PSYCHOSOCIAL SUPPORT

TRAINING MANUAL AND ACTIVITY TOOLKIT

ABSTRACT

This Manual and Toolkit is focussed on the support to children for their psychosocial well-being. This is directed towards supporting activities mentioned in LEVEL 3 – Focused Non Specialised Services.

We have separated the basic needs for psychosocial well-being of a child into three areas, all three being dependent and yet distinct in the way they are met.

1. Individual needs: personal development, assertion of the identity, personal recognition;

2. Social needs: groups of belonging, social recognition;

3. Existential needs: religion, beliefs, meaning in life.

This Training Manual and Activity Toolkit is directed mainly towards strengthening the "Individual Needs" and "Social Needs".

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TRAINING MANUAL AND ACTIVITY TOOLKIT – PSYCHOSOCIAL SUPPORT

Forum for Learning and Action with Innovation and Rigour

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A. PURPOSE AND STRUCTURE OF TRAINING MANUAL AND ACTIVITY TOOLKIT

A.1 PURPOSE

This Manual and Toolkit is focussed on the support to children for their psychosocial well-being. This is directed towards supporting activities mentioned in LEVEL 3 – Focused Non Specialised Services.

We have separated the basic needs for psychosocial well-being of a child into three areas, all three being dependent and yet distinct in the way they are met.

1. Individual needs: personal development, assertion of the identity, personal recognition;
2. Social needs: groups of belonging, social recognition;
3. Existential needs: religion, beliefs, meaning in life

This Training Manual and Activity Toolkit is directed mainly towards strengthening the "Individual Needs" and "Social Needs".

The psychosocial well-being of a child develops by stimulating his or her capacity to realise his full potential through the three fundamental needs: individual, social and existential. Both these "invisible" needs as well as material needs for food and shelter must be regularly met. It is important not to forget them, even, and especially, in situations which can sometimes prevent the individual from developing his potential for a long or short period of time (natural disaster, poverty, famine, war, trauma, etc.)

Psychosocial intervention seeks to stimulate the child's development:

The desire **to be** (identity) by meeting individual needs. These are linked to their need for love, recognition, security and protection. Stimulation of this emotional axis (unconditional) helps to build the child's confidence and self-esteem.

The desire **to do** by meeting social needs. These are the needs for limits, rules, requirements, order, authority, etc. Stimulation of this normative axis (conditional) helps to bring out social skills such as cooperating, developing knowledge, managing frustration, understanding the law and learning a job.

The desire **to live** by meeting existential needs. These are linked to the need for recognition of a project in life, understanding the meaning of life, their role in the world. Stimulation of this axis of meaning (belief) helps to develop a feeling of belonging and their responsibility to transmit universal values.

These three dimensions form the essential psychosocial nutrients for the development of a child's well-being. Communities must be built on the basis of these needs. Consolidating them as quickly as possible after an event like the COVID-19 pandemic will facilitate the child's return to normal development. It is a question of giving back to the children their desire to live, to do and to be in spite of the crises they encounter.

Based on the ideas of the humanist A. Maslow, who considers each person as actor of his own life capable of making choices and taking initiative, we believe that a child is capable of developing resources and therefore his own well-being, if he is accompanied by adults who know how to give the appropriate psychosocial support.

Caring for the psychosocial well-being of children is a key investment in human capital. It reinforces all other processes for the development and stability of societies.

Psychosocial support can be both preventive and curative. It is preventive when it decreases the risk of developing mental health problems. It is curative when it helps individuals and communities to overcome and deal with psychosocial problems that may have arisen from the shock and effects of crises. These two aspects of psychosocial support contribute to the building of resilience in the face of new crises or other challenging life circumstances.

A.2 STRUCTURE

This Manual has been designed to serve the following two purposes –

1. Training Manual for the Community Level PSS Worker to acquire Knowledge and Skills to carry our Psycho Social Support Activities and Exercises in the Community.
2. Activity Toolkit – Set of Activities and Exercises that the trained Community Level PSS Workers can use while working with Children in the field.

The Manual starts with an INTRODUCTION, which briefly explains the theoretical bases of Psycho Social Support. It deals with –

- What is Psycho Social Support
- Mental Health and Psycho Social Support
- Why are Psycho Social activities needed
- Why are psychosocial activities needed?
- What is psychosocial well-being?
- Who are psychosocial services provided to?
- Who provides Psycho Social Support?

Pages 5 to 12

The second section of the Manual deals with Ethics and Standards that need to be followed during providing Psycho Social Support. It covers applicable brief from the following -

- Ethics and Principles for Using Mental Health and Psychosocial Support Assessment Tools - Guiding Principles (cf. IASC, 2007)
- Universal Declaration of Human Rights
- Convention on the Rights of the Child (CRC)
- The Sphere Project. 2008. Humanitarian Charter and Minimum Standards in a Disaster Response
- The Sphere standards and the Coronavirus response
- Inter-Agency Standing Committee, 2007. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings
- Principles under the Juvenile Justice (Care and Protection of Children) Act 2015

Pages 13 to 18

- Data Protection Principles

The third section of the Manual contains Modules to train Community Level PSS Workers on Understanding Psychosocial Support. It has sessions and activities with toolkits to build the knowledge and skills of the Community Level PSS Workers to carry out sessions with children. It contains 10 sessions for children in general and three additional sub-sessions for children who need additional support

Pages 19 to 83

The fourth section of the Manual contains Tools and Exercises to be carried out by the Community Level PSS Workers with Children in the Communities. It contains 6 ACTIVITY T**OOLS TO work with children**

Pages 84 to 95

The fifth section of the Manual deals with Psycho Social Support Assessment and Referral Pathways. It explains and details out the process of making a decision on who should receive Focused Non Specialised Psycho Social Support. It has Tools and Exercises for the following –

- Basic Individual Assessment
- Participatory Assessment
- Child Behaviour Checklist

This section also gives a logical Referral Pathways in the form of the flow chart.

Pages 96 to 108

The sixth section of the Manual covers the Record Keeping and Reporting Formats to be used for Psycho Social Support and Follow Up after referrals. It gives the following formats to be used by the practicing Community Level Psychosocial Support provider. –

- First Intervention Report
- Case Work Process Recording
- Group Activity Report
- Follow Up Report
- Monthly Report - Format

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SECTION 1 - INTRODUCTION

1.1 What is Psychosocial Well-Being?

The Constitution of the World Health Organisation defines health as "a state of complete physical, mental and social well-being" and not merely "the absence of disease or infirmity".[1]

1.2 What is Psycho Social Support?

Psychosocial support refers to any type of local or outside support that helps with people's psychosocial well-being and mental health. This Toolkit focusses on community psychosocial support through a Community Level PSS Worker, which is aimed at helping people who are facing difficult situations. Treating mental disorders is something that goes beyond the scope of this Toolkit.

