Good mental Health &amp; Well being among Institutionalized Children &amp; Adolescents</td>
<td>Dr Deepak Kumar (IHBAS) &amp; Dr Jahanara M G (IHBAS)</td>
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<tr>
<td>4:00 pm to 5:00 pm</td>
<td><strong>Session-V</strong>: Open Session</td>
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### Day 2

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<th>Day/Date</th>
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<tr>
<td>9.30 am to 10.00 am</td>
<td><strong>Review of Day 1</strong></td>
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<tr>
<td>10.00 am to 11.00 am</td>
<td><strong>Session-III</strong>: a. Children and Substance use b. Children and suicidal behaviour</td>
<td>Dr Deepak Kumar (IHBAS) &amp; Dr Amit Khanna (IHBAS)</td>
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<tr>
<td>11.00 am to 11.15 am</td>
<td><strong>TEA BREAK</strong></td>
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<tr>
<td>11.15 am to 12.15 pm</td>
<td><strong>Session-VII</strong>: Strategies to Address Mental Health Issues in Children at Risk and Victims of Abuse</td>
<td>Dr N G Desai (IHBAS) &amp; Dr Sarita Sarangi (DCPCR)</td>
</tr>
<tr>
<td>12.15 pm to 1.15 pm</td>
<td><strong>Session-VIII</strong>: Laws relating to children with emphasis on Implications of legal provisions for care (JJ Act, POCSO Act.)</td>
<td>Ms Bharti Ali (Haq foundation)</td>
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<tr>
<td>01.15 pm to 02.15 pm</td>
<td>Open Session</td>
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<tr>
<td>2:15 pm to 2:30 pm</td>
<td>Valedictory session: Concluding Remarks, Feedback and Vote of Thanks</td>
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<tr>
<td>02.30 pm</td>
<td><strong>LUNCH</strong></td>
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2nd CPD Programme 8th - 9th August, 2014

An Overview of Continuous Professional Development (CPD) was given by Dr Nimesh G Desai, Director, IHBAS and a brief session of matching expectations was held with the participants.

It was emphasized to the group of Counselors that the rationale for using the term ‘Continuous Professional Development’ and not ‘training’ was to promote active participation with sharing of experiences from those who were already working in the Child Care Institutions (CCI).

Programme Outline for 8th - 9th August, 2014

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<tr>
<td>9.00 am to 9.30 am</td>
<td>Registration</td>
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<tr>
<td>9.30 am to 9:45 am</td>
<td>Inaugural address by Chairperson NCPCR</td>
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<td></td>
<td>Overview of CPD by Director, IHBAS</td>
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<tr>
<td>9.45 am to 10:45 am</td>
<td>Session - I Psychosocial Needs of Institutionalized Children and Adolescents</td>
<td>Dr Nimesh G Desai (IHBAS) &amp; Dr Amit Khanna (IHBAS)</td>
</tr>
<tr>
<td>10:45 am to 11:00 am</td>
<td>Tea break</td>
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</tr>
<tr>
<td>11.00am to 12.30 pm</td>
<td>Session-II Mental Health related aspects of Institutionalized children &amp; Adolescents</td>
<td>Dr Uday K Sinha (IHBAS)</td>
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<td></td>
<td>(Sharing of case studies by the counselors)</td>
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<tr>
<td>12.30 pm to 1.30 pm</td>
<td>Session - III Children and Substance use Children and suicidal behaviour</td>
<td>Dr Rajesh Kumar (IHBAS) &amp; Dr Sumit Kumar Gupta (IHBAS)</td>
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<tr>
<td>01.30pm to 02.30 pm</td>
<td>LUNCH</td>
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<tr>
<td>02.30pm to 4.00 pm</td>
<td>Session-IV: Strategies for Promotion of Good mental Health &amp; Well being among Institutionalized Children &amp; Adolescents</td>
<td>Dr Deepak Kumar (IHBAS) &amp; Dr Jahanara M G (IHBAS)</td>
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<tr>
<td>4.00pm to 5.00 pm</td>
<td>Session-V: Open Session</td>
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<td>Day 2</td>
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<tr>
<td>9.30 am to 10.00 am</td>
<td>Review of Day 1</td>
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<tr>
<td>10.00 am to 11.00 am</td>
<td>Session-VI: Psychosocial Disabilities and care issues</td>
<td>Dr Paramjeet Singh (IHBAS)</td>
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<td>11.00am to 11.15 am</td>
<td>TEA BREAK</td>
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<td>Session-VII: Strategies to Address Mental Health Issues in Children at Risk and Victims of Abuse</td>
<td>Dr N G Desai (IHBAS)</td>
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<td>12.15pm to 1.15 pm</td>
<td>Session-VIII: Laws relating to children with emphasis on implications of legal provisions for care (JJ Act, POCSO Act.)</td>
<td>Dr Sarita Sarangi (DCPCR)</td>
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<tr>
<td>01.15pm to 02.15 pm</td>
<td>Open Session</td>
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<tr>
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<td>Valedictory session: Concluding Remarks, Feedback and Vote of Thanks</td>
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<td>02:30pm</td>
<td>LUNCH</td>
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3rd CPD Programme 22nd- 23rd August, 2014

The Chief Guest Dr Satbir Bedi, Principal Secretary, Department of Social Welfare and Women and Child Department (W&CD) shared her experience with the participants of working in the field of Child Rights. The difficulties encountered in child care institutions were detailed and included problems of a safe and secure living environment, hygienic and nutritious food, love and care for the children brought in the homes and provisions for their education and occupational productivity. The need to remain in touch with one’s own child like and sensitive side was highlighted in dealing with children.

The Guests of Honour Ms Saumya Gupta, Director, Women and Child Department (W&CD) and Ms Garima Gupta, Director, Department of Social Welfare emphasized the various homes being run across the state of Delhi and the changes that are being brought about in these homes for the holistic development of the children.

An Overview of Continuous Professional Development (CPD) was given by Dr Nimesh G Desai, Director, IHBAS and a brief session of matching expectations was held with the participants.

It was emphasized to the group of Counselors that the rational for using the term ‘Continuous Professional Development’ and not ‘training’ was to promote active participation with sharing of experiences from those who were already working in the Child Care Institutions (CCI).
### III – Round 3 of CPD

Programme Outline for 22nd-23rd August, 2014

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<th>Day/Date</th>
<th>Topic</th>
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<td>Day 1</td>
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<tr>
<td>9.00 am to 9.30 am</td>
<td>Registration</td>
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<tr>
<td>9.30 am to 9:45 am</td>
<td>Inaugural address by Chief Guest</td>
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<tr>
<td></td>
<td>Dr Satbir Bedi</td>
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<td>Principal Secretary, Department of Social Welfare and Women and Child</td>
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<td>Department (W&amp;CD)</td>
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<td></td>
<td><strong>Guest of Honour</strong></td>
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<td></td>
<td>Ms Saumya Gupta</td>
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<td></td>
<td>Director, Women and Child Department (W&amp;CD)</td>
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<td>Ms Garima Gupta</td>
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<td>Director, Department of Social Welfare</td>
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<td>Mr Anupam Mishra</td>
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<td></td>
<td>Director, NCPCR</td>
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<td>Overview of CPD by Director, IHBAS</td>
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<td>Dr Uday K Sinha (IHBAS)</td>
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<td>12.30 pm to 1.30 pm</td>
<td><strong>Session – III</strong></td>
<td>Dr Rajesh Kumar (IHBAS) &amp; Dr Sumit Kumar Gupta (IHBAS)</td>
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<td>01.30pm to 02.30 pm</td>
<td><strong>LUNCH</strong></td>
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<tr>
<td>02.30pm to 4:00 pm</td>
<td><strong>Session-IV: Strategies for Promotion of</strong></td>
<td>Dr Deepak Kumar (IHBAS) &amp; Dr Jahanara M G (IHBAS)</td>
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<tr>
<td></td>
<td><strong>Good mental Health &amp; Well being among</strong></td>
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<td><strong>Institutionalized Children &amp; Adolescents</strong></td>
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<tr>
<td>4:00pm to 5:00 pm</td>
<td><strong>Session-V: Open Session</strong></td>
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<tr>
<td>'Day 2'</td>
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<tr>
<td>9.30 am to 10.00 am</td>
<td><strong>Review of Day 1</strong></td>
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<tr>
<td>10.00am to 11.00 am</td>
<td><strong>Session-VI: Psychosocial Disabilities and</strong></td>
<td>Dr Amit Khanna (IHBAS)</td>
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<tr>
<td></td>
<td>care issues</td>
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<tr>
<td>11.00am to 11.15 am</td>
<td><strong>TEA BREAK</strong></td>
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<tr>
<td>11.15am to 12.15 pm</td>
<td><strong>Session-VII: Strategies to Address</strong></td>
<td>Dr N G Desai (IHBAS)</td>
</tr>
<tr>
<td></td>
<td>Mental Health Issues in Children at Risk</td>
<td></td>
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<td></td>
<td>and Victims of Abuse</td>
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<tr>
<td>12.15pm to 1.15 pm</td>
<td><strong>Session-VIII: Laws relating to children</strong></td>
<td>Mr Chander Suman (Child Rights Advocate)</td>
</tr>
<tr>
<td></td>
<td>with emphasis on Implications of legal provisions for care (JJ Act, POCOSO Act.)</td>
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<tr>
<td>01.15pm to 02:15 pm</td>
<td><strong>Open Session</strong></td>
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<tr>
<td>2:15 pm to 2:30 pm</td>
<td><strong>Valedictory session: Concluding Remarks, Feedback and Vote of Thanks</strong></td>
<td></td>
</tr>
<tr>
<td>02:30pm</td>
<td><strong>LUNCH</strong></td>
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</tbody>
</table>
Key Objectives of Sessions of the CPD Programme

Session 1: Psychosocial Needs of Institutionalized Children and Adolescents
1. Understanding of the Complete Spectrum of Psychosocial Care.
2. Understanding Maslow’s Hierarchical model.
5. Techniques to help relate to a child

Session 2: Mental Health related aspects of Institutionalized children & Adolescents
1. Various Mental Health problems in Children.
2. Understanding causes for stress in children.
3. Clinical manifestations of externalizing and internalizing behavioural problems.
4. Strategies to modify behavioural problems in children

Session 3a: Children and Substance use
1. Progression of drug use in adolescence
2. Clinical and Behavioural Indicators of drug use in children
3. Myths and Facts about substance use
4. Management of Substance use

Session 3b: Children and suicidal behaviour
1. Understanding of the types of Suicidal behaviours and gradation of suicidal ideation
2. Assessment of Risk of Suicide
3. Demonstration of risk of suicide and interview technique in a role play.
4. Do’s and Don’ts in suicide risk assessment

Session 4: Strategies for Promotion of Good mental Health & Well being among Institutionalized Children & Adolescents
1. Concept of Mental Health and Well being.
2. Helping children deal with Conflicts
3. Importance of recognizing the need to address issues related to one’s own mental health.
4. Strategies for addressing Mental health concerns
5. Strategies to promote positive mental health

Session 5: Open Session

Session 6: Psychosocial Disabilities and care issues
1. Problems and difficulties especially discrimination in Mental Retardation.
2. Attitudes of different staff members towards intellectually disabled children.
3. Correct approach in dealing with Intellectually disabled children
4. Special needs and attention that is required.
5. UNCRPD Rights for the disabled.

Session 7: Strategies to Address Mental Health Issues in Children at Risk and Victims of Abuse
1. To understand the psychological trauma of child sex abuse
2. The role of a counselor in such cases
3. Helping the child deal with the emotional cascade of sex abuse
4. Human Rights perspective in child sex abuse
5. Management issues in child sex abuse

Session 8: Laws relating to children with emphasis on Implications of legal provisions for care (JJ Act, POCSO Act)
2. Various sections of POCSO Act relevant to Mental Health.
Summary of Open Sessions with Participants

A. Process of Counseling

1. While dealing with a client – all assumptions and presumptions should be dropped, all preconceived notions should be dropped, this will influence the management of the client, and one needs to be objective but sensitive.

2. Even with limited resources a difference can be made by knowledge, skills, thoughts and concepts and attitudinal change.

3. It was discussed that in practice Knowledge, Attitude and Practice do not have such a linear relationship and one may lead to another in a nonlinear way. Hence knowledge may not always lead to change in attitude or a change in practice. In practice while dealing with a client we need to know what knowledge or attitudinal changes in us can benefit the patient.

4. Need for Participatory decision making in dealing with children was discussed with emphasis on the importance of having peer groups in the Child care homes.

5. Focusing on the strengths of the child is important while dealing with a child.

6. It was emphasized that the child should not be countered or rebuked. The pros and cons of all actions should be discussed with the child.

7. The basic principles of interviewing techniques were discussed with special emphasis on the need to interview any girl child in the presence of a female and never alone.

8. Forming a good rapport with the child is of paramount importance in counseling. One should be attentive, non judgmental and have unconditional positive regard for the child.

9. The technique of Reflective listening was demonstrated through role play and emphasized that it involves factual clarification which reassures the client that the person is truly listening to him and is useful in rapport building.

10. In the process of interviewing the Counselor should be aware of being supportive for the child and not interrogative.

11. The importance of silence during a session and how to deal with it was discussed.

12. There was also discussion about how to deal with an angry or abusive client. The importance of limit setting and defining boundaries in relationship was talked about.