In the field of psychosocial support, the past two decades have seen immense development. The need for community-based psychosocial support in crisis response and development work has become increasingly clear, particularly as we have watched major operations such as the 2001 Gujarat Earthquake, the 2004 Indian Ocean tsunami and subsequent emergency responses. Psychosocial support empowers individuals and their communities to tackle emotional reactions to critical events and also creates community cohesion essential for adaptation, transforming problems into opportunities for sustainable progress and moving forward.

The term "**psychosocial**" is used to describe the interconnection between the individual (i.e. a person's 'psyche') and their environment, interpersonal relationships, community and/or culture (i.e. their social context). Psychosocial support is essential for maintaining good physical and mental health and provides an important coping mechanism for people during difficult times.

Box 1: What is Psychosocial Support?

According to Save the Children, Psychosocial refers to the child's inner world and relationship with his or her environment. Psychosocial support helps maintain a continuum of family and community-based care and support during and after an emergency and prevents immediate or long-term mental health disorders. Psychosocial support involves a range of care and support interventions. It includes care and support offered by caregivers, family members, friends, neighbours, teachers, healthworkers, and community members on a daily basis. It also extends includes care and support offered by specialised psychological and social services. An important shift from an individualized approach has taken place in psychosocial interventions. The focus is now on community-based approaches which enhance the resiliency of children and families.

Save the Children's psychosocial interventions aim to address children's issues and needs in a holistic manner and place psychosocial interventions inside wider developmental contexts such as education or healthcare. This creates an integrated developmental approach to promoting the psychosocial wellbeing of children.

[1] Constitution Of The World Health Organization, https://www.who.int/governance/eb/who_constitution_en.pdf

Psychosocial wellbeing is about the connections between the child, its family, community and society ("social"). It is also about how a child feels and thinks about him or herself and about life ("psycho"). It is often linked to the African concept of "ubuntu" – "I am, because we are, and we are, because I am".[2]

Such wellbeing includes many different aspects of the child's life, such as physical and material aspects, psychological, social, cultural and spiritual aspects. The focus of psychosocial wellbeing is not just on the individual, but on households, families and communities.

1.3 Mental Health and Psychosocial Support

The Inter-Agency Standing Committee describes mental health and psychosocial support as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder".[3]

Although mental health problems and psychosocial support needs require different approaches, they are strongly related. Psychosocial problems that are either very severe or persist over a long period of time without any intervention can lead to the development of mild, moderate or even severe mental health problems. Equally, people with mental health problems also often have psychosocial problems.

The term "**mental health**" is used to denote psychological well-being. Mental health interventions aim to improve psychological well-being by reducing levels of psychological distress, improving daily functioning and ensuring effective coping strategies. Such interventions are overseen by a mental health professional and target individuals, families and/or groups.

Psychosocial interventions constitute the backbone of any Mental Health and Psychosocial Support (MHPSS) response and include a range of social activities designed to foster psychological improvement, such as sharing experiences, fostering social support, awareness-raising and psychoeducation.

Psychosocial interventions have become increasingly recognized as a valued and important dimension of immediate and long-term disaster response. As Community Based Psychosocial Approach adds a mental and social dimension to traditional humanitarian aid, it has assumed considerable significance as a focus for relief efforts along with material support such as food, water and shelter.

The foundation of all community based psychosocial work is the belief in the affected community's capacity for recovery and resilience as all communities and individuals have resources and strategies for dealing with difficulties, illness and distress.

[2] Ubuntu is sometimes also referred to as – "I am because you are" or "Humanity towards others"
[3] IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007

By psychosocial we mean the direct relationship which exists between psychological and social, each influencing the other mutually and continually. In effect, both are constructed through integration on two levels:

1. The psychological components: mind, thoughts, emotions, feelings and behaviour;
2. The social components: social context in which we live, environment, culture, traditions, spirituality, relationships with the immediate and extended family, community, school and professional activities.

1.4 Why are psychosocial activities needed?

Crises typically disrupt a person's life in many different ways. They can lead to the loss of:

- near and significant loved ones
- control over own life and future
- a sense of security
- hope and initiative
- dignity
- social infrastructure and institutions
- access to services
- property
- prospects of a livelihood

Everyone who has experienced or witnessed crises is likely to be affected in one way or another. Reactions may be shock from the actual event; grief reactions to having lost loved ones; feeling a 'loss of place' and feeling distress due to other consequences of the crises. The extent of reactions varies between individuals and whole communities, as does the need for responding interventions.

Psychosocial support activities are planned for whole communities, focusing both on individual and community needs, and on their resources to cope and recover. Such activities can help individuals, families and communities to overcome stress reactions and adopt positive coping mechanisms through community-based activities.

Psychosocial support activities also include identifying and referring individuals requiring specialized support through professional mental health services, besides addressing the psychological and social factors mentioned earlier. Psychosocial support activities are built on the concept of Psychosocial Well-Being.

1.5 Influencing Factors of Psycho-Social Well-Being

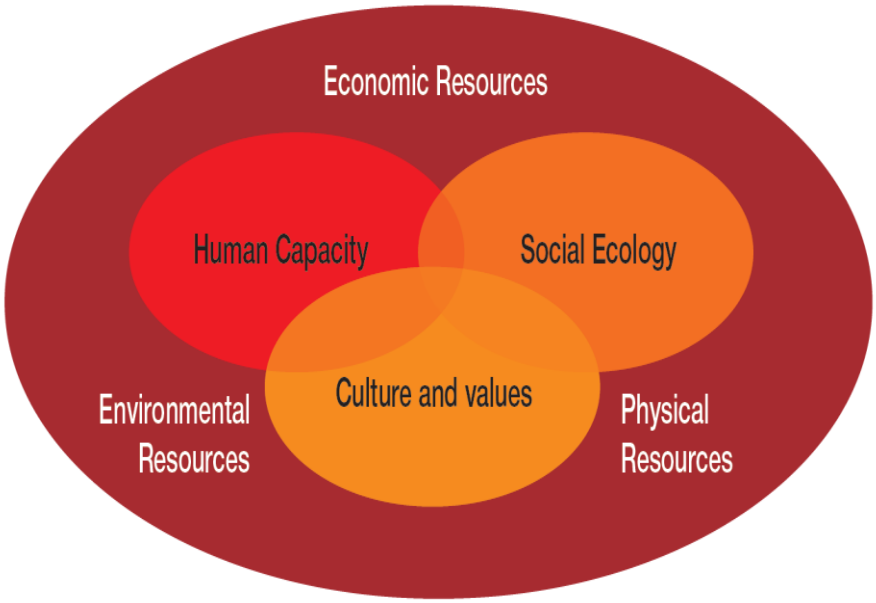
According to the Psychosocial Working Group's Working Paper - 'Psychosocial Intervention in Complex Emergencies: A Conceptual Framework', published in 2003, the psychosocial well-being of individuals and communities is best defined with respect to three core domains (Please see Figure 1):

Human capacity refers to physical and mental health and specifically considers individuals' knowledge, capacity and skills. Identifying an individual's own human capacity is the same as realizing his or her own strengths and values.

Social ecology refers to social connections and support, including relationships, social networks, and support systems of the individual and the community. Mental health and psychosocial well-being are dependent on cohesive relationships that encourage social equilibrium.

Culture and values refers to cultural norms and behaviour that are linked to the value systems in each society, together with individual and social expectations. Both culture and value systems influence the individual and social aspects of functioning, and thereby play an important role in determining psychosocial wellbeing.

Figure 1: Influencing Factors of Psychosocial Well-Being: A Model



Source: The Psychosocial Working Group. (2003) Working Paper. 'Psychosocial Intervention in Complex Emergencies: A Conceptual Framework'

Psychosocial well-being is dependent on the capacity to draw on resources from these three core domains in response to the challenge of experienced events and conditions. The Psychosocial Working Group suggests that challenging circumstances, such as crises, deplete these resources resulting in the need for external interventions and assistance to rebuild individual and communal psychosocial wellbeing.

Psychosocial well-being is experienced both in the personal individual and the social interactive domain, and is also influenced by external factors, such as livelihood, shelter and physical health, as shown in the model below. A child's psychosocial well-being is for example affected by his/her family's access to money as well as what support they can get from the neighbourhood and kinship.

1.6 Who are psychosocial services provided to?

Psychosocial support activities are planned for whole communities, focusing both on individual and community needs, and on their resources to cope and recover. Such activities can help individuals, families and communities to overcome stress reactions and adopt positive coping mechanisms through community-based activities.

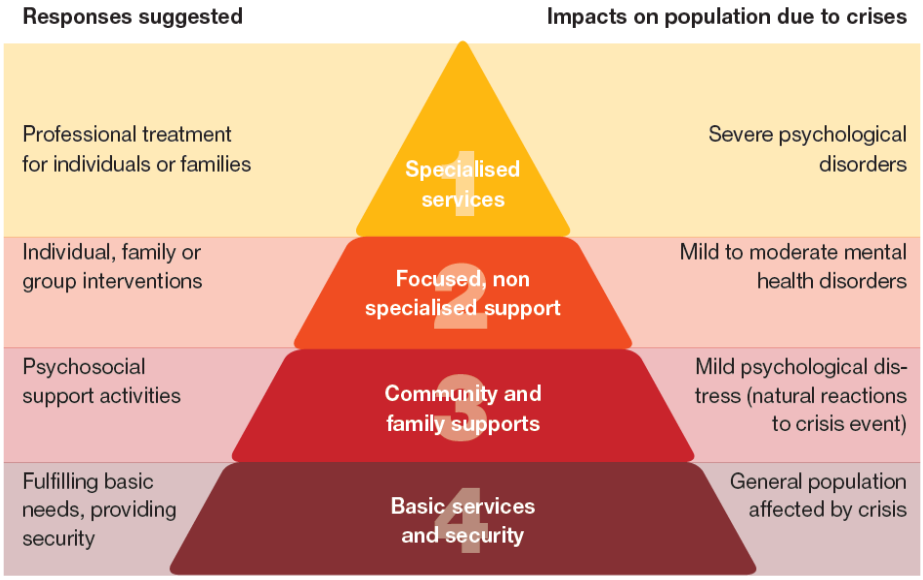
Psychosocial support activities also include identifying and referring individuals requiring specialized support through professional mental health services, besides addressing the psychological and social factors mentioned earlier.

1.7 The affected population

Psychosocial support should be available to all persons affected by a crisis. Different groups such as children, adults, men, women, older people and people with disabilities, have different reactions to crises. Even within these groups, some will have stronger or different reactions than others. For this reason, psychosocial interventions are designed according to the particular needs and resources in a group or subpopulation, and according to the individuals in these groups.

The diagram below illustrates in the form of a pyramid a layered system of complementary supports needed for a population affected by a crisis.

Figure 2: Complementary Supports needed when affected by a crisis (Mental health and psychosocial support services)



Source: This illustration is based on the intervention pyramid for mental health and psychosocial support in emergencies in the IASC Guidelines (2007).

Level 4 - Basic services and security

The well-being of all who are affected by a crisis should be protected by services that address their basic needs and provide protection from harm. Most of these services are provided

through the other areas of response of health and care, water and sanitation, food distribution and nutrition, and shelter. When planning a psychosocial intervention it is very important to be aware of these services, and to advocate for basic physical needs to be met. All interactions with the affected population should in fact be done with consideration of psychosocial well-being. In this stage, planned advocacy and support is required to ensure practical needs of the families and children are met in a safe and socially appropriate manner & protect the dignity of the rights holders/ beneficiaries.

Level 3 - Community and family support

The majority of the affected population will need some form of psychosocial support to restore a sense of normality in their lives, enabling people to get on with daily tasks and demands. Psychosocial support can assist in a multitude of ways, for example helping those affected to mourn the loss of loved ones and to adapt to changed life circumstances. Family and community networks may have broken down and family tracing and reunification may therefore be included as activities in a psychosocial response at this level of intervention. In this stage, it is important to resume existing routine and social practices within the community, activate social networks for mutual support and welfare services, Child Friendly Space etc.

Level 2 - Focused, non-specialized support (This is where Save the Children intervenes mostly - programmatically)

A small percentage of the population will be more severely affected than others by a crisis and may develop mild to moderate mental health disorders. These people will need individual, family or group interventions, typically carried out by trained and supervised staff or volunteers. Without any intervention, recovery from feelings of distress is likely to take much longer and there is a risk of developing severe psychological disorders. Hence, basic emotional & practical support to selected individuals by trained workers such as **PFA/ MHPSS** OR mental health care by medical staff within the community is required. Preliminary care and support at the frontline is also provided by the Community Level PSS Workers.

Level 1 - Specialized services

A smaller percentage of the affected population will need referral and care for severe psychological disorders, which includes professional psychological or psychiatric support. This can be individuals, entire families or whole communities who experience a very strong reaction to the crisis. It also includes individuals who have pre-existing psychological disorders, or pre-dispositions for such developments. The support giver at this level can be individual or may require complex social interventions. Complex Social Interventions include simultaneously intervening on the psychological needs by professionals, managing physical health conditions of the affected persons by specialised physicians, interventions that are there to support in terms of immediate financial needs and long term employment/livelihood support. In this stage, professional and focused mental health care interventions are required by health specialists (such as psychiatrist, Nurse, psychologist etc.)

1.8 Who provides psychosocial services?

Psychosocial support is typically provided to affected populations with the help of trained community members that often come from the same affected population. Ideally such people are identified through an interactive community process and are trusted and respected in the community.