B. Discussion of scientific principles

13. The concept of Jo-hari window was discussed
14. The concept of ventilation and catharsis was discussed.
15. Concept of disability, handicap and impairment were discussed

**C. Changing attitudinal biases and self awareness**

16. Often under the stress of modern day living and the burden of work, the counselors do not get enough time to work on building an awareness of self. The Counselors were motivated to strive for generating a proper awareness of self which in turn would help them improve their counseling skills.

17. The effects of burnout in counselors- negative thoughts, exhaustion can affect the process of therapy.

18. To deal with burnout the participants were provided the following options – positive suggestion, leisure activities, diverting the mind, spending time with friends and family.

19. The need to have sensitivity to understand processes in self and the organization and bring about a change it. Emphasizing that inclusion of such children in the mainstream is the need of the hour and that exclusion and discrimination against such children is detrimental not only to the child but to the society in general.

20. Discussion on the difficulties faced by children with disability and the attitudinal barriers of caregivers with an attempt at self reflection of feelings and attitude was done.

21. It was discussed that because of the disability in children there are higher chances of their exploitation, abuse and neglect.
Feedback received from participants:

Before all three CPDs a questionnaire was designed by NCPCR and vetted by IHBAS team and same was sent to all the participants to gather information with regard to their work and get their feedback.(copy enclosed). After each CPD programme in open session participants were asked to share their experiences and problems faced during their work. Following views were expressed by the group members;

1. It was expressed by the group members that it is difficult to have training on so many important topics related to counseling and other related aspects, so time limit, mainly days of training to be exceeded.
2. Most of the participants gave feedback that printed reading material/outline of the content of the workshop to be given well in advance.
3. Some participants felt that adequate time should be given to participants for sharing of common situations which are encountered in the field.
4. Increased need was felt to discuss practical issues.
5. Participants reported that a format for making mental health care plan should be provided.
6. It was felt that there should be more Role play sessions with experienced counselors and live case discussions.
7. To inculcate sessions to highlight basic counseling skills.
8. To have video demonstrations of experienced mental health experts taking sessions with patients.
9. The participants agreed to be trainers for the Counselors in their regional areas but reported that they would require at least 2-3 more workshops to feel proficient in training others in their homes.
10. It was given in their questionnaire in column of suggestions to conduct training on mental health awareness for all staff members of CCI.
11. It was also mentioned that each CCI should have a professional psychologist/psychiatrist.
12. Weekly visit should be paid by the professional like, Psychiatrist/Psychologist to each CCI.
Outcome and Recommendations

1. It was recommended by the participants that simple tools for assessment of intelligence, psychological assessment in English or Hindi to be provided for rapid screening of possible mental health problems.

2. Most of the Counselors appointed in CCIs are through ICPS and they hardly get any induction and training during their appointment. It was recommended that there should be an induction programs prior to placement of the counselors. Also, Regional centers may be identified for conducting training of counselors.

3. Duration of training of counselors should be around 2-4 wks prior to their field placement.

4. It was felt by most of the participants that two days training programme is very short for them as few of the important topics are not being covered, therefore, the counselors should have advanced training for duration of at least 15 days.

5. It was mentioned in their feedback form and pre training questionnaire that there is a strong need of training and sensitization of caretakers in these Children homes and this should be done at State level (preferably at State capital).

6. The main objective of the CPD programme was to develop a training manual and a Handbook for counselors working in CCIs. The suggestions were given by the participants that the training manual that needs to be developed should include:
   - Demonstration of practical techniques
   - Basic skills and characteristics of a counselor
   - Counseling strategies for parents
   - How to identify psychological problems in a child
   - Practical application of theoretical concepts
   - Psychotherapies, mainly Group Therapy
   - Documentation process and policies
   - Psychosocial issues concerning disasters, ethnic conflicts/ violence
   - Individual Care Plan

7. A need for Periodic Continued Professional Development Workshops for sensitization and professional enrichment for Counselors was strongly expressed.

8. It was expressed by most of the participants that they need experience sharing and supervision and guidance from their senior counselors or recognized psychologist time to time as they being experience can guide the fresh counselors. This can easily
be organized by the counselors in the region and periodic interactive meets of both the
groups can be conducted (as part of peer group support).

9. Regional centers for training may be identified e.g. IHBAS (North), TISS (West),
NIMHANS (SOUTH).

10. An example of Mental Health Care Unit was given by one of the children home in
Delhi, Nirmal Chaya. This unit is being run by an NGO working in mental health
with support of Psychiatrist, psychologist and social worker. It was strongly felt by
the group members that Mental Health Units should be attached to each Child care
Institution, CCI.

11. Mental Health Assessment of each child which is very important to know whether is a
child is undergoing some psychological problem should be done by the counselor
working at CCI.

12. Most of the psychological problems in children are because of poor health, mainly
malnutrition, therefore it was recommended that Health/Weight assessment should be
done regularly by a nutritionist.

13. The main objective of the CPD programme was to develop a Handbook for
Counselors working in CCI to know how to deal with a child when comes to any
Child Care Institution. It was decided that IHBAS will draft the same with support of
participants.

14. Simple tools like: IQ Assessment and other psychological tools to be added in
Training Module for Counselors working in CCIs.

15. It was suggested by the participants that a format for Mental Health Care Plan should
be given in the Training Module.

16. Separate training on Child Rights, Juvenile Justice Act and POCSO Act to be
organized by the Commission.

17. Few Case studies which were brought by the participants were discussed during the
Programme and it was very useful for the group to understand a particular case and
successful intervention. It was suggested that five Cases studies should be discussed
in the trainings and a method to share these case studies should be developed.

18. It was expressed by the counselors that at times it is difficult to provide psycho
education to the parents/guardians of the child. It was felt that counseling of
Parents/guardians should also be conducted.

19. Rehabilitation records of children who are restored back to their families should be
kept.
20. Counselors should be oriented to identify if a child is suffering from any psychological disorder and referral case should be made.

21. One month intensive advance skill development training to be kept for the counselors.

22. It was expressed by the counselors that do deal with children with disabilities a separate training on sign language should be added in the training module.

23. Database of each child in CCI should be kept as a soft copy.
Development of Handbook for counselors working in CCI's

Three series Continuous Professional Development (CPD) workshop for Counselors conducted between July-August, 2014 helped understand the prevailing circumstances in Child Care Institution's from the counselors and caregivers themselves and evaluate the feasibility, utility and operationalization of a training structure for the Counselors and caretakers working in these Child care homes.

The format of the 1½ day programme was interactive with group activities, role play, knowledge and experience sharing between Counselors and Experts. This helped in developing and providing workable skills to the Counselors in the CCI to effectively and more importantly sensitively address the mental health concerns of children in CCI's. The overarching goal was to further professional development of the counselors and equip them to be able to promote and provide personalized psychosocial care and positive mental health for children in child care Institutions.

Furthering this venture, IHBAS with support of NCPCR organized a one day Stakeholder's Consultative Meeting between various Organizations including State Child Protection Agencies, Department of Women and Child, Govt of NCT Delhi and Counselors from various Child Care Institutes during the celebration of Mental Health Week on the 7th October, 2014 to take inputs from all the concerned stakeholders for development of a Handbook for Psychosocial care for Counselors in Child Care Institutes.

The Handbook would not only provide a structure for the Counselors to follow but also provide them with a ready reference of dealing with common issues that are confronted by them in these homes. The draft copy of the Handbook was provided to the Stakeholder's beforehand and the event provided an opportunity to highlight and suggest inputs from all the stakeholders placed and working for children in Child care homes.

Detailed discussions were held on various sections of the Handbook and the summary of the discussions was as follows:

1. Handbook is intended only for Counselors in Child Care Institutions.

2. It should have a balance of Theory and Practice and should be skills based.

3. It should address enhancing the counseling skills of counselors from both Psychology and Sociology background.

4. It is not intended to be a training manual.
5. It should include case studies demonstrating both successful and unsuccessful therapy.

6. Handbook not intended to be a complete exercise on training but for dealing with concrete situations in mental health.

7. Learning objectives need to be addressed in each session.

8. It should have 3 SECTIONS which should address: Theoretical knowledge to complement background of each counselor, Sensitivity awareness and skills building.

9. To have a section on how to dialogue with a child.

10. Child development milestones and stages of development (Physical, Social, Emotional, Psychosexual, Cognitive and Moral) should be included as it would help dissect Normative from the Pathological behaviors.

11. Life skills training to be included as part of skills building. Additionally, it should include play, recreation, self awareness building of the child.

12. Importance of Social learning by engaging and getting involved in festivities.

13. Problems of after 18 yrs of age should be included in the 'After care' plan section to broaden the horizon of the Counselors awareness.

14. Adolescence issues to be addressed in continuum of normal development or have a separate chapter addressing the issues especially Reproductive health issues.

15. It should address the level of Motivation in the counselors.

16. Specifics of Group Counseling need to be included.

17. Timely Supervision of Counselors by Mental health/training centers after identifying them on the lines of ICPS Scheme under which NIPCID does the training through it’s regional centers.

18. Handbook intended to be Inclusive than exclusive.

19. The possibility of publishing the book on line through e-books may be considered.

20. To address the belief system of the counselor/Society of labeling any child in CCI’s as having a problem

21. Circulating the inputs and handbook outline to Counselors across different states for feedback.

22. Focus on ‘Children in difficult circumstances’, (the old terminology) or ‘(CNCP) Children in need of Care and Protection’

23. Condition in CCI’s impacting mental health should be included.

24. Addressing strengths and weakness of Counselors given their background.
25. 'Quality of life' of Counselors to be addressed. Advice for Sharing, ventilating and group sessions for Counselors themselves.

26. Sensitizing and training of welfare officers may be taken as a separate exercise, given the reality that in many CCI's Welfare Officer's are engaged in preparing Child care plans.

27. Intended to be Bilingual first, English and Hindi and then later be translated into Regional languages.

28. To consider preparing the handbook on the lines of NACO training manual and to work out the logistics for it.
Presentations by the Experts: (Presentation 1: Drug Abuse in Children and Adolescents)

DRUG ABUSE IN CHILDREN AND ADOLESCENTS

DR. RAJESH KUMAR
ASSOCIATE PROFESSOR
IHBAS

WHAT IS SUBSTANCE ABUSE?

"First you take a drink, then the drink takes a drink, then the drink takes you" - F. Scott Fitzgerald.

INTRODUCTION

- Adolescence is a unique period in neurodevelopment with neurobiological changes
- Adolescence marks a period of rapid development between childhood and adulthood involving complex social, psychological and biological changes
- Heightened vulnerability to substance abuse including greater severity in progression of drug use

INTRODUCTION (CONT.)

- Addiction is a developmental disease that starts in adolescence and childhood
- Addiction has significant neurobiological basis and is considered a Brain disorder
- Adolescents Brains are still developing and adolescents react differently than adults to substances of abuse

THE HEALTH PARADOX OF ADOLESCENCE

- Adolescence is (physically) the healthiest period of the lifespan: prior to adult declines; beyond the frailties of infancy and childhood:
  - Improved strength, speed, reaction time, reasoning abilities, immune function
  - Increased resistance to cold, heat, hunger, dehydration, and most types of injury
- Yet: overall morbidity and mortality rates increase 200% from childhood to late adolescence

ADOLESCENCE

- Period of physical, social, psychological and cognitive growth
- No longer children and not yet adults
- Can’t see the link between what is done today and the consequences tomorrow, tendency to risk-taking and unawareness to the problems that others experience
- Make significant choices about their health and develop attitudes and behaviors
- Drug use can impede the attainment of important developmental milestones, development of intimate interpersonal relationships, general interaction and social behaviors

ADOLESCENCE (CONT.)

- Heightened peer influence and tendency toward risk taking - normal developmental changes
- Experimentation with drugs is common
- Use at young age increases the risk of dependency, addiction and related hazards
- Balance of risk and protective factors - cognitive flexibility, ability to delay gratification, sense of school belonging and a
ADOLESCENT SUBSTANCE USE

- Adolescents/young adults have higher rates of substance use disorders than older adults
- Addictive disorders in adults most often have onset in adolescence/young adulthood
- Earlier onset of substance use predicts greater addiction severity and morbidity

MAGNITUDE

- 80% -- alcohol
- 63% -- tobacco
- 49% -- marijuana
- 16% -- amphetamines
- 9% -- cocaine

MAGNITUDE (CONT.)

- A nationwide, cross-sectional study done on children under 18 years of age (n = 4024) by NCPOR in 2013
- Tobacco -- 75%
- Alcohol -- 57%
- Inhalant -- 31%
- Cannabis -- 29%
- Mean age of starting tobacco was 12.3 years and for inhalants 12.4 years
- In Delhi, 70% reported usage of Tobacco, 39% of Inhalant, 34% of Cannabis and 23% of Alcohol

ADOLESCENT SUBSTANCE USE

- By 12th grade in the US, adolescents have used substances as follows:
- 80% -- alcohol
- 63% -- tobacco
- 49% -- marijuana
- 16% -- amphetamines
- 9% -- cocaine

“STAGES OF USE”

- Stage 1: Potential for Abuse (at risk youth)
- Stage 2: Experimentation (for pleasure, hedonic theory)
- Stage 3: Preoccupation with Substance Use
- Stage 4: Addiction (continued use to prevent withdrawal symptoms)
- Stage 5: Deterioration of Self
PROGRESSION OF DRUG USE AMONG ADOLESCENTS

REASONS FOR DRUG USE AMONG ADOLESCENTS
- Imitation of adult substance use behaviour (family member or neighbour using substances)
- Media (advertisements of substances)
- Poor communication skills
- Depression, anxiety

INDICATORS OF DRUG USE AMONG ADOLESCENTS

As recreation at parties
- To express independence
- To handle low self-esteem
- To deal with academic stress
- To experiment
- To deal with family stress
- For instant gratification

b. Behavioral indicators
- sudden change in attitude, work, or behavior - a new, "I don’t care attitude"
- sudden deterioration of long friendships, relationships
- "explosive" arguments and disagreements over small matters
- frequent hangover symptoms
- secretive behavior
- erratic behavior - forgetfulness - indiscipline

b. Behavioral indicators
- poor coordination, tripping, spilling, bumping into things and other people
- large or small (dilated) pupils
- a faint skin odor - either sweet or acid
- easily fatigued or constantly fatigued
- hyper-excitability
INDICATORS OF DRUG USE AMONG ADOLESCENTS (CONT.)