In the context of Save the Children India the roles of providing a comprehensive Psycho-Social Support are played by the people given below:

1. Save the Children staff, partner organizations and other professionals, frontline workers and teachers can give psychological first aid for children as a first and immediate intervention in their work with vulnerable children.
2. Remote or direct face-to-face psychosocial support through:
    - a technological platform;
    - local communication channel
    - taking services of frontline workers
    - using established mechanisms and trusted networks, Partner NGOs, PRIs, frontline workers etc. to share information by phone, online,
    - IEC materials, audio-visuals etc.

A small number of children have problems that are not met through the natural systems of care provided by caregivers, families, and community members. They require additional support that is more directly focused on improving psychosocial well-being and helping them overcome their problems. This additional support is typically provided through psychosocial interventions and programmes that concentrate on specific issues affecting the children.

Examples of this are:

- Individual or group interventions, typically carried out by trained and supervised workers
- Counselling
- Children's Groups
- Memory work
- Support groups and life skills training for adolescents

These programmes are called "non-specialised" because anyone can deliver them; you do not need to be a professional to run these programmes. They are called "focused" because they focus on specific groups of children with special problems.

In places that do not have much, if any, experience of psychosocial responses, it is beneficial and often necessary to bring in external resources, such as independent consultants or experienced colleagues from within Save the Children to help to plan a psychosocial intervention.

SECTION 2 - ETHICS AND STANDARDS IN PSYCHOSOCIAL INTERVENTIONS

2.1 Ethics and Principles for Using Mental Health and Psychosocial Support Assessment Tools, Guiding Principles (cf. IASC, 2007)

Participation of relevant stakeholders (e.g. governments, NGO's, community and religious organizations, local research and university capacities, affected populations) in design, implementation, interpretation of results, and translation of results into recommendations

Inclusiveness of different sections of the affected population, including attention to children, youth, women, men, older people, people with mental health problems, people with disabilities and different cultural, religious, and socio-economic groups.

Relevant data collection with a focus on action rather than purely collecting information. Collecting too much data (i.e. so much data that not all can be analysed) or data that is unlikely to guide or translate into action is a waste of resources. Psychiatric epidemiological surveys - assessing the prevalence, distribution and correlates of mental disorders - can be of academic and advocacy value but are outside the scope of the IASC (2007) MHPSS Guidelines and the current document. It means that only that much data must be collected from the recipients of PSS services that is necessary for providing support and referral services. Extra data collected for the purposes of academic or research interests in the guise of support and service is an unethical practice.

Attention to conflict, including maintaining impartiality, independence, and being considerate of possible tensions and power structures.

Protection of people and groups providing data by taking into consideration protection threats and putting people at risk by asking questions, or inappropriately storing and/or sharing data.

Cultural appropriateness of assessment methodology, terminology and the behaviour and attitudes of assessment team members.

Ethical principles, including respecting privacy, confidentiality, voluntary participation, informed consent, and the best interest of the interviewee. Assessors should take care to avoid raising expectations and make sure that assessments are linked to action and tangible benefits where possible.

Assessment teams trained in ethical principles, possessing basic interviewing skills, supportive when encountering people in distress (e.g. basic principles of psychological first aid), knowledgeable about the local context, and balanced in terms of gender. Some of the team members should be members of (or intimately familiar with) the local context.

Data collection methods should adopt multi-method approaches including review of relevant literature, agency reports and policy documents, qualitative and quantitative data collection methods (e.g. key informant interviews, focus group discussions, surveys), observation, and site visits.

Dynamism and timeliness. The guidelines describe assessment as a dynamic phased process. Assessments can take place in phases, with more detailed assessment taking place in later phases.

Notes of Caution for Interviews

a) **Choose questions selectively.** Do not use all questions from these tools. Assessors should choose those questions that are of relevance to their setting.

b) **Avoid lengthy interviews.** Remember that the most common mistake in assessments is to ask too many questions that are not subsequently analyzed, reported or otherwise used. Do not ask more questions than needed. Interview length should be no more than 1 hour. If interview takes more than 1 hour, then it is advised to make a second appointment at another time for a follow-up interview.

c) **Be careful.** Highly sensitive questions that put people (interviewee, interviewer, or other people) in danger should not be asked. Questions that are not sensitive can be asked during group interviews. Depending on the context, sensitive questions may be asked during individual interviews.

d) **Adapt to your setting.** Questions may be adapted for use in a group or individual setting.

e) **Use probes only when necessary.** Some questions contain probes; these should only be asked if necessary (i.e. when the respondent cannot think of a response after some time). It is *not* necessary to use each probe one-by-one; they are meant as examples to stimulate a more elaborate response.

2.2 Universal Declaration of Human Rights

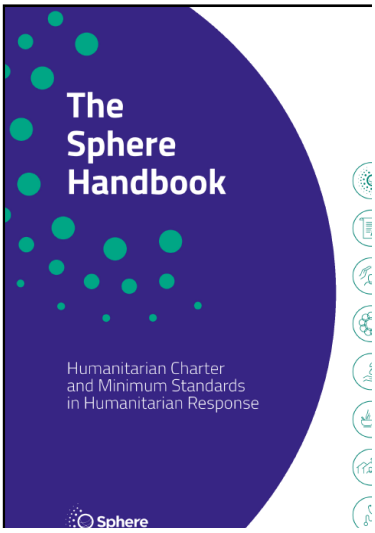
Most humanitarian responses are based on the aim to fulfil the rights in this declaration. Individuals, families and communities are at heightened risk of human rights violations during crises. It is vital that staff and volunteers promote the human rights of all those in their care. For example, access to psychosocial support should be on the basis of equity and non-discrimination.

2.3 Convention on the Rights of the Child (CRC)

The Convention on the Rights of the Child sets out the rights that must be realized for children to develop their full potential, free from hunger and want, neglect and abuse. The CRC applies to all children equally, with special protections for particularly vulnerable groups, such as refugee children. In the course of planning, implementing and evaluating psychosocial

programmes, it is crucial that the standard of 'do no harm' is observed at every stage. For example, Article 3 of the CRC states that 'in all actions concerning children….the best interests of the child shall be a primary consideration.'

2.4 The Sphere Project. 2018. Humanitarian Charter and Minimum Standards in a Disaster Response



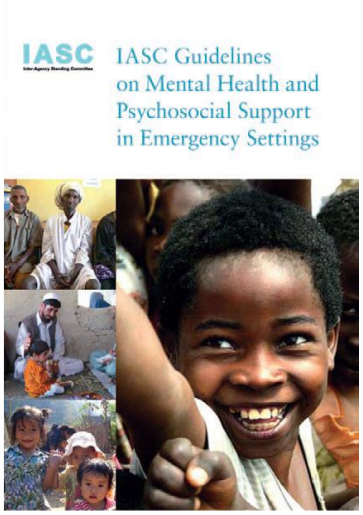
Actions for acute phases following crises are presented in the section on mental and social aspects of health in the chapter on "standards on control of non-communicable diseases". The standard reads:

"People have access to social and mental health services to reduce mental health morbidity, disability and social problems."

Supporting this standard, the Sphere Handbook lists key access points across the community. These access points combine external assistance alongside engaging family, community and cultural resources. In this way, they provide a good example of psychosocial support. For example, the family tracing service, which is an example of external assistance, in the list of social interventions stands alongside cultural and religious events being maintained, which is an example of community and cultural resources.

2.5 Inter-Agency Standing Committee, 2007. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

This comprehensive document provides detailed guidelines for minimum (immediate) responses in emergency settings. A matrix of interventions indicates 11 key areas of work in crisis settings. Areas of work include such functions as coordination, health services, food security and nutrition. For every area of work, the table shows what actions might be taken before, during and after a crisis.



The final section of the guidelines contains action sheets for all actions suggested during a crisis as a minimum response.

The three main topics are common functions (action sheets 1- 4), core mental health and psychosocial support (action sheets 5 - 8), and social considerations in sectoral domains (action sheets 9 -11) Each action sheet includes practical steps that can be taken, provides sample indicators, gives examples, and indicates online resources.

The relevant action sheet from the IASC Guidelines is the Action Sheets 5 to 8. These can be accessed from – https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

2.6 Principles under the Juvenile Justice (Care and Protection of Children) Act 2015

- Principle of presumption of innocence
- Principle of dignity and worth
- Principle of participation
- Principle of best interest
- Principle of family responsibility
- Principle of safety
- Positive measures
- Principle of non-stigmatising semantics
- Principle of non-waiver of rights
- Principle of equality and non-discrimination
- Principle of right to privacy and confidentiality
- Principle of institutionalisation as a measure of last resort
- Principle of repatriation and restoration
- Principle of fresh start
- Principle of diversion
- Principles of natural justice

2.7 Data Protection Principles

While practising Psycho-Social Support, it is necessary to adhere to the Principles of Data Protection, especially in the context of storage and transmission of Data in Digital forms.

Article 5 of the General Data Protection Regulation (GDPR) sets out key principles which lie at the heart of the general data protection regime. These key principles are set out right at the beginning of the GDPR and they both directly and indirectly influence the other rules and obligations found throughout the legislation. Therefore, compliance with these fundamental principles of data protection is the first step for controllers in ensuring that they fulfil their obligations under the GDPR. The following is a brief overview of the Principles of Data Protection found in article 5 GDPR:

Lawfulness, fairness, and transparency: Any processing of personal data should be lawful and fair. It should be transparent to individuals that personal data concerning them are collected, used, consulted, or otherwise processed and to what extent the personal data are or will be processed. The principle of transparency requires that any information and communication relating to the processing of those personal data be easily accessible and easy to understand, and that clear and plain language be used.

Purpose Limitation: Personal data should only be collected for specified, explicit, and legitimate purposes and not further processed in a manner that is incompatible with those

purposes. In particular, the specific purposes for which personal data are processed should be explicit and legitimate and determined at the time of the collection of the personal data. However, further processing for archiving purposes in the public interest, scientific, or historical research purposes or statistical purposes (in accordance with Article 89(1) GDPR) is not considered to be incompatible with the initial purposes.

Data Minimisation: Processing of personal data must be adequate, relevant, and limited to what is necessary in relation to the purposes for which they are processed. Personal data should be processed only if the purpose of the processing could not reasonably be fulfilled by other means. This requires, in particular, ensuring that the period for which the personal data are stored is limited to a strict minimum (see also the principle of 'Storage Limitation' below).

Accuracy: Controllers must ensure that personal data are accurate and, where necessary, kept up to date; taking every reasonable step to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay. In particular, controllers should accurately record information they collect or receive and the source of that information.

Storage Limitation: Personal data should only be kept in a form which permits identification of data subjects for as long as is necessary for the purposes for which the personal data are processed. In order to ensure that the personal data are not kept longer than necessary, time limits should be established by the controller for erasure or for a periodic review.

Integrity and Confidentiality: Personal data should be processed in a manner that ensures appropriate security and confidentiality of the personal data, including protection against unauthorised or unlawful access to or use of personal data and the equipment used for the processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

Accountability: Finally, the controller is responsible for, and must be able to demonstrate, their compliance with all of the above-named Principles of Data Protection. Controllers must take responsibility for their processing of personal data and how they comply with the GDPR, and be able to demonstrate (through appropriate records and measures) their compliance, in particular to the DPC.

In the Indian context, the Personal Data Protection (PDP) Bill proposes that the personal data of a child should be processed such that the rights and the best interests of the child are protected. Further, such processing can be done only after verifying the age of the child and obtaining consent from the parent or guardian. Entities which process the personal data of children, or provide services directed at children will be categorised as 'guardian' data fiduciaries and will be prohibited from profiling, tracking or processing the data such that it may cause significant harm to the child.

SECTION 3 - UNDERSTANDING PSYCHOSOCIAL SUPPORT – MODULES TO TRAIN COMMUNITY LEVEL PSS WORKERS (KNOWLEDGE AND SKILLS)

Session Number: 1
Session Title: Understanding Child's Development

TIME: 40 minutes

Purpose	The participants will be able to – (a) List the difference between childhood and adulthood, (b) Describe and differentiate between development phases of the child.
Learning Points/Key Messages/Key Takeaways	1. Any person who is less than 18 years of age is a child 2. Each child is unique and undergoes through various developmental phases 3. Children acquire difference capacities and degrees of maturity as they grow older
Resources	- Large Poster of Adult and a Child (both the gender) - Flash cards of children (both the gender) at various development stages - Chart Papers - Markers, Tape - Display arrangement for charts **Handouts required for training** Development Stages of children and their characteristics (Physical, social, cognitive, behavioural) – Handout 1

Methodology

Focused Group Discussions

Chart paper preparations – Group Work

Facilitator Notes

- Flash cards of different age groups (0-3 years, 3-6 years, 6-9 years, 9-12 years, 12-15 years, 15-18)
- Both sets of pictures: Boys and Girls
- Remember there is no right or wrong answer specifically when discussing developmental features. Some of the features may overlap across ages and amongst development domains.

1. Initiate the informal discussion with the participants. Show them a picture of an 'adult male and a boy child' and ask them to list differences between the two. List the answers on a chart paper and display it in front of them. After this exercise, do a similar exercise with the picture of an 'adult female' and 'girl child'.