- Psychological indicators
  - Unexplained change in personality or attitude.
  - Sudden mood changes, irritability, angry outbursts or laughing at nothing.
  - Periods of unusual hyperactivity or agitation.
  - Lack of motivation, inability to focus, appearing listless or "spaced out."
  - Appearing fearful, withdrawn, anxious, or paranoid, with no apparent reason.

CONSEQUENCES

- Gateway drugs (alcohol, tobacco and inhalants)
- Multi-dimensional problem, physical and psychosocial consequences
- Illegal activity, gambling, drug peddling, pick pocketing, stealing, fighting, rape and self-directed aggression
- Forced into sexual activities for commercial purposes especially when they are intoxicated
  (Berenjel et al., 1998)

CONSEQUENCES OF DRUGS USE AMONG SCHOOL GOING CHILDREN

- Personal and social factors
  - Social, emotional and mental health
  - Social and emotional development
  - Social and emotional function

MYTHS AND FACTS

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
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</thead>
<tbody>
<tr>
<td>There is no harm to taking a drug at any age.</td>
<td>Taking even small amounts of drugs can have serious consequences.</td>
</tr>
<tr>
<td>Drug use is a normal part of growing up and can be acceptable.</td>
<td>Drug use is illegal and can have serious physical and psychological consequences.</td>
</tr>
<tr>
<td>Drug use is not a problem.</td>
<td>Drug use can lead to addiction and other problems.</td>
</tr>
<tr>
<td>Drug use is a way to cope with problems.</td>
<td>Drug use can worsen problems.</td>
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</table>

MYTHS AND FACTS (CONT.)

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most people use illegal drugs.</td>
<td>Most people do not use illegal drugs.</td>
</tr>
<tr>
<td>Illegal drugs are not dangerous.</td>
<td>Illegal drugs can be dangerous.</td>
</tr>
<tr>
<td>Illegal drugs can be obtained legally.</td>
<td>Illegal drugs cannot be obtained legally.</td>
</tr>
<tr>
<td>Illegal drugs are not addictive.</td>
<td>Illegal drugs can be addictive.</td>
</tr>
</tbody>
</table>

TERMS USED IN DESCRIBING DRUG USE AMONG ADOLESCENTS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition/Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Any beverage that contains ethyl alcohol.</td>
<td>Beer, wine, spirits.</td>
</tr>
<tr>
<td>Marijuana</td>
<td>Any plant part or product of cannabis sativa.</td>
<td>Dried plant material, hashish.</td>
</tr>
<tr>
<td>Opioids</td>
<td>Any drug that acts on the opioid receptor.</td>
<td>Morphine, heroin.</td>
</tr>
<tr>
<td>Stimulants</td>
<td>Any drug that increases the activity of the central nervous system.</td>
<td>Caffeine, amphetamines.</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>Any drug that depresses the central nervous system.</td>
<td>Phenobarbital, diazepam.</td>
</tr>
<tr>
<td>Inhalants</td>
<td>Any substance that is inhaled for its psychological effects.</td>
<td>Solvents, aerosols.</td>
</tr>
</tbody>
</table>

TERMS USED IN DESCRIBING DRUG USE AMONG ADOLESCENTS (CONT.)

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition/Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>Any preparation of morphine.</td>
<td>Heroin, diacetylmorphine.</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Any preparation of coca.</td>
<td>Cocaine hydrochloride, cocaine base.</td>
</tr>
<tr>
<td>LSD</td>
<td>Any preparation of lysergic acid diethylamide.</td>
<td>LSD, acid.</td>
</tr>
<tr>
<td>PCP</td>
<td>Any preparation of phencyclidine.</td>
<td>PCP, angel dust.</td>
</tr>
<tr>
<td>Naloxone</td>
<td>Any preparation that acts as an opioid antagonist.</td>
<td>Naloxone, Narcan.</td>
</tr>
<tr>
<td>Methadone</td>
<td>Any preparation of methadone.</td>
<td>Methadone, Dolophine.</td>
</tr>
<tr>
<td>Naltrexone</td>
<td>Any preparation that acts as an opioid antagonist.</td>
<td>Naltrexone, Vivitrol.</td>
</tr>
<tr>
<td>Disulfiram</td>
<td>Any preparation that causes a reaction when alcohol is consumed.</td>
<td>Antabuse, Disulfiram.</td>
</tr>
</tbody>
</table>

TERMS USED IN DESCRIBING DRUG USE AMONG ADOLESCENTS (CONT.)

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition/Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lamotrigine</td>
<td>Any preparation of lamotrigine.</td>
<td>Lamotrigine, Lamictal.</td>
</tr>
<tr>
<td>Topiramate</td>
<td>Any preparation of topiramate.</td>
<td>Topiramate, Topamax.</td>
</tr>
<tr>
<td>Valproate</td>
<td>Any preparation of valproate.</td>
<td>Valproate, Depakene.</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Any preparation of carbamazepine.</td>
<td>Carbamazepine, Tegretol.</td>
</tr>
<tr>
<td>Phenytoin</td>
<td>Any preparation of phenytoin.</td>
<td>Phenytoin, Dilantin.</td>
</tr>
<tr>
<td>Phenytoin sodium</td>
<td>Any preparation of sodium phenytoin.</td>
<td>Phenytoin sodium, Dilantin.</td>
</tr>
<tr>
<td>Sodium valproate</td>
<td>Any preparation of valproate sodium.</td>
<td>Sodium valproate, Depakene.</td>
</tr>
<tr>
<td>Topiramate sodium</td>
<td>Any preparation of sodium topiramate.</td>
<td>Sodium topiramate, Topamax.</td>
</tr>
<tr>
<td>Lamotrigine sodium</td>
<td>Any preparation of sodium lamotrigine.</td>
<td>Lamotrigine sodium, Lamictal.</td>
</tr>
<tr>
<td>Valproate sodium</td>
<td>Any preparation of sodium valproate.</td>
<td>Valproate sodium, Depakene.</td>
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<td>Carbamazepine sodium</td>
<td>Any preparation of sodium carbamazepine.</td>
<td>Carbamazepine sodium, Tegretol.</td>
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<tr>
<td>Phenytoin sodium (3-week loading)</td>
<td>Any preparation of sodium phenytoin (3-week loading).</td>
<td>Phenytoin sodium (3-week loading), Dilantin.</td>
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WHAT ARE THE SYMPTOMS OF TEEN SUBSTANCE ABUSE?
- Sudden personality changes that include abrupt changes in work or school attendance, quality of work, work output, grades, discipline.
- Unusual flare-ups or outbreaks of temper.
- Withdrawal from responsibility.
- General changes in overall attitude.
- Loss of interest in what were once favorite hobbies and pursuits.
- Changes in friends and reluctance to have friends visit to talk about them.
- Difficulty in concentration, paying attention.
- Sudden irritability, nervousness or aggression.

SIGNS OF INTOXICATION VARY BY TYPE OF DRUG
- Impaired judgment and motor skills
- Nausea and vomiting
- Lack of coordination
- More talkative than usual
- Rapid heartbeat and breathing
- Bloodshot eyes
- Visual or auditory hallucinations
- Marked difference in appetite
- Extreme moods like euphoria or depression
- Slurred speech
- Agitation, irritability, anxiety, paranoia or confusion
- Tremors, shaking
- Excessive energy or drowsiness

WARNING SIGNS OF TEENAGE ALCOHOL AND DRUG USE
- Physical fatigue, repeated health complaints, red and glazed eyes, and a lasting cough
- Emotional: Personality change, sudden mood changes, irritability, irresponsible behavior, low self-esteem, poor judgment, depression, and a general lack of interest
- Family: Starting arguments, breaking rules, or withdrawing from the family
- School: Decreased interest, negative attitude, drop in grades, many absences, truancy, and discipline problems
- Social problems: New friends who are less interested in standard home and school activities, problems with the law and changes to less conventional styles in dress and hair

ITEMS USED IN CONNECTION WITH ILLICIT DRUGS
- Pipes and rolling papers
- Syringes
- Razor blades
- Metal spoons or foil shaped into a bowl
- Small glasses vials or plastic baggies
- Altered soda cans or bottles
- Empty medicine bottles/doctor packs
- Excessive use of incense, cologne or room deodorizers like Febreze

HOW SOMEONE CURRENTLY USING HEROIN MIGHT

WHEN YOU LOOK AT HER

- Flushed skin
- Slurred speech
- Sore eyes
- Tense shoulders
-阳光 poor

WHEN YOU HEAR HER

- Incoherent speech
- Slurred speech
- Disorganized speech
- Apathetic
t

WHEN YOU SMELL HER

- Bitter
- Damp
- Head

HOW SOMEONE CURRENTLY USING TOBACCO MIGHT

WHEN YOU LOOK AT HER

- Appearance in the classroom
- Sitting
- Music
- Writing

WHEN YOU HEAR HER

- Inspiration
- Communication
- Apathetic

WHEN YOU SMELL HER

- Tobacco

HOW SOMEONE CURRENTLY USING MARIJUANA MIGHT

WHEN YOU LOOK AT HER

- Appearance in the classroom
- Sitting
- Music
- Writing

WHEN YOU HEAR HER

- Inspiration
- Communication
- Apathetic

WHEN YOU SMELL HER

- Marijuana
### Marijuana's Unique Effects in Adolescence
- Greater damage in adolescence
- Learning impairment and memory
- Tests of coping skills
- Interferes with reproductive development
- Suppresses immune system
- Interacts with serotonin
- Higher rates of anger and depression
- Panic attacks in susceptible users
- Recent research: long term damage to hippocampus

### Risk and Protective Factors and Safety Networks

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### Treatment Should be Individualized and Comprehensive
- Addiction is a biopsychosocial disorder
- Emphasis on evidence-based treatments
- Detox to be followed by relapse prevention strategies
- Practical problems (legal, vocational) are important in addition to medical, psychiatric and family issues
- The community context is relevant
- Family involvement necessary, improves outcomes
- Role of Self Help Groups

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Suicidal Behavior: A Serious Problem

- Rates of other suicidal behavior are high according to a nationally representative sample of high school students:
  - 13.9% report suicidal thoughts
  - 12.0% made a plan or took steps
  - They would attempt suicide
  - 7.9% attempted suicide one or more times
  - 2.4% made a suicide attempt that resulted in an injury, poisoning, or an incident that required medical attention

Common Myths about Suicide

- "People who talk about suicide won't really do it.
- "Anyone who tries to kill himself must be crazy.
- "If a person is determined to kill himself, nothing is going to stop him.
- "People who commit suicide are unwilling to seek help.
- "Suicide is a solve-all answer to life's problems or difficulties.

Assessment of Suicidal Behavior

- The cornerstone of a risk assessment is to establish an interactive, dynamic relationship with the client.
- It is a response, not a question, to the client's behavior.
- It also involves an assessment of the patient's intent, whether it is more imminent or not.

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Risk and Protective Factors

- Risk factors - Increase likelihood that a young person will engage in suicidal behavior
- Interpersonal, social, structural, cultural, environmental
- Protective factors - Mitigate or eliminate risk
- Interpersonal, social, emotional, cultural, environmental
- Consider the balance between the two

Warning Signs

- A warning sign does not mean automatically that a person is going to attempt suicide, but it should be responded to in a serious & thoughtful manner
- Do not dismiss a threat as a cry for attention

What kinds of warning signs are cause for concern?

Specific Warning Signs

- Talking About Dying - Any mention of dying, disappearing, jumping, shooting oneself, or other types of self harm
- Change in Personality - Sad, withdrawn, irritable, anxious, tired, indecisive, or apathetic
- Change in Behavior - Difficulty concentrating on school, work, or routine tasks
- Change in Sleep Patterns - Insomnia, often with early waking or oversleeping, nightmares
- Change in Eating Habits - loss of appetite and weight, overeating
- Fear of losing control - Acting erratically, harming self or others

Intervention Programs

- Psychotherapy is an important component in the management of suicidal ideation and behaviors
- There are two documented effective psychotherapies for treating those who attempt suicide:
  - Cognitive behavior therapy (CBT)
  - Dialectical behavior therapy (DBT) for youth diagnosed with borderline personality disorder and recurrent suicidal ideation

Questions?
Presentation: 3: Mental Health of Children & Adolescents in CCI

Mental Health of Children & Adolescents in CCI

Where do we stand?
- All children & adolescents in Child Care Institutions have mental health problems (Emotional and Behavioural Problems)
- None in CCI has mental health problems, the only fact is that they are in specific circumstances

A little about me....
- Experience
- Background
- Education
- Current Employment

What is the fact?
- 50-55 percent have MH problems
- Externalizing & internalizing problems are present in almost equal proportions
- Non-disturbed children are at risk for MH problems

What is to be done?
- Identification
- Assessment
- Intervention
- Referral for treatment
- Follow-up
- Reintegration

Diagnosable Psychiatric Disorders
- Depression
- Anxiety Disorder
- Attention Deficit Hyperactivity Disorder
- Conduct Disorder
- Substance Use Disorder
- Oppositional Disorder
- Severe Psychiatric Disorders (Psychosis, Schizophrenia)
- Mental Retardation

How to identify?
- Self Report
- Report of Significant Others
- Observation
- Use of Psychological Tools
  What to identify?
  Problems related to
  - Emotions
  - Thinking
  - Behaviour
  - Manner in relating with others

Stress in Children
- Fear of parents
- Fear of teachers
- Academic pressure
- Lack of materials
- Being bullied
- Parental problems
- Illness in family
- Death in the family
- Physical problems
- Conflict with neighborhood
Stress in Children
- Physical abuse
- Sexual abuse
- Domestic violence
- Witnessing other child being abused
- Being away from family/parent
- Entry into CCI
- Contact with various agencies including police

Indicators of EBP
- Crying
- Being non-communicative
- Being detached
- Staying aloof
- Appearing fearful or apprehensive
- Anger & aggression
- Non-compliance or disobedience
- Running away from home

Indicators of EBP
- Irregularity in work or academics
- Lack of interest and concentration
- School refusal
- Fighting with other children
- Stealing and/or lying
- Complaining of aches and pains
- Other physical problems (vomiting, fits etc.)

Strategy
- Differential
- Participatory
- Collaborative
- Continuity
- Consistency

SLAP
Strategic Logical Award & Punishment

Do we agree?
- "If a child doesn't know how to read, we teach."
- "If a child doesn't know how to swim, we teach."
- "If a child doesn't know how to multiply, we teach."
- "If a child doesn't know how to drive, we teach."
- "If a child doesn't know how to behave, we teach?"...punish?"

"Why can't we finish the last sentence as automatically as we do the others?"
Tom Herten (1998) in Counterpoint, p.2

Approach with children
- Non-threatening
- Friendly
- Warmth
- Empathy
- Firm & Confident
- Clarity in communication
- Caring & supporting
- Non-judgmental

Tips for practice
- Develop rapport
- Explain the objective and purpose of dialogue
- Ensure privacy
- Use simple, brief, and direct communication
- Allow enough time to process and respond
- Use physical touch (reasonably) for support
- Accept silence
- Encourage and facilitate talk
- Give humor and compliments

Damaging
- Lecturing
- Sermonizing
- Demoralizing

Multisystemic Therapy
Multisystemic Therapy is a treatment for behaviourally disturbed children including juvenile offenders that uses a combination of empirically-based treatments (e.g. cognitive behavior therapy, behavioral parent training, functional family therapy) to address multiple variables (i.e. family, school, peer groups) that have been shown to be factors in problem behavior.
Presentation 4: Psychosocial needs of Institutionalized children and adolescents

Psychosocial needs of Institutionalized children and adolescents

Dr. Andrew G. Smith
Assistant Professor
Department of Psychiatry
University of Alberta

- "I do not know anything about Psychosocial care for Children in CIC's"
- "Providing basic amenities is more important than providing Psychosocial care"
- "Psychosocial care is needed only for children with mental illness"
- "I know about Psychosocial care but do not know how to provide it"
- "I know about Psychosocial care and know how to provide it"

Components of Psychosocial Assessment

1. Critical Event/Stressful situation
2. Feelings and Behaviour
3. Coping Behaviour
4. Resources

Oliver Twist by Charles Dickens, 1839

PSYCHO+SOCIAL
Reasons for institutionalization

Child characteristics
1. Discrimination and negative social attitudes towards children with physical/mental disabilities, children from ethnic minority.
2. Illegitimate children
3. Single mother children with broken families
4. Gender differences with a female child being more abandoned than a male child
5. Victims of child sexual and peer abuse

Family characteristics
1. Poor families
2. Unemployment in family
3. Dysfunctional and broken families
4. Serious drug use in family
5. Intra-familial physical/sexual abuse
6. Family members in prison
7. Large unplanned families and inability to cope
8. Migration for work and breakdown of family

Society/State characteristics
1. Impoverished child welfare services
2. Low community health and social service expenditure by state

Impact of Institutionalization on Physical development

What cripples our Child Care Institutions?
- Overcrowding
- Inadequate infrastructure
- Unfavorable caretaker: child ratio
- Poor motivation in staff
- Lack of opportunity for selective attachments
- Lack of "personalized" care
- Lack of adequate nutrition to children
- Lack of adequate medical interventions
- Lack of play and stimulation
- Physical and sexual abuse

- Physical underdevelopment
- Hearing and visual problems because of poor nutrition
- Motor skills delay
- Poor health and sickness because of overcrowding
- Physical and learning disability as a result of a combination of motor skills delay and retarded development

Carter 2005, Mulher and Brown 2007
Psychosocial interventions to improve Mental Health of children in Public care

Interventions in Child care institutions

- The quality of relationships between staff and young people is the major factor in identifying problems and promoting positive mental health.
- Supportive and containing relationships between the child and the staff ameliorate effects of past negative relationships.
  (Moses 2000 and Heritage 2004)

Comprehensive assessment

- Nearly 90% of children entering care placement have complex difficulties including mental health, academic and language difficulties.
- Evans, Scott and Schultz, 2004

- In addition to conventional mental health assessment by a specialist, the child's strengths, interests, and potential protective factors and current relationship functioning is also assessed.

Group activity 2:
What can help you relate to a child?

Techniques for Psychosocial care for children

- Observation
- Listening
- Empathy
- Resourcefulness
- Reassurance
- Normalising routine activities

"All societies need to decide how to respond when children lose or are abandoned by their parents, when parenting breaks down or when serious abuse, neglect or family dysfunction means that children need to be safeguarded by removal from their biological families."

Alan Rushton and Helen Minnis
Presentation: 5: Strategies for Promotion of Good Mental Health & Well-Being among Institutionalized Children and Adolescents.

Dr. Ishaq & M. Geographical
Institute for Development
Department of Psychology & Social Work
Institute of Human Behaviour and Allied Sciences
Delhi University

Mental Health & Well Being

- The mental health and well being of children requires our attention. The mental health programmes that include life skills education, mental health education, school and home based health interventions.
- The aim of CCF based intervention is to provide a holistic approach towards health, and equip the children and adolescents with skills that will strengthen the coping abilities of the children.
- Environment Centred
- Child Centred
- Need for openness, understanding & empathy
- Necessary training and capacity building to all professional groups including NGO working with the youths.

What causes mental health issues?

- Individual
  - Genetic
  - Psychological
  - Social
  - Family
  - Family history of illness
  - Psychological
  - Social
- Environmental or social factors
  - Housing
  - Employment
  - Depression
  - Lack of peer support
  - Abuse

Intervention Model

Comprehensive Mental Health Programme
- Promoting Psychosocial Competence
- Mental Health Education
- Psychosocial Intervention
- Professional Treatment

What is Adolescence?

- Important transitional period
- Problematic age
- Identity crisis, role confusion, day dreaming
- Need for independence, responsibility, economic independence,
- Period of storm, stress, heightened emotionality
- A time of major biological, psychological and social change
- A period of experimentation during which young people try to establish a sense of their own identity
- A time during which young people seek to separate

Why is focus on Mental Health necessary?

- We believe that children who are mentally healthy will have the ability to:
  - develop psychologically, emotionally, creatively, intellectually and spiritually
  - initiate, develop and sustain mutually satisfying personal relationships
  - use and enjoy solitude
  - become aware of others and empathise with them
  - play and learn
  - develop a sense of right and wrong

Resilience factors

- Individual
  - Self-esteem/confidence
  - Problem solving
  - Adaptability to change
- Family
  - Positive relationships/role models
  - Supervision, support & appropriate discipline
- Community support
  - Range of positive sport/leisure activities

Dealing with conflicts

- Ventilation
- Listen actively
- Empathize with them
- Reassurance about security
- Help them to adopt healthy coping strategies
- Normalize routines
- Externalize their interest
- Decrease emotional affect by emotional support

Generic Skills & Life Skills

- Critical and Creative Thinking
- Decision making
- Problem Solving
- Effective communication
- Coping with stress, emotion
- Self-awareness, Self-esteem, Empathy, good interpersonal relations

Dealing with their conflicts

- Make time to listen
- Take time to talk to them
- Empathize with them
- Accept them as they are
- Understand their behavior
- Provide moral support
- Strengthen social Support
- Involve them in their interest
- Value their uniqueness
- Focus on their strengths
- Give constructive feedback
- Appreciate positive progress
- Build self reliance

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Promoting Psychosocial Competence

- Decision Making & Problem Solving
- Critical & Creative thinking
- Communication & IPR Skills
- Self Awareness and Empathy
- Coping Skills

Mental Health Education

- Life Skills
- Basic Knowledge of risk factors
- Basic Knowledge of mental Disorders
- Ability to recognize Psychosocial & mental Disorders
- Management of Psychosocial Problems
- Mental Health Intervention
- Use of referral resources

Psychosocial & Mental Health Interventions

- Health Promotion
- Primary Prevention
- Early Problem Identification
- Group Therapy
- Play Groups
- Behavioral Modification
- Referral for Psychiatric Treatment

Psychosocial & Mental Health Interventions

Identification & Intervention

- Identification Of Psychosocial Problems and High Risk Population
- Identification Of Mental Disorders Seen in Schools
- Instruments for Identification Of Psychosocial Problems & Mental Disorders
- Deciding On An Intervention

Conclusion

- Your own mental health & Well being is of prime importance.
- Deal with your family issues effectively.
- Handle work issues positively and proactively.
- Attend Training programmes and meetings to share your experiences and learn new skills.
- Deal with Burn Out by adopting various positive strategies.
- A healthy and happy individual can largely create healthy and happy environment around him/her.
Strategies to Address Mental Health Issues in Children at Risk and Victims of Abuse:

Types of Child Abuse:
- Physical abuse
- Sexual abuse
- Emotional abuse
- Neglect

Myths about Child Abuse:
- Child abuse only happens to mentally retarded
- It's only done by people with mental illness
- It's only happening in low socioeconomic strata
- It's not sexual abuse when a perpetrator when an adult perpetrator has sex with a "willing" underage victim
- Perpetrator is always an unknown individual
- Boys are safe, only girls are abused

Risk Factors for Victimization:
- Female sex
- Unaccompanied children
- Children in foster care, adopted children, stepchildren
- Children with physically or mentally disability
- History of past abuse
- Poverty
- Single parent homes/broken homes
- Social isolation—parent(s) with mental illness, or alcohol or drug dependency

WHO ARE THE PERPETRATORS OF CHILD SEXUAL ABUSE?

Gender:
The perpetrators of sexual abuse are overwhelmingly male. Studies found that more than 90% of the perpetrators of sexual offenses against minors were male.

Age:
Juveniles themselves commit a considerable proportion of sexual offenses against children, with estimates indicating about a third (ranging from 20-41%) are juveniles. Among adult perpetrators, young adults, under the age of 30, are overrepresented.

Acquaintances and family members commit most sexual abuse and assault. Several studies agree that approximately half of the offenders are acquaintances. The studies differ more about the percentage who are family members, the range going from 14% to 47%.

Strangers make up the smallest group of perpetrators ranging from 7% to 25%.
DYNAMICS OF DISCLOSURE

- Child sexual abuse disclosures are usually a process rather than a single event.
- Majority of cases, children do not disclose abuse immediately following the event.
- Reluctance to disclose abuse tends to stem from a fear of the perpetrator; the perpetrator may have made threats, such as "if you tell anyone I will kill you/kill your mother."

Short-Term Problems

- fear and anxiety
- sexualized behaviors
- nightmares
- social withdrawal or isolation
- sleep problems
- anger/acting out
- gastrointestinal difficulties, school difficulties
- posttraumatic stress disorder
- difficulty regulating emotional responses
- interpersonal problems

Long-Term Problems

- depression
- anxiety disorders
- substance abuse
- SUICIDALITY
- sexual dysfunctions
- interpersonal difficulties
- posttraumatic stress disorder

TRAUMAGENIC DYNAMIC MODEL

Traumatic sexualization
Betrayal
Stigmatization
Powerlessness

TRAUMATIC SEXUALIZATION

- Heightened awareness of sexual issues
  Sexual preoccupation
  Display knowledge inappropriate to age
- Sexual dysfunction
  Aversion/impaired desirability, difficulty with arousal and orgasm
  Vaginismus
- Sexual Identity

STIGMATIZATION

- Isolation
- Drug abuse
- Criminal activity
- Prostitution
- Self-destructive behavior and suicidal attempt
- Decrease self-esteem
- Shame and guilt
- Depression

POWERLESSNESS

- Fear and anxiety
- Nightmares and phobia
- Hypervigilance
- Clinging behavior
- Somatic complaints
- Decrease efficacy and coping skills – dissociation, despair, and depression
- Learning problems
- Running away
- Compensation—bullies and offenders

BETRAYAL

- Hostility and anger
- Grief reactions and depression
- Extreme dependency and clinging behavior
- Mistrust and suspicion—impaired judgment
- Antisocial behavior and delinquency

BARRIERS TO THE REPORTING AND DISCLOSURE OF CHILD ABUSE AND IMPLICATIONS FOR SERVICE USE
PERSONAL BARRIERS TO DISCLOSURE
- Shame, embarrassment;
- Self blame or fearing blame by others;
- Regarding it as a private matter;
- Close relationship with perpetrator;
- Not thinking what has happened is a crime;
- Not wanting anyone else to know;
- Dealing with it themselves.