2. Probable answers could be (but not limited to):
3. Adult is taller, whereas child is smaller in height
4. Adult female is wearing full clothes (that have covered her entire body), whereas girl child is wearing frock/skirt
5. Adult person take decisions, whereas children depends on the adults to take decisions
6. Categorize the responses into 'physical', 'emotional', 'cognitive' and ''social' development features differences between adult and children
7. 'Now share the photographs of children of different age groups. Do detailed discussion on the development features of each groups of children (0-3 years, 3-6 years, 6-9 years, 9-12 years, 12-15 years, 15-18 years). Now take different flash cards (Flash Cards 1.1) and divide the groups as per the age groups given in the flash card.
8. The facilitator should encourage the group to first identify various developmental features of a child in a specific age group, followed by discussion on any specific developmental needs for boys and girls. Refer to Handout 1 to cover all characteristics.

Emphasize the key messages:

a. Child development is the process of individual growth and maturation from birth to adulthood.
b. It concerns various changes that happen in children such as physical growth, cognitive development, and emotional growth:
    - Physical changes are about body growth and maturation such as growing taller, gaining weight, hand-eye coordination, fine motor skills (grabbing or holding a pen), muscle development, gross motor skills (crawling and walking) puberty.
    - Cognitive development is about learning language, learning and remembering facts, processing information, solving problems, curiosity, imagination and abstract thinking.
    - Emotional growth is about learning to identify emotions in self and others, learning to express and regulate emotions, building self-confidence, and developing a sense of self.
    - Social development is about learning appropriate verbal and non-verbal communication skills, and the ability to express needs, opinions and motives, learning to develop empathy and helping others

c. Like there is a difference between children and adults, there is also a difference amongst children
d. Each child is unique and develop as per the developmental phases. Children acquire difference capacities and degrees of maturity as they grow older
e. There may be some children who may take more time or less time to develop on various parameters. This is ok and normal unless in specific cases.
f. Children acquire competencies not only with age but through experience, culture and support provided by the environment.
g. According to difference stages as discussed above, the needs of these children may also be specific and also on the basis of gender.

Handout 1: Development Stages of children and their characteristics (Physical, social, cognitive, Emotional)

Stage	Cognitive Development	Physical Development	Emotional Development	Social Development
0-3 years	Watches face intently	Crawls	Emotionally attached to caregiver	Follows/Imitate emotions of caretaker
	Follows moving objects	Walks by holding hands by 1 year	Attachment to the objects	Enjoying playing with others. Usually cries if playing is stopped
	Recognizes familiar things and people at a distance	Walks on his/her own by 1.5-2 years		Communicates with body and expressions; crawls
	Repeats words overheard in conversation	Climbs staircase by 1.5 years		Cries to communicate with others
	Starts recognizing names of the familiar people, objects	By the age of 2, child sits without support	Starts demonstrating independence from primary caregiver	Starts interacting and liking for the company of other children
	Starts saying names of single words		Develops different emotions and starts imitating people nearby	Starts walking with ease
3-6 years (Pre-School)	Starts understanding pre-reading and pre-writing concepts such as shapes, colours	Begin to loose baby fat/chubbiness by age 3	Starts developing affection with some friends	Becomes more independent; may visit next house on his/her own
	Has the ability to grab new words (vocabulary)	The heads of children are still disproportionately large	Starts doing fantasy and imaginative play	Starts developing the concept of “self” and “other”
	Start speaking in full sentence	Skipping, swinging, climbing starts		Likes to sing, dance and act

6-9 years	Can count objects	Good hand-eye coordination	Understands better the difference between fantasy and reality	Starts to know the rules and their importance
	Knows the concept of time and days	Preference for left or right handed becomes clear	Start of the development of nature and personality	Peers starts becoming more important
	Knows various things used in homes	Permanent teeth comes by age 6		
9-12 years	Interested to know new things	Hormonal changes amongst boys and girls brings stark physical changes	Gradually gains emotional control	Starts to understand social and cultural norms
	Begins to use logic in solving various problems	Height increases at faster rate	Dominant personality emerges	Fear of exclusion from the peer group
	Starts to have increased attention span	Weight gain, muscle growth, genital growth		
12-15 years	Starts reasoning	Skin becomes oilier, possibility of acne/pimples	Mood swings due to hormonal changes	Strong identification with heroes, role models
	Abstract and logical thinking	Body proportion changes, sweating increases	Confusion about the bodily changes	Likely to engage in risky behaviour
16-18 years	Deductive thinking	Boys continue to grow height and weight	Increased influence of peers	Needs independence
	Starts to analyse about one's career	Overall, they look physically older than their age	Self Esteem and personality entirely developed	Likely to engage in risky behaviour; think can do anything

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    a. ……
    b. ……

2. Were all the learning points covered? Provide examples
    a. ……
    b. ……

3. Reactions/Reflections of the participants
    a. ……
    b. ……
    c. ……

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. ……
    b. ……

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 2
Session Title: 4Ws of Psychosocial First Aid: What, Why, When & Where

TIME: 1 hour

Training Schedule		
No.	**Duration**	**Sub-session Title**
1.	20 Minutes	What is and is not Psychosocial First Aid (PFA)
2.	30 Minutes	Why is Psychosocial First Aid (PFA) required? And who can give it?
3.	10 Minutes	When and where is it required?

Purpose	The participants will be able to – (a) Explain the need of PFA in humanitarian as well as development interventions, (b) Identify and break any myths around PFA, (c) Recognize and list potential situations which can arise the need for PFA intervention
Learning Points/Key Messages/Key Takeaways	1. PFA is a description of a humane, supportive response to a fellow human being who is suffering and who may need support 2. Psychological first aid helps prevent short- and long-term psychological problems as a consequence of distressing and traumatic incidents. 3. Save the Children staff, partner organizations and other professionals can also give psychological first aid for children as a first and immediate intervention in their work with vulnerable children.
Resources	- Markers, tapes, chart paper - LCD projector - Sound System - Movie clips: Ammu & Aman DVD and Bollywood movie clips as mentioned in sub-section 2 - Alternatively, storyboard of Ammu & Aman, Chhoti Si Asha movie

Sub-Session 2.1: What is and is not Psychosocial First Aid (PFA)

Duration: 20 mins

Methodology

Focused Group Discussions

Movie screening

Movie discussions

Note for Facilitator

- Ensure that participants remain comfortable on talking about the issues (shown in the movie) in the group freely
- Discuss with the participants that sensitivity and confidentiality should be maintained during the discussions

1. Show 'Chhoti Si Asha' (Ammu Aman movie on the issue of child sexual abuse) to the participants.
2. Discuss the **enablers** in Asha's life as shown in the movie which help her to come out of her situation.
3. Discuss the impact on her life if the enablers were not there in Asha's life.
4. Discuss how Ammu and Aman approach and interact with Asha in the movie.
5. Lightly bring into the discussion the principles of PFA: Look, Listen and Link and find out how this takes place in the movie
6. Take the participants through the definition of PFA. **Psychological First Aid, PFA** is a description of a humane, supportive response to a fellow human being who is suffering and who may need support[4].
7. Discuss what is and is not PFA with the help of the table given below

Scope of Intervention during PFA

In Scope	**Out of Scope**
Giving practical care and support that does not intrude	Professional counselling
Assessing needs and concerns	Psychiatric Intervention
Helping people access basic needs (e.g. food and water)	Psychological de-briefing
Comforting people and helping them to feel calm	Asking someone to analyse what happened to them or to put time and events in order
Helping people connect to information, services and social supports	Pressing people to tell you their story
Protecting people from further harm	Asking people details about how they feel or what happened

[4]WHY, War Trauma Foundation and World Vision International, 2011, based on Sphere, 2011 & IASC MHPSS Guidelines, 2007

Sub-Session 2.2: Why is Psychosocial First Aid (PFA) required and who can give it?