BARRIERS AT THE LEVEL OF THE JUSTICE SYSTEM
- Believing that the police would not or could not do anything or would not think it was serious enough;
- Fear of not being believed or being treated with hostility;
- Fear of the police and/or the legal process;
- Lack of proof that the incident occurred;
- Not knowing how to report; and
- Doubt that the justice system will provide redress.

BARRIERS AT THE LEVEL OF THE HEALTH SYSTEM
- Lack of capacity within hospitals and clinics
- Medical care may be unavailable in close proximity to the assault;
- No protocol for sexual assault management

IMPLICATIONS FOR SERVICE PROVIDER
- Range of health services to be made available
- Hospitals to develop standardized procedural protocols for handling such cases & train
- Inform patient about their legal rights & existing provisions
- Appropriate referrals to social support agencies
- Responsible judiciary

ISSUES
- Assessment
- Safety of the child
- Who is the client?
- Involve siblings?
- Role of the therapist
- Confidentiality

ASSESSMENT
- COMPREHENSIVE – History, Examination, Investigation, Documentation

HISTORY
MEDICAL OR HEALTH HISTORY
It should be taken in a manner to avoid further traumatization information is not lost or distorted.

INTERVIEWING CHILD VICTIMS
Open-ended questions
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.

INTERVIEWING VICTIMS OF CHILD ABUSE
Should be approached with extreme sensitivity
If possible, interview the child alone
Establish a neutral environment and rapport
Try to establish the child's developmental level
Identify yourself as a helping person
Describe in their own words

PHYSICAL EXAMINATION
Keeping following in mind visit to a health professional at earliest should be ensured:
- If last contact was more than 72 hours previously and the child has no medical symptoms, an examination is needed as soon as possible but not urgently.
- If last contact was within 72 hours and the child is complaining of symptoms (i.e. pain, bleeding, discharge) immediately.
- Examination and investigations for sexually transmitted diseases to be arranged.
**SIMPLE GENERAL RULES**
- Always ensure patient privacy.
- Ask whom they would like in the room for support during the examination.
- Be sensitive to the child's feelings of vulnerability and embarrassment.
- Stop the examination if the child indicates discomfort or withdraws permission to continue.

---

**CLINICAL MANAGEMENT**

**GOAL OF MANAGEMENT**
- **PRIMARY IMPORTANCE:**
  - HEALTH & SAFETY OF PATIENT
- **SECONDARY IMPORTANCE:**
  - MEDICO LEGAL SAFETY

---

**CLINICAL MANAGEMENT**

**SERVICES OFFERED TO SEXUAL ASSAULT VICTIMS SHOULD BE CENTRED ON:**

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<td>Right to Privacy:</td>
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<td>Right to Confidentiality:</td>
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**MENTAL HEALTH INTERVENTIONS**

- **Assessment and examination of victims**
- **EMERGENCY TRIAGE**
- **EARLY DETECTION**
- **PROMPTNESS OF SERVICE DELIVERY**
- **ARRANGE FOR SAME GENDER THERAPIST IF POSSIBLE**

---

**MENTAL HEALTH INTERVENTIONS**

- **Assessment and examination of victims**
  - GENERAL MEDICAL HISTORY
  - GYNECOLOGICAL HISTORY
  - ACCOUNT OF ASSAULT
  - HEAD TO TOE EXAMINATION
  - MEDICO LEGAL EXAMINATION & Appropriate referrals including gynaecology / surgery in nearby hospital accompanied with a doctor

---

**CRISIS MANAGEMENT**

**Psychological Intervention:**
- Restoring patient to psychological safety.
- Ventilatory support with non-judgmental, non-directive, facilitatory attitude & continuous reassurance along with environmental manipulation, if required.
- Providing information related to current medical status, addressing fears related to misattributions.

---

**PSYCHOLOGICAL INTERVENTIONS**

- Trauma focused Cognitive behaviour therapy
- Art therapy.
- Play therapy.
- Supportive Psychotherapy
Presentation: 6: Psychosocial Disabilities & Care Issues

**Psychological Disabilities Concept**

Disabilities in the psychosocial domain refer to difficulties in the mental and psychological aspects of an individual's development.

**Causes:**
- AS per PWDA (1995)
  - Mental illness
  - Mental Retardation
- As per NTA (1999)
  - Autism

**Indicators of Mental Retardation in Children:**
- Delays in milestone development
- Poor understanding
- Inadequate self-help skills
- Age inappropriate in scholastic performance
- Discrepancy in MA & CA (MA/CA x 100)

**Evaluation:**
- Poor eye contact
- Restricted or absence of communication
- Poor social interaction
- Repetitive actions & rigidity in behavior

**Indian Disability Evaluation Assessment Scale (IDEAS) (2002):**
- Manualized cognitive scale for 4 domains: Social, interpersonal, activities, communication work
- Score range: 0-90

**Indian Scale for Assessment of Autism (ISAA) (NIMH, 2009):**
- 40 items under 9 domains
- Score of 70 indicates: 40% disability
- IU tests for MR

**Multiple Disability:**
- Certification
  - Mild MR 40-49%
  - Moderate 50-70%
  - Severe 70-90%
  - Profound 100%
- Benefits
- Guardianship

**a + b (90-a)x90**
- "a" will be the higher score and "b" will be the lower score. However, the maximum total percentage of multiple disabilities shall not exceed 100%.
Management
- Foster hope, self-esteem & self-
  empowerment
- Encourage advocacy & peer support
- Promote education, role models, & self-
  determination
- Teach life, stress & symptoms
  management skills

Symptom management
- Hearing voices
- Social isolation
- Drug & alcohol misuse
- Suicide risk
- Pharmacological Rx
- Non-pharmacological Rx

Counselling
- Emotional Problems due to abuse,
  rejection, neglect, orphan
- Social isolation, aggression
- Supportive therapy, non-judgemental
  attitude, trust, confidentiality
- Recognition & Early intervention

Activities of Daily Living
- Educational
- Vocational
- Skills training, social life, coping
- Healthy relationships
- Communication
- Symptom management
- Family involvement

Functional deficits:
- Pre-vocational skills
  - Mild: Educable
  - Moderate: Trainable
  - Severe: Trainable for self-help skills
  - Profound: Custodial

Book-binding
- File making
- Canning
- Carpentry
- Cooking & bakery
- Cutting & Tailoring
- Envelopes & Cards

Psychoeducation
- Dealing with behavioral problems
- Addressing stigma, discrimination &
  social isolation
### List of Participants who attended the NCPCR CPD programme 25th-26th July, 2014

<table>
<thead>
<tr>
<th>S.NO</th>
<th>NAME OF PARTICIPANT</th>
<th>DISTRICT, STATE</th>
<th>DESIGNATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Rajinder Kumar</td>
<td>Mansa, Punjab</td>
<td>Counsellor</td>
</tr>
<tr>
<td>2.</td>
<td>Gurpreet Singh</td>
<td>Ludhiana, Punjab</td>
<td>Counsellor</td>
</tr>
<tr>
<td>3.</td>
<td>Tejinder Singh</td>
<td>Ferozpur, Punjab</td>
<td>Social Worker</td>
</tr>
<tr>
<td>4.</td>
<td>Puneet Singla</td>
<td>Patiala, Punjab</td>
<td>Social Worker</td>
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<tr>
<td>5.</td>
<td>Chetan Sharma</td>
<td>Bathinda, Punjab</td>
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<td>6.</td>
<td>Gurpreet Singh</td>
<td>Ambala, Punjab</td>
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<td>Harikishan</td>
<td>Bhiwani, Haryana</td>
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<td>8.</td>
<td>Asha Rani</td>
<td>Fatehabad</td>
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<tr>
<td>9.</td>
<td>Amos</td>
<td>Gurgaon, Haryana</td>
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<tr>
<td>10.</td>
<td>Mohit</td>
<td>Gurgaon, Haryana</td>
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<tr>
<td>11.</td>
<td>Mamta Sharma</td>
<td>Jind., Punjab</td>
<td>Counsellor</td>
</tr>
<tr>
<td>12.</td>
<td>Ms. Gita Rana</td>
<td>Alipur, Delhi</td>
<td>Welfare Officer</td>
</tr>
<tr>
<td>13.</td>
<td>Mr. Pushesh Atria</td>
<td>Alipur, Delhi</td>
<td>Welfare Officer</td>
</tr>
<tr>
<td>14.</td>
<td>Mr. vakeel</td>
<td>Alipur, Delhi</td>
<td>Welfare Officer</td>
</tr>
<tr>
<td>15.</td>
<td>Ms. Seema Malik</td>
<td>Alipur, Delhi</td>
<td>Welfare Officer</td>
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<tr>
<td>16.</td>
<td>Yogesh Sharma</td>
<td>Lajpat Nagar, Delhi</td>
<td>Welfare Officer</td>
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<tr>
<td>17.</td>
<td>Cheta</td>
<td>CHG-I, Nirmal Chhaya Complex, Delhi</td>
<td>Welfare Officer</td>
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<tr>
<td>18.</td>
<td>Eva</td>
<td>Sanskar Ashram, Delhi</td>
<td>Welfare Officer</td>
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<td>Geeta Rawat</td>
<td>Sanskar Ashram, Delhi</td>
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<td>20.</td>
<td>Sunjay</td>
<td>Sanskar Ashram, Delhi</td>
<td>Welfare Officer</td>
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<td>21.</td>
<td>Sunita Singh</td>
<td>Udyan Care, Lajpat Nagar, Delhi</td>
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<td>22.</td>
<td>Ms. Archana Rai</td>
<td>Varanasi, Uttar Pradesh</td>
<td>Counsellor</td>
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<tr>
<td>23.</td>
<td>Mr. Sunil Kumar</td>
<td>Kanpur Nagar, Uttar Pradesh</td>
<td>Counsellor</td>
</tr>
<tr>
<td>24.</td>
<td>Ms. Neelam Bharti</td>
<td>Ferozabad, Uttar Pradesh</td>
<td>Counsellor</td>
</tr>
<tr>
<td>25.</td>
<td>Ms. Ruby Meraz</td>
<td>Allahabad, Uttar Pradesh</td>
<td>Counsellor</td>
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<tr>
<td>26.</td>
<td>Ms. Archana Gaud</td>
<td>Devriya, Uttar Pradesh</td>
<td>Counsellor</td>
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<tr>
<td>27.</td>
<td>Ms. Malini Dwivedi</td>
<td>Meerut, Uttar Pradesh</td>
<td>Counsellor</td>
</tr>
<tr>
<td>28.</td>
<td>Ms. Azima B</td>
<td>Rampur, Uttar Pradesh</td>
<td>Counsellor</td>
</tr>
<tr>
<td>29.</td>
<td>Ms. Jyoti Kulshreshth</td>
<td>Agra, Uttar Pradesh</td>
<td>Counsellor</td>
</tr>
</tbody>
</table>
ANNEXURE – 1b

List of Participants who attended the NCPCR CPD programme 8th-9th August, 2014

<table>
<thead>
<tr>
<th>S.NO</th>
<th>NAME OF PARTICIPANT</th>
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<tbody>
<tr>
<td>1.</td>
<td>Shri Suryakant Munde</td>
<td>Thane, Maharashtra</td>
<td>Counselor</td>
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<tr>
<td>2.</td>
<td>Shri Amit Gunjal</td>
<td>Thane, Maharashtra</td>
<td>Counselor</td>
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<tr>
<td>3.</td>
<td>Shri Santosh Khopade</td>
<td>Thane, Maharashtra</td>
<td>Counselor</td>
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<tr>
<td>4.</td>
<td>Shri Dyaneshwar Pawar</td>
<td>Thane, Maharashtra</td>
<td>Counselor</td>
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<tr>
<td>5.</td>
<td>Dulichand Lodha</td>
<td>Rajasthan</td>
<td>Co-coordinator</td>
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<td>6.</td>
<td>Ms. Dnyanechya Tanaji Fadte Bandokar</td>
<td>Goa</td>
<td>Probation Officer</td>
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<tr>
<td>7.</td>
<td>Ms. Niteela Gawas</td>
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<td>Counselor</td>
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<td>8.</td>
<td>Michael Kujar</td>
<td>Goa</td>
<td>Team Member</td>
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<td>9.</td>
<td>Ms. Irene George</td>
<td>Goa</td>
<td>Counselor</td>
</tr>
<tr>
<td>10.</td>
<td>Ms. Sarita Santa Maria</td>
<td>Goa</td>
<td>Counselor</td>
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<tr>
<td>11.</td>
<td>Smt. Dipikaben Palodra</td>
<td>Gujrat</td>
<td>Counselor</td>
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<td>12.</td>
<td>Shilpaben Patel</td>
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<td>Mayaben Dimple</td>
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<td>Smitaben k. Asodia</td>
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<td>Counselor</td>
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<td>15.</td>
<td>Shri Sushil Sajnani</td>
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<td>Counselor</td>
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<td>Smt. Anita Sahu</td>
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<td>Shri Aashish Verma</td>
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<td>Shri Pankaj Dube</td>
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<td>Shri Vijay</td>
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<td>20.</td>
<td>Dharmender Singh</td>
<td>Gurgaon, Haryana</td>
<td>Counselor</td>
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<td>S.NO</td>
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<tr>
<td>1</td>
<td>P Chitra</td>
<td>Tamil Nadu</td>
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<tr>
<td>2</td>
<td>S Sasi Kala</td>
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<td>Dr G Beulati Thilgaty</td>
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<td>S Sathasivam</td>
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<td>Dr S Ramanathan</td>
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<td>6</td>
<td>Kiran Sarwal</td>
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<td>7</td>
<td>Md Amar Ahmed</td>
<td>Manipur</td>
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<td>8</td>
<td>Ms Saikia</td>
<td>Assam</td>
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<td>9</td>
<td>R Lahon</td>
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<td>D Das Roy</td>
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<td>11</td>
<td>Jyotinoyce Gogoi</td>
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<td>12</td>
<td>Santosh Kumar</td>
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<td>13</td>
<td>Kamini Kumari</td>
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<td>Neetu Bala</td>
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<td>15</td>
<td>Sangeeta Mukherjee</td>
<td>West Bengal</td>
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<tr>
<td>16</td>
<td>Anjali Sikhar</td>
<td>West Bengal</td>
<td>Counselor</td>
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<tr>
<td>17</td>
<td>Srabani Maiti</td>
<td>West Bengal</td>
<td>Counselor</td>
</tr>
</tbody>
</table>
Annexure

IN THE HIGH COURT OF DELHI AT NEW DELHI

W.P. (CRL) 694/2012

AMARDEEP Petitioner MALIK...