Duration: 20 mins

- Start a discussion with participants with the objective of remembering the stories of popular movies such as Agneepath (old or new), Mother India, Deewar, Bajrangi Bhaijan, Kahaani 2, Vaastav, Drishyam to identify one critical event which shaped their life and how it shaped their life. Facilitator can add to this list of movies and even show some clips of relevant movie scenes

- Continue the discussion by identifying whether they received prompt help during or soon after the occurrence of the event. For instance: In Agneepath, the hero witnesses a traumatic event of his father being lynched to death by the fellow villagers. In absence of any support and his mother also being helpless, he resorts to harmful coping mechanisms such as a criminal himself but with an intention to avenge his innocent father's death. Mother India and Deewar can be referred to as examples of chronic trauma and distress which impacts the lives of one of the surviving sons who grows up to become a dacoit and smuggler (respectively).
- Movies such as Bajrangi Bhaijan and Kahaani 2 can be used as examples of how availability or access (even so by chance) to help right after or during a crisis situation can help one in overcoming the adverse outcomes of the crisis.

WHY

First aid assistance is given to any person suffering from sudden illness or injury that requires treatment to prevent the condition from worsening before professional medical help become available.

Similarly, Psychosocial First Aid, whether is development or humanitarian context, is critical as it fosters adaptive functioning and coping in a child. Psychological first aid helps prevent short- and long-term psychological problems as a consequence of distressing and traumatic incidents. Today, a growing body of research underpins adequate support from family, professionals such as teachers and other persons in the immediate environment as the most important factor for children's development and recovery from difficult experiences.

Most children survive distressing events without developing long-term mental health problems and many recover by themselves. However, it is extremely important to note that the recovery can be helped when children receive appropriate support at an early stage, and this can reduce the risk of developing long-term mental health problems dramatically.

WHO

Save the Children staff, partner organizations and other professionals can also give psychological first aid for children as a first and immediate intervention in their work with vulnerable children.

Save the Children's child protection staff and their counterparts working directly with children, such as partner organizations, community mobilisers, teachers, educators, health and social workers, can provide psychological first aid for children. Others who support children in distress, including anyone who arrives shortly after a crisis event, can also give psychological first aid for children.

Note: Facilitator may ask the participants to quickly speak out names of people they may know (around them, in school, slum community) who can be such potential PFA professionals.

Sub-Session 3: When and where is it required?

Duration: 10 mins

- Share the below mentioned information in discussion model with participants

WHEN

Psychological crisis happen to all people throughout life. Some crises are based on natural changes in our lives: when we grow from childhood to adulthood; or when we fall seriously ill. Other crises, traumatic crisis, are external incidents caused by traumatic events that suddenly change the lives of an individual. They are beyond the range of normal everyday experiences, thus causing a feeling of powerlessness and helplessness. Children are in these cases more vulnerable than adults due to their young development stage.

Distressful and traumatic events like natural disasters, armed conflicts, kidnapping, unnatural loss of loved ones, internal displacement, deadly epidemics and displacement are all examples of events causing psychological crisis. A child remains in a psychological crisis as long as he/she is not able to cope with the current situation.

HUMANITARIAN CONTEXT	NON-HUMANITARIAN CONTEXT
Psychological first aid for children can be given during a humanitarian crisis or immediately after a critical event. However, psychological first aid is used not only in connection with major crises such as a tsunami or an earthquake, but also during or after a crisis affecting a small group of individuals.	Psychological first aid in a non-humanitarian crisis can be used for children who have been sexually or physically abused or neglected, children in conflict with the law or after accidents, children in street situations or harmful work.
Training in psychological first aid for children can take place as part of an immediate response or as part of a capacity building activity in disaster preparedness in humanitarian crisis prone areas, as well as when preparing staff on the global humanitarian response list.	Training in psychological first aid for children can take place as part of an on-going or planned development programme.

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    a. ……
    b. ……

2. Were all the learning points covered? Provide examples
    a. ……
    b. ……

3. Reactions/Reflections of the participants
    a. ……
    b. ……
    c. ……

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. ……
    b. ……

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 3
Session Title: Key Concepts and Principles of Psychosocial Support[5]

Time – 2 Hours 30 Minutes

Purpose	The purpose of the session is to introduce the key concepts and principles of psychosocial support
Learning Points/Key Messages/Key Takeaways	Psychosocial support is about helping individuals cope with, and overcome difficult life situations. You do not have to be an expert to be able to provide psychosocial support. There are many ways in which communities and Community Level PSS Workers can promote psychosocial well-being and provide psychosocial support. Good psychosocial support is comprehensive and focuses on protection resilience and coping mechanisms.
Resources	Handout 2: Key Concepts and Principles of Psychosocial Support Training Activity 1: Matching Key Concepts of psychosocial support with their definitions

Methodology

Focused Group Discussions

Group Work

Plenary Exercises

Notes for Facilitator/s

- Ensure that participants remain comfortable on talking about the issues (shown in the movie) in the group freely
- Discuss with the participants that sensitivity and confidentiality should be maintained during the discussions
- This session is best done by two facilitators. Note down the True/False on Chart papers. Prepare FLASH CARDS for Training Activity 1. Write or Print Handout 2 on Chart Paper.

[5] Adapted from – "psychosocial support for education in emergencies - training and resource package for teachers and counsellors", Department of Education, Draft June 2013

1. **Introduce** the key concepts of psychosocial support. (see *handout 1: key concepts and principles of psychosocial support*)

2. **Ask participants** to match the key concepts of psychosocial support with their definitions. (see *training activity 1*: *matching key concepts of psychosocial support with their definitions*)

3. **Ask participants** to answer the following 10 true and false statements that you may read aloud:

   a. Psychosocial well-being is important for learning and development.

   b. Only professionals such as psychosocial counsellors and psychologists can provide psychosocial support.

   c. It is not useful for general people to know of psychosocial support.

   d. Psychosocial support should help individuals to maintain their resilience, encourage ways of coping and promote positive aspects of life.

   e. Good psychosocial support focuses on correction of problems and deficits.

   f. Good psychosocial support recognizes children's needs and abilities.

   g. Psychosocial support is only about counselling.

   h. By making communities and groups more child-friendly Community Level PSS Workers can foster children's psychosocial well-being.

   i. The way a teacher interacts with students will influence their psychosocial well-being.

   j. Children have the right to be protected from harm and violence at Community Centres.