Through: Mr. Preet Pal Singh, Ms. Gurmeet Kaur Kapur and Ms. Priya Mahta, Advocates

versus

STATE GOVT. OF NCT OF DELHI and ORS. ....
Respondents

Through: Mr. Pawan Sharma, Standing Counsel (Crl.)
Ms. Asha Menon, Member Secretary DSLSA.
Mr. M.K Chaudhary, advocate for Apna Ghar.
Mr. Binod Kumar Sahu, Registrar, NCPCR.

CORAM:

HON'BLE MR. JUSTICE S. RAVINDRA BHAT
HON'BLE MR. JUSTICE S.P. GARG

ORDER

01.06.2012
1. The present writ petition began as a claim for a writ of habeas corpus for the production of the writ petitioner’s son, Tanush. He had been directed by the Chairman of the Dilshad Garden Child Welfare Committee, constituted under provisions of the Juvenile Justice (Care and Protection) Act, 2007, (the Act) to be handed over to the Apna Ghar shelter home, recognized by the Govt of NCT of Delhi (hereafter GNCT) under the Act. The court directed immediate restoration of the child to the writ petitioner, and kept the matter for recording compliance. At that stage, the writ petitioner drew the attention of the court to the conditions in the said shelter home, which appeared to be less than satisfactory, in terms of physical infrastructure. Resultantly, the Court by its order dated 17th May, 2012, asked Ms. Richa Kapoor, a counsel practicing in this court, and also an Additional Public Prosecutor appearing on behalf of the GNCT, to act as Commissioner, visit the place, and submit a report.

2. The directions of the Court resulted in a report, and submission of photographs as well as a video footage, (all of which were considered on 25th May, 2012) which disclosed appalling conditions in Apna Ghar. The Court, as a result, constituted a Committee comprising of the Secretary, Delhi Legal Service Authority, child psychologists, a doctor, and the Director of the GNCT, department of women and child development, tasked to inspect the home, and submit a report. The report was submitted. Apparently, on the basis of this inspection, and the other materials on record, the GNCT issued a notice to the Apna Ghar, asking it to show cause why the permission granted to it, and renewed in 2010, should not be cancelled.

3. This Court heard the Standing Counsel for the GNCT of Delhi, the Commissioner Ms. Kapoor, the writ petitioner’s counsel, Counsel for Apna Ghar, the Standing Counsel (Criminal) GNCT of Delhi and members of the in detail, on 30-05-2012.

4. To say that the picture shown about Apna Ghar is lamentable, would, in this Court’s opinion, be putting it mildly. The materials on record, by way of the report of the Commissioner, the interim report, given by the Committee mandated by the Court, the photographs brought on record, and the documents which were accessed during the course of inspection of the facility, prima facie paint a sordid picture of neglect and apathy. The facility is being operated from public land (owned by the Railways, for which the operating agency, an NGO called Children of Mother Earth or COME does not appear to have any formal official approval) in premises that was formerly a yard or go-down, and which seems to be, by all accounts, decrepit and run down. The materials available on the record disclose serious infrastructural and human resource shortcomings, in the operation of the home, which prima facie may amount to large scale violation of the Rules framed by the GNCT, under the Act. The deficiencies which glaringly stand out, include woefully inadequate
building infrastructure, such as dilapidated building, run down and uneven flooring, poor hygiene conditions, and grossly un-trained, or undertrained staff who are in charge of the day to day operations. The reports point to abysmal state of toilets, less than acceptable conditions in the dormitories, almost primitive conditions for play and no educational facilities. A worrisome feature which emerged during the two previous hearings was that there are no educational facilities, contrary to the clear mandate of the law, and the medical facilities which are to be attached to the facility are also non-existent. Furthermore, the area where the facility is housed, also appears to have been leased out partly to some others. There is no provision for appropriate security, and a serious lapse in the facility is utter chaotic documentation. These deficiencies prima facie appear to be violative of Rules 45, 47 and 49 of the Delhi Juvenile Justice (Care and Protection) Rules, 2009. The inspection by the overseeing committees mandated under law, do not appear to have been conducted. These are only a few salient features which the court discerns. This Court desists from making any further comments since the Govt. of NCT of Delhi, during the course of hearing on 30th May, 2012, stated that a fresh detailed show cause notice would be issued, asking the explanation from the Apna Ghar management, and after considering its response, taking such necessary consequential action as is necessary by 14th June 2012. This Court also directs the Govt. of NCT of Delhi, in the course of its inquiry, look into the books of account maintained by Apna Ghar, and its parent organization, for the purpose of ascertaining the moneys received by way of donations, the utilization of such moneys and the co-relationship with the articles purchased, or the services and facilities provided, in terms of what is claimed to have been expended.

5. During the previous hearings, the Court had called for the relevant records of the Child Welfare Committee (CWC). The file pertaining to the boy Tanush, for whose production the present writ petition had been instituted, disclosed that the Chairman telephonically required the police constable, who reported the matter to him, over telephione, despite being aware that the child was then in the custody of a parent, i.e father, to be taken away and kept in the Apna Ghar shelter home. The file (of the CWC) pertaining to Apna Ghar showed that apparently an inspection had been conducted of the home, on 6-3-2012, which listed out certain deficiencies. However, there is no trace of this inspection report in the file of the CWC, maintained by the GNCT of Delhi. Several serious irregularities in the conduct of proceedings of the CWC were noticed, on the record, and a comparison of the record. The inspection report pertaining to Apna Ghar, which is on the record of the GNCT of Delhi, is of August, 2011. This shows, facially that either the CWC is feuding its records, or grossly neglecting its duties. In this context, the Court recollects Rule 24 of the Delhi Rules, which casts obligations on the CWC, and says, inter alia, that: The Committee shall visit each institution where children are sent for care and protection or adoption at least once in three months to review
the condition of children in institutions, with support of the State Government and suggest necessary action; they should also monitor associations and agencies within their jurisdiction that deal with children in order to check on the exploitation and abuse of children.

The serious nature of the deficiencies is apparent on the face of the record. This Court also had occasion to look into the records of the CWC, in respect of the institution, as well as the records maintained in respect of the children whose welfare and well-being it is obliged to oversee. There appears to be no semblance of regularity of its proceedings. It is designated as a Bench of Magistrates; yet, its members conceded that registers and diaries to keep track of children scheduled to be produced before them are not maintained. Another grave deficiency in the functioning of the CWC appeared to be the casual procedure adopted by it to restore children which had been placed under the care of Apna Ghar. The records shown to the court by that institution, and the CWC reveal that in many instances, when individuals claim to be guardians of children, who were admitted to the Apna Ghar, as being lost, no proper verification of identity, and cross checking of claims was resorted to; no follow up, in the manner prescribed by Rule 63, was conducted (as is mandated for two years, continuously). The overall impression which the Court gathered from the record is that the CWC is not discharging its functions properly.

6. In view of the above observations, the Court is of opinion that there should be a thorough inspection of all the children homes (similar to Apna Ghar) and facilities managed by NGOs and which have been recognized or granted permission by the Govt of NCT of Delhi. The Court is informed that there are 41 such institutions managed by NGOs, and 21, by the Govt. of NCT of Delhi. In all, about 2200 children are housed in these institutions. This Court hereby directs the National Commission for Protection of Child Rights (hereafter called NCPCR,) a national statutory body under the Protection of Child Rights Act, 2005 to inspect all such shelter or care homes ? both private as well as government run institutions- in co-ordination with the Delhi Legal Services Authority, and prepare a comprehensive report as to the functioning of each such institution. The report shall point to such deficiencies and short comings as may exist in terms of physical, medical and manpower infrastructure of each institution, with specific reference to the existing rules and prevailing norms, in that regard. Since both are statutory bodies, tasked with performance of duties in the aid of law, the Govt of NCT shall render all assistance and co-operation, including manpower and financial support. The inspection of each institution shall be conducted by nominees of the NCPCR, the Delhi State Legal Services Authority, (who shall be a judicial officer). The NCPCR, and the DSLSA shall jointly evolve a convenient procedure in this regard. The report shall be prepared and filed in court at the earliest, and in any event within 10 weeks. This court notices that under the Rules, particularly Rules 63 and 64 provision for such overseeing or control mechanisms have
been prescribed; yet if such measures had been effective, the plight of children in Apna Ghar would not have been what it is.

7. This Court further directs that the DSLSA shall inspect each Child Welfare Committee, and the files with the Government of NCT pertaining to each of them, and report to the court, as regard such deficiencies and deviations in their functioning, on all aspects, i.e. procedure for holding of inspection, the records available with them, the qualifications of its members, the frequency with which the committees perform their tasks, and report to the Government of NCT as required by the rules. These are only illustrative aspects; we emphasize that the inspection and reporting shall be full and comprehensive, and shall consist of all functioning aspects, as well as the requirements under the Act and rules. This task is important, because the CWCs exercise magisterial powers which implicate and affect the lives of the children whom they are expected to look after, and would fall within the supervisory jurisdiction of this Court. The State, we may notice, acts as parens patriae as far as the lives, welfare and well being of these children are concerned. It has to ensure that these children’s right to life is not diminished in any manner. The Govt. of NCT of Delhi shall extend all necessary co-operation, including providing access to its files in relation to these CWCs and all matters connected with it. This report too shall be prepared within 10 weeks.

8. The reports mentioned in the previous two paragraphs shall each outline the summary of conclusions and recommendations, with specific reference to the provisions of the Act and Rules, for facility of easy reading and further follow up action. The Court also directs that the first committee tasked with inspecting the various institutions shall also co-opt, for the purpose of assessment of each child’s well-being, a child psychologist or counselor, as prescribed by the rules; it shall also associate doctors who shall assess the health of each inmate, and also look into the medical records maintained in respect of such children by the institution. The honorarium payable to such doctors and psychologists shall borne by the Govt. of NCT of Delhi.

9. The Govt of NCT of Delhi is at liberty to proceed, with its inquiry further to the show cause notice already issued, or to be issued, in respect of the Apna Ghar in accordance with law and take such further action as is warranted ? under the Act, or any other provision of law. However, this enquiry be completed with utmost expedition; in any event within three weeks. In the meanwhile, the Govt of NCT of Delhi is directed to ? in coordination with the first inspection committee ? monitor the institution once a week through inspection. The inspection of Apna Ghar shall be conducted by a nominee of the Govt of NCT of Delhi, a nominee of NCPCR and one of DSLSA. The health, well-being and welfare of every child shall be closely monitored, and if any inmate is to be restored to his or her parents or guardians, the CWC shall carry out its tasks in accordance with law, after proper verification of all facts,
subject to the supervision and direction of a judicial officer, nominated by the DSLSA. The restoration files (of Apna Ghar) are directed to be handed over to the DSLSA. Copies of such files shall be made available to the Apna Ghar through its counsel within the next three days.

Similarly, one file of the CWC furnished to the Court and fourteen files pertaining to the children of Apna Ghar institution shall be handed back after photo copies of the same are retained by the Court. The photocopies of these files (duly certified) shall be made available with the DSLSA within three days.

10. It is open to any of the parties to approach the Court for clarification or further directions in respect of implementation of this order.

11. List on 24.08.2012 for consideration of the reports.

S.RAVINDRA BHAT, J

S.P.GARG, J
June 01, 2012
Report of Government and NGO run Children Homes – inspected by IHBAS Team between 14\textsuperscript{th} to 26\textsuperscript{th} June, 2012

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 the inspection work of both Govt. and NGO run Children Homes, to be conducted in a time bound manner. The professional expertise of IHBAS was primarily sought for the mental health assessment of the children in these homes.

The IHBAS team involved Psychiatrists, Clinical Psychologists and Psychiatric Social workers. The team was lead by the Director of IHBAS, Dr Nimish Desai. The constitution of the teams was done in such a way so as to ensure gender sensitivity for inspection & assessment of both the Boys and the Girls Home. The visits were made between 14\textsuperscript{th} to 16\textsuperscript{th} June, 18\textsuperscript{th} to 20\textsuperscript{th} June and on 26\textsuperscript{th} June 2012.

The Seven homes that were inspected were as follows:
1. Alipur Aashiana home on 14\textsuperscript{th} June, 2012.
2. Alipur Phulwari home on 15\textsuperscript{th} June, 2012.
4. Nirmal Chhaya CHG-II on 18\textsuperscript{th} June, 2012.
5. Nirmal Chhaya CHG-I on 19\textsuperscript{th} June, 2012.
6. Salaam Balak Trust, Tis Hazari on 20\textsuperscript{th} June, 2012.
7. Nirmal Chhaya CHG-III on 26\textsuperscript{th} June, 2012.

The details of the team members involved in the inspection process is in Enclosure-I.

The inspection of the Seven homes for children involved a little more than fifty person-days for the team. Each team from IHBAS had 6-7 members and each of the team members made between 1-5 visits in all. The organising of the teams for the seven Homes for the staff from IHBAS involved a lot of rescheduling of the routine clinical services at the hospital. The team pooled in a taxi from IHBAS to make the visit to the Homes.
The Comprehensive mental Health Assessment was broadly carried out in a three step manner. Figure -1 illustrates the assessment procedure, so as to cover the mental health assessment of the population of children in each home.

Step1: Based on a list of broad indicators, the caretakers of homes were asked to report/provide the list of children identified with psychological problems/unruly children etc.

Step2: Focussed Group Discussions (FGD) were conducted with preformed probes, to elicit overall subjective wellbeing/current living conditions The perceptions and attitudes of the children, the perceived support/coping of the children/ positive & unpleasant aspects of home.

Step3: Application of Child Behaviour Questionnaire (CBQ) on a sub-section of the children for assessment of mental health including behavioural and emotional problems (on the apparently “normal” children as per caretakers).

![Comprehensive Mental Health Assessment](image)

**Figure-1**

1) Assessment of Referred cases
The seven homes were inspected by the respective team members from IHBAS along with members from NCPCR and DSLSA. During the rounds the caretakers/welfare officers/counsellors were asked to provide a list of children they felt had psychological problems. These children were then assessed by the mental health team using information from the caretakers and through clinical assessment and the findings were documented. Children with medical problems were seen by the attending paediatrician. The total number
of children with psychological problems as reported by the caretakers ranged from 9%-11% in all homes except in Salaam Balak Trust (SBT) where the number was reported to be 35. The total number of children with psychological problems divided by the total number of children in the respective homes was used as a rough indicator of the mental health morbidity in that home (Table 1).

2) Focussed Group Discussion (FGD)
Focussed Group discussions were held as per the guidelines developed by the members, consisting of 7 domains (Enclosure-II). Groups not larger than 8-15 children were formed. The children were informed of the purpose of the discussion by the group co-ordinator and that their complaints, if any, were not meant to punish anyone but only to assist the Court in providing for better facilities to them. Fourteen such FGD’s were conducted in total which threw light on the general living conditions of the children, their subjective wellbeing, perceptions and attitudes. The highlights of the discussion were as follows:

**Living Conditions**
The living conditions were reported to be comfortable for the children in most homes with adequate toilet facilities. However, unsatisfactory living conditions were reported in Nirmal Chhaya CHG I & II. In these two homes particularly, there were basic problems of water and sanitation with no proper facility of drinking water and poor maintenance of toilet facilities. Food was of very poor quality, with occasional worms being found in the rice, glass pieces in the ‘kadi’, uncooked or overcooked rice etc. The girls expressed that the toiletries and sanitary pads provided to them were inadequate and needed to be increased. The accommodation was in the form of dormitories, which had grilled balconies with no contact or view of the outside world. Children were made to help in cooking, cleaning toilets and rooms, which was disliked by them. The clothes/slippers provided by the homes were reportedly satisfactory in all the venues. The beds/ pillows and living space provided was also satisfactory.

**Facilities provided**
Both Formal and Non-formal educational facilities were available to the children and they were encouraged to utilize it to an optimum level. Most of the children expressed a positive attitude and satisfaction towards these facilities. Some of the children were
attending regular schools (in/near the home) while others were receiving some form of non-formal education by trained volunteers/teachers, within the premises. Tuition facilities were also being provided. Besides, children were also being encouraged to be involved in other activities like music, dance and sports. In Alipur Phulwari home, training to adolescents was being provided in welding and electrical works by experts as a means to earn their livelihood after child leaves the home. This was reportedly very encouraging for the children. “Hole in the Wall” at Alipur, Nirmal Chhaya homes was very innovative for keeping the children engaged. At Salaam Balak trust, children were taught computers and were exposed to music, drama and even given opportunities to act in films. The vocational and recreational avenues had a positive bearing on the children. In most homes, the children adequately utilized the vocational and recreational opportunities provided to them except in Nirmal Chhaya 3 where vocational/recreational facilities provided in the home were not at all utilized and high level of disinterest was shown by the girls towards the same. Dissatisfaction was reported by the children about the limited availability of vocational training both in terms of the number of trades and level of training, which was perceived as a source of engagement rather than for skill development.

Perception regarding Home Environment

The children generally seemed happy and cheerful in the homes. They felt they were in safe hands and were being cared for and protected. It was common to find the children distressed because of the delay in the process of restoration. A supportive and friendly environment was provided in most homes where the child could either get in touch with the welfare officer or the counsellor. This helped the children forget to some extent the difficult times they faced prior to their rescue and looked ahead to going back to their homes or rebuilding a new life. In most homes children maintained a positive attitude towards life. In Nirmal Chhaya homes particularly, discrimination and differential treatment by staff based on reasons of stay and prolonged medical illness was noticed and girls had a negative attitude towards staff with no inclination to interact with anyone other than their peers. In Alipur Phulawari home, punishment by caretakers, on occasions
subsequent to certain complaints, disobedience and non-conforming behaviour were reported and was a cause of concern.

3) Assessment of children
After having excluded the children who were referred by the welfare officers and counsellors. Some children were randomly selected for assessment of Psychological problems. These children were rated on Child Behaviour Questionnaire (Enclosure-III) by the mental health team members. The number of children having any symptom on CBQ was divided by the number of children assessed in the sample. Although, it was intended to get a representative sample but the logistics did not permit this in the field and so a sub-section of the children was taken which gave a very high percentage of children with psychological problems in that sample. This step 3 phase of the assessment did not work out as planned and the results should not be interpreted as representative of the sample population. Had the sample been reasonably representative, appropriate projections could have been drawn, but this was not possible.
Table-1

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Observation Home</th>
<th>%age of children with symptoms (Referred cases)</th>
<th>%age of children with symptoms (FGD)</th>
<th>Children with symptoms on CBQ&lt;sup&gt;2&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Aashiana</td>
<td>10/110X100 = 9.09%</td>
<td>2&lt;sup&gt;4&lt;/sup&gt;/15X100 = 10.3%</td>
<td>29/36X100 = 80.56%</td>
</tr>
<tr>
<td>2.</td>
<td>Phulwari</td>
<td>12/155X100 = 7.74%</td>
<td>6&lt;sup&gt;4&lt;/sup&gt;/42X100 = 14.3%</td>
<td>7/8X100 = 87.5%</td>
</tr>
<tr>
<td>3.</td>
<td>Prayas</td>
<td>10/64X100 = 15.62%</td>
<td>6/35X100 = 18.7%</td>
<td>N.A.&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>4.</td>
<td>Nirmal Chhaya-1</td>
<td>9/114X100 = 7.89%</td>
<td>17/40X100 = 42.5%</td>
<td>8/8X100 = 100%</td>
</tr>
<tr>
<td>5.</td>
<td>Nirmal Chhaya-2</td>
<td>11/108X100 = 10.18%</td>
<td>16/32X100 = 50%</td>
<td>6/6X100 = 100%</td>
</tr>
<tr>
<td>6.</td>
<td>SBT</td>
<td>10+25* = 35/114X100 = 30.7%</td>
<td>6&lt;sup&gt;4&lt;/sup&gt;/18X100 = 33.3%</td>
<td>21/28X100 = 75%</td>
</tr>
<tr>
<td>7.</td>
<td>Nirmal Chhaya-3</td>
<td>9/42X100 = 21.42%</td>
<td>3&lt;sup&gt;4&lt;/sup&gt;/15X100 = 20%</td>
<td>2/14X100 = 14.28%</td>
</tr>
</tbody>
</table>

* Total no. of children under follow-up of the counsellor who refused for CBQ assessment on grounds of confidentiality

# The numbers are estimate figures drawn by IHBAS team based on FGD’s and is subject to recall bias.

$ The results may not reflect the Mental Health problem in actuality.

@ Not Applied (because of logistic problems)

4) Observations and Impressions
   a) Magnitude of the Mental health problem
      In almost all homes, most children had suffered some form of difficulty/abuse/trauma prior to coming to the home. About 50% of the children in the homes had some form of adjustment difficulty with regard to living conditions, poor food and basic necessities, attitude of staff, delay in restoration process etc.
which made them sad and angry at times. However, these children did not have severe Psychological distress.

As per the FGD estimates, 10%-50% of the children had psychological symptoms as seen in Table-I.

In all three of the Nirmal Chhaya homes most of the girls reported that verbal and physical abuse was common. Problem behaviours such as restlessness, bed-wetting, stealing, lying, anger outbursts, bullying, verbal and physical aggression, indecent behaviour were commonly reported in all homes. Children also reported having sadness of mood, having crying spells and some reported fearfulness at night especially during their initial days at the home. In Alipur phulwari and Nirmal Chhaya CHG-II homes particularly homosexual behaviour amongst children was also reported but limited to a small number of home-mates.

In Nirmal Chhaya CHG-III particularly, girls expressed that they were forcibly pulled out from their places of stay in GB road and produced before the court and housed there. They claimed to have crossed the age of 21 yrs and that they were into flesh trade at their own behest. Hostility was expressed towards the police personnel who did not restore them back to their places even after ascertaining their bone age and confirming them to be majors and continued to be held captive, with no freedom to move out of the building.

In each of the homes at least 10%-15% of the residents had a diagnosable syndrome and were under follow-up. These many cases were easily identified by the home officers and were referred to higher centre for receiving treatment and subsequently followed up with the mental health unit attached to the home. The major mental health problems were Mild Mental Retardation, Depressive Disorder, Seizure Disorders, Conduct Disorder, Slow Learning and speech defects. Of the 600 children in the 7 homes, Children Behaviour Questionnaire (CBQ) was applied on 90 children in the convenience sample that was taken. More than 66% were either aggressive or had bullying behaviour, more than 33% were having depressive symptoms, an equal number showed truant behaviour, 25% reported restlessness, 11% had symptoms of hyper activity, and approximately 10% had speech defects.
b) **Extent of recognition of mental health problems**

In most of the homes 10%-15% of the children were identified as having mental health problems but in majority the mental health needs were unmet. In homes with an In-house counsellor like SBT, Prayas and Nirmal Chhaya, the extent of recognition of mental health problems was higher but where specialized services were not available the recognition was lower, as in Alipur homes. As seen in table 1 in SBT 31% of the children were identified with having psychological symptoms/disorder, 21% in Nirmal Chhaya-III and upto 16% in Prayas home. The recognition was as low as 8%-11% in both the Homes at Alipur and Nirmal Chhaya-I&II Homes. Estimates of IHBAS team based on FGD and other inputs were as high as 35% of children having psychological problems. In the management of these homes, there is a widespread and a reasonably common belief that all children in these homes have some problem but we at IHBAS believe that this should not be subscribed to.

c) **Profile of nature of mental health needs**

The children who were identified with psychiatric disorder required specialized professional management & comprehensive bio-psycho-social management and for the same, they were referred to a higher centre. The percentage of such children was 10-15%.

Those with psychological symptoms of concern requiring intervention by trained Mental Health professional should be seen by an In-house counsellor for counselling and crisis intervention. 10%-40% of the children were in need of such forms of intervention. However, the same could only be provided in homes with an attached mental health facility such as Prayas, SBT and Nirmal Chhaya.

A large number of children did not report any emotional/behaviour disturbance. This population was as high as 50%. All the children were imparted life skills training, taught various adaptive techniques, vocational skills training and were imparted advance skills training for easier re-integration into the society after the child leaves the home.
5) Suggestions and Recommendations

For better home management

1. Total number of staff at all levels should be increased to enhance children’s wellbeing as per the number of hommates.
2. A supervisory team to be set up for each home to supervise the maintenance of hygiene, quality of food & sanitation. Quantity of food and fruits provided to the children should be adjusted as per the age and nutritional requirements of the children.
3. Basic requirement should be fulfilled (like drinking water and water facility in the toilet). More flexibility & understanding needs to be practiced in meeting the daily requirement needs of children for toiletries like soap, oil, sanitary pads etc.
4. Participatory decision making would help in furthering the healthy environment at the homes.
5. Storage facilities for personal things to be made available to also avoid stealing.
6. Children need to be permitted occasional recreational outings to the parks, temples etc keeping the security concerns in mind.
7. Easy interaction with family needs to be encouraged and maintained through regular telephone calls, letters and visits etc.

For mental health/well being

1. Sensitisation programme for staff at all levels in handling of children would reduce the gap noted in the mental health assessment.
2. A full time medical officer be appointed and be given incentive to stay within the campus.
3. Provision of an in-house counsellor and attachment with a mental health team for e.g. in Alipur homes, a liaison with IHBAS outreach services at Jahangirpuri through District Mental Health Programme could be explored which could provide the first level of contact for the children with emotional and behavioural problems.
4. The vocational training programmes could be certified courses in order to help in placement after the children turn 18 years.
5. Reproductive health education should be imparted to adolescent children by trained professionals.

6. Expansion of the mental health unit with more counsellors and a nurse may be considered to meet the unmet demand.

7. Counsellors to have a more proactive role in handling special needs of children who have been recently placed in the home.

For reintegration of the children into the society
1. More efforts to be put in the area of facilitation of restoration through coordination with Child Welfare Committees (CWC) & other Legal and Law Enforcement Agencies.

2. Restoration work and entire process require more attention and it should be expedited.

3. At regular intervals the progress of restoration efforts of children needs to be monitored.

Summary of Findings
1. The living conditions were reported to be comfortable for the children in most homes.

2. Most of the children expressed positive attitude and satisfaction towards the Formal and Non-formal educational facilities in these homes.

3. 10-15% of the children had an identifiable syndrome and were receiving treatment for the same, 35-40% of the children were suffering from some or the other psychological symptom and their mental health needs were unmet.

4. 50% of the children did not have any subjective or objective psychological problem and were involved continuously in constructive and productive work.

5. Manpower related to child care, in some of the homes in comparison to the in house capacity was low.
Continuing Professional Development of Counselors of Children's Homes

QUESTIONNAIRE FOR PARTICIPANTS (Draft)

Name:
Designation:
Email:
Contact No.:

Note: The following questionnaire has been prepared to help us understand the status of mental health services for children in children homes. You may elaborate, wherever it is felt necessary by you and wherever it is mentioned. You may respond in English or Hindi. If required, please use additional sheets to respond.

1. What is the name of the Children's Home where you are working? Please provide the complete address.

2. How long have you been working as a counselor in the said children's home?

3. Is a mental health assessment of a child conducted at the time of admission to the home?

4. Is the Mental health record of each child in your institution recorded and maintained?

5. Rule 46(2) of the JJ Act, 2000 makes both milieu based intervention ie creating an enabling environment for children and individual therapy, mandatory. Is this being followed in your Home? If yes, please elaborate how this is ensured.
6. Is the mental health care plan for every child developed in consultation with mental health experts, associated with the institution? Are recommendations of these experts integrated into the individual care plan?

7. Is individual therapy a part of mental health intervention in the home? If yes, kindly provide details.

8. What components of mental health (for eg. IQ, treatment etc.) are included in the individual care plan of a child?

9. How do you identify if a child is facing any psycho-social/emotional or behavioural problem? Please elaborate.

10. What procedure is followed for the psychological evaluation of a child who is identified as having some psychosocial/emotional or behavioural problem?

11. If a child is identified as having a specific psycho-social, emotional or behavioural problem, what is the procedure followed for:
   i. treatment of the child
Continuing Professional Development of Counselors of Children's Homes

12. How do you ensure that each child's abilities are identified? Please give examples, if necessary.

13. What are the existing support systems available in the home in case there is a need for psychological intervention?

14. Have you attended any training program related to the mental health of children? If yes, please mention below.

15. Please give suggestions for improving the mental health services provided to children in institutional care
   a)
   b)
   c)
   d)
   e)
   f)

16. Have you faced any difficulties in performing your role effectively? If yes, please elaborate stating how you overcame the difficulty.
Workshop for Counsellors of Child Care Institutes (CCI) BY NCPCR and IHBAS

Pre & Post-assessment Questionnaire

Name of the participant ___________________________ Date __________________

Q1. All Behavioural and Psychological problems in children is purely medical
   a) Correct
   b) Incorrect
   c) Don’t Know

Q2. All Behavioural and Psychological problems in children is purely because of disturbed family and faulty parenting
   a) Correct
   b) Incorrect
   c) Don’t Know

Q3. Children with behavioural problems usually reach child care institutions
   d) Correct
   e) Incorrect
   f) Don’t Know

Q4. The emotional and behavioural problems of such children cannot be treated
   a) Correct
   b) Incorrect
   c) Don’t Know

Q5. Most children are aware about whom to contact in the home if they have a psychological problem
   a) Correct
   b) Incorrect
   c) Don’t Know
Q6. Most children are able to deal with relationship problems, inferiority complex and other social/familial problems
   a) Correct
   b) Incorrect
   c) Don’t Know

Q7. Participatory decision making and ‘Negotiation skills’ do not work with children living in CCI’s
   a) Correct
   b) Incorrect
   c) Don’t Know

Q8. If a child does not adhere to rules/regulations or shows behavioral problems, the counselor should
   a) Interrogate the child
   b) Provide emotional support to the child and be understanding
   c) Ignore the problem
   d) Punish the child

Q9. To counsel the child and provide emotional support, one needs to have adequate background information
   a) Correct
   b) Incorrect
   c) Don’t Know

Q10. In the event of threats of self harm/suicide, the counselor should
   a) Ignore it as a minor issue as those who give threats never commit
   b) Seek a referral to a mental health specialist/ higher center
   c) Provide a comfortable environment to the child for support and seek a mental health expert opinion after participatory decision making

Q11. In the event of a suicidal attempt, the counselor should
   a) Ignore it as a minor issue as those who give threats never commit
   b) Refer to a General hospital Psychiatric unit or a psychiatric care facility for admission
   c) Provide a comfortable environment to the child for support and seek a mental health expert opinion after participatory decision making
Q12. Substance use disorders are not a problem in CCI's as the children are under care and protection
   a) Correct
   b) Incorrect
   c) Don’t Know

Q13. The commonest substance of abuse in children and adolescent population is tobacco.
   a) Correct
   b) Incorrect
   c) Don’t Know

Q14. Under chapter IV of Juvenile Justice Act, 2000 rehabilitation and social reintegration of the child begins at the time the child is brought in the home
   a) Correct
   b) Incorrect
   c) Don’t Know

Q15. Rule 46 of the Juvenile Justice Act, 2000 deals with Mental Health Component of After care Organizations
   a) Correct
   b) Incorrect
   c) Don’t Know
Counseling Aptitude Questionnaire (CAQ)
Institute of Human Behaviour & Allied Sciences
Delhi 110095

1. Which is the most desirable quality of an effective counselor?
   a. Kind hearted
   b. Good looking
   c. Sympathetic
   d. Genuineness

2. Ability to view the problems from client’s perspective is known as
   a. Empathy
   b. Unconditional positive regard
   c. Connectedness
   d. Sensitivity

3. Which is a counseling technique?
   a. Inquiry
   b. Interrogation
   c. Confrontation
   d. All of them

4. Counselor must set a limit for the client in counseling
   a. True
   b. False
   c. Sometimes true
   d. None of them

5. Cognitive counseling aims at modification of
   a. Attention
   b. Feelings
   c. Thinking and belief
   d. Impulsive behaviour

6. Which of the following is not required in counseling with children?
   a. Highly disciplined setting
   b. Comparison of the child with other children
   c. Punishment
   d. All of them
7. If ignoring causes a child's temper-tantrums to cease, a psychologist would call this effect

a. Shaping
b. Punishment
c. Time out
d. Extinction

8. When a counselor attempts to see the world through the client's eyes and to feel some part of what he or she is feeling, the counselor is using

a. Authenticity
b. Reflection
c. Empathy
d. Ego-centricity

9. Which of the following promotes mental health?

a. Identity confusion
b. Personal autonomy
c. Lack of self control
d. Type A personality

10. Which of the following can be the psychosocial consequences of child labour?

a. Feeling of stress
b. Emotional problems
c. Lack of appropriate social skills
d. All of them

11. When a counselor highlights emotions of the clients during interaction, the counselor is said to use

a. Paraphrasing
b. Rephrasing
c. Reflection
d. Feedback

12. What an emotionally disturbed child would require most by the counselor?

a. Limit setting
b. Patience listening
c. Encouragement
d. Ignorance

13. When a child client is not ready to speak with the counselor, what a counselor can do continue the process of counseling?

a. Discontinue the session
b. Allow some time to the client
c. Use play techniques
d. Use sign language
14. According to Erikson, a major conflict in the first year of life is that between
   a. Trust versus mistrust
   b. Initiative versus guilt
   c. Autonomy versus shame & doubt
   d. Relatedness versus isolation

15. A common mistake made by many concerned parents is likely to be
   a. Deliberately creating high levels of stress for their child
   b. Unintentionally creating high levels of stress for their child
   c. Attempting to protect their children from all stress
   d. Unintentionally rewarding their children for creating stress

16. Identification with peer groups
   a. Decreases during adolescence
   b. Gives an adolescent a measure of security and a sense of identity
   c. Reduces self-esteem and self-worth
   d. Seems to always lead to incredibly destructive behaviors

17. When counselor tries to bring clarity into what is spoken by the client in session, he uses
   a. Rephrasing
   b. Paraphrasing
   c. Summarization
   d. Summing-up

18. Which of the following is the characteristic of active listening?
   a. Proper eye contact
   b. Leaning forward
   c. Humming and reflecting
   d. All of them

19. When client cries in the counseling session, the counselor must
   a. Ask the client to stop crying
   b. Cry with the client
   c. Let the client cry for some time then clarifies the reason
   d. Crack jokes to make the client laugh

20. According to Kübler-Ross, the most common order of emotional reactions in preparing for
dead is
   a. Anger, depression, bargaining, denial, acceptance
   b. Denial, anger, bargaining, depression, acceptance
   c. Anger, depression, denial, bargaining, acceptance
   d. Depression, anger, denial, bargaining, acceptance
21. One recommended way for parents to handle problems of occasional bed wetting in children is to
   a. Limit the amount of water they drink in the evening
   b. Punish them for "wet" nights
   c. Wake them up during the night to use the toilet
   d. Consider medication or counseling

22. Girls who mature early are more likely to
   a. Engage in earlier sexual relations
   b. Be socially ostracized in middle and high school
   c. Withdraw and become socially isolated
   d. Become tall and thin

23. Who can be the most reliable agent to provide information regarding the child client?
   a. Teacher
   b. Friend
   c. Grand parent
   d. Parent

24. What a counselor should do when a child client is so fearful that he is reluctant to talk
   a. Stop talking to the client and break the session
   b. Get near the child, hold his hand or pat his shoulder and reassure
   c. Be a little firm and ask the child to speak
   d. Ask the child to explain his fear in writing if he does not want to speak

25. When a counselor tries to see the conviction of the client about his experience and interpretation, the best method would be
   a. Exploration
   b. Confrontation
   c. Re-examination
   d. Verification

26. The counselor-client relationship should necessarily involve
   a. Comfort
   b. Clarity
   c. Trust
   d. Compatibility

27. Effective communication in counseling would be
   a. Brief
   b. Simple and indirect
   c. Brief and complex
   d. Simple and direct
28. Which of the following should not be avoided in counseling?
   a. Sermonizing
   b. Blaming
   c. Moralizing
   d. Encouraging

29. While counseling children the counselor should keep the following into consideration
   a. Age of the client
   b. Level of intellectual development
   c. Verbal abilities
   d. All of them

30. A counselor should encourage the parents to talk about the child's problem
   a. In presence of the child
   b. In absence of the child
   c. Either in presence or in absence as per the parents’ convenience
   d. Either in presence or in absence as per the child’s convenience

31. ‘I am sure you are very much troubled by your problem, isn’t it?’ This is an example of
   a. Open end question
   b. Leading question
   c. Close end question
   d. Cross question

32. Which is the incorrect statement regarding handling silence in counseling?
   a. Give time to the client to think about what to say next
   b. Provide space to experience feelings
   c. Persuade to break silence
   d. Allow client to proceed at own pace

33. Which of the following task used by counselor in rapport-building with the client
   a. Assuring confidentiality
   b. Allowing ventilation of feelings
   c. Clarifying expectations and describing method of working
   d. All of them

34. Which of the following is ensured before terminating the counseling process?
   a. Paying capacity of the client
   b. Comfortable stay at home
   c. Ability to manage and cope with daily life
   d. Ability to help others in distress
35. The counselor revealing own thoughts and experiences which might be useful to the client is known as
   a. Self-disclosure
   b. Personalization
   c. Thought sharing
   d. None of these

36. The process of bringing to the surface what is happening between counselor and client in the relationship is called
   a. Insightful
   b. Immediacy
   c. Ventilation
   d. Clarification

37. In SWOT analysis the letter T stands for
   a. Treatment
   b. Tenure
   c. Threat
   d. Termination

38. What that the client needs first in crisis counseling is
   a. Support and understanding
   b. Acquisition of skills
   c. Problem solving
   d. Hospitalization

39. What a counselor should do if the client is bothered by suicidal thoughts
   a. Inform the police
   b. Refer to the mental health specialist
   c. Advise the client to practice distraction
   d. Educate the client that suicide is immoral act

40. A counselor must practice __________________ for professional growth
   a. Self-analysis
   b. Counseling training
   c. Yoga and meditation
   d. Religious rituals

[Uday K. Sinha, Dept. of Clinical Psychology. IHBAS, Delhi]