4. **Introduce** the principles of psychosocial support (*handout 1*) going through participants' answers to the true and false statements. The following are the correct answers and their explanations:

Statement No.	True/False	Comment
1	True	Principle: holistic
2	False	Psychosocial support can be provided by anyone with some basic awareness and a sense of empathy
3	False	Psychosocial support is useful for everyone
4	True	principle: enabling

5	False	A focus on problems and deficits may lead to blaming individuals for their situation and expecting them to correct their behaviours instead of providing support
6	True	Principle: child-centred
7	False	Psychosocial support can be many things: for example a teacher who listens to the students or an opportunity to participate in recreational activities
8	True	Principle: child-friendly
9	True	Principle: comprehensive
10	True	Principle: rights-based

5. **Highlight the key messages:**

    a. Psychosocial support is about helping individuals cope with and overcome difficult life situations.

    b. You do not have to be an expert to be able to provide psychosocial support.

    c. There are many ways in which communities and Community Level PSS Workers can promote psychosocial well-being and provide psychosocial support.

    d. Good psychosocial support is comprehensive and focuses on protection, resilience and coping mechanisms.

Training Activity 1: matching key concepts of psychosocial support with their definitions

Cut out the cards and ask trainees to match the key concepts with their definitions

The growth of thoughts, motions, behaviours, memories and social competence shaped by the child's temperament, the socio-economic context, social, cultural and religious values, major life events, interaction with others, and the way the child is being treated by other people.

basic elements children require for a positive social, emotional and intellectual development, such as a secure attachment to caregivers, meaningful peer relations and social competence, sense of belonging, sense of self-worth and value, trust in others and hope about the future

A situation in which children's basic social and emotional needs are sufficiently met. It is crucial for effective learning and a healthy and balanced development.

Things caused by the outside environment and other people that negatively impact a child's psychosocial well-being such as lack of parental support and guidance, harsh teacher attitudes, bullying from peers, stigma, discrimination, exposure to conflict and violence, neglect or abuse.

External issues that support well-being and development: for example protective and child-friendly environments, opportunities for learning, play and recreation, friendships with peers, supportive parents and teachers.

Is about helping individuals cope with and overcome difficult life situations. It does not require mental health specialists and it is not about treating mental illness. Rather it is about practical actions that can be done to enhance well-being, respond to needs, and provide protection, healing and

Behaviours and thoughts that help a person to master, tolerate or minimize stressful or difficult situations, these include for example ways of thinking about oneself, others and different situations.

A person's ability to cope with difficult life situations, adapt to change and have a positive outlook for the future.

Barriers to psychosocial well-being

Coping mechanisms

Psychosocial development

Psychosocial support

Protective factors

Psychosocial needs

Emotional resilience

Psychosocial well-being

Handout 2 - Key Concepts and Principles of Psycho Social Support

In order to understand how Community Level PSS Worker can support children's psychosocial wellbeing it is useful to be familiar with some basic concepts:

Psychosocial development– the development of thoughts, emotions, behaviours, memories and social competence. Psychosocial development is shaped by the child's temperament, the socio-economic context, social, cultural and religious values, major life events, interaction with others, and the way the child is being treated by other people including teachers, parents and peers.

Psychosocial needs – basic elements children need for a positive social, emotional and intellectual development such as a secure attachment with caregivers, meaningful peer relations and social competence, sense of belonging, sense of self-worth and value, trust in others, access to opportunities, intellectual and physical stimulation, physical and psychological security, optimism about the future, responsibility, empathy, adaptability and creativity.

Psychosocial well-being– a situation in which children's basic social and emotional needs are sufficiently met. Psychosocial well-being is crucial for effective learning and a healthy and balanced development.

Barriers to psychosocial well-being– things caused by the outside environment and other people that negatively impact a child's psychosocial well-being such as lack of parental support and guidance, harsh teacher attitudes, bullying from peers, stigma, discrimination, exposure to conflict and violence, neglect or abuse.

Psychosocial support– is about helping individuals cope with and overcome difficult life situations. It does not require mental health specialists and it is not about treating mental illness. Rather psychosocial support is about practical actions that teachers, counsellors and other adults can do to enhance children's well-being, respond to their needs, and provide protection, healing and comfort.

At community centres activities this support should include:

- Child-friendly and protective environments
- Supportive group interaction
- Opportunities for play, creative, recreational and life-skills activities
- Individual assistance such as counselling for students who need some more advanced help

Protective factors – external issues that support psychosocial well-being and development: for example protective and child-friendly school environments, opportunities for learning, play and recreation, friendships with peers, supportive parents and teachers.

Coping mechanism– behaviours and thoughts that help a person to master, tolerate or minimize stressful or difficult situations, these include for example ways of thinking about oneself, others and different situations.

Emotional resilience–a person's ability to cope with difficult life situations, adapt to change and have a positive outlook for the future.

With some basic understanding on the principles of psychosocial support, Community Level PSS Workers can do much to support children's well-being in community and group settings. The following principles are based on best practices that have proved effective in supporting children's psychosocial wellbeing:

Figure 3: Principles of Psychosocial Support[6]

[6] Adapted from - "psychosocial support for education in emergencies - training and resource package for teachers and counsellors", Department of Education, Draft June 2013

My Session Reflection

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1. Broad observation about how the session went by:
    a. ……
    b. ……

2. Were all the learning points covered? Provide examples
    a. ……
    b. ……

3. Reactions/Reflections of the participants
    a. ……
    b. ……
    c. ……

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. ……
    b. ……

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 4
Session Title: How do children react to a crisis situation?

Time – 1 Hour 30 Minutes

Purpose	The purpose of the session is to explore children's reactions to a crisis situation, in order to better understand these reactions and the basic principles of recovery from crisis.
Learning Points/Key Messages/Key Takeaways	1. There is a range of reactions and feelings that children may have as a normal response in a crisis situation. 2. The way children react to a crisis depends on their age, development and personality as well as the way others interact with them. 3. Children cope better if they have a stable, calm adult around them. 4. Not all children will be traumatised. 5. The majority of children will be resilient and recover if their basic psychosocial needs are met through normal developmental activities such as schooling, recreation and play.
Resources	Handout 3: How do children react to a crisis situation? Handout 4: Case Study – Chandan's situation after his father's death

Methodology

Focused Group Discussions

Group Work

Plenary Exercises

Notes for Facilitator/s

- Ensure that participants remain comfortable on talking about the issues (shown in the movie) in the group freely. Discuss with the participants that sensitivity and confidentiality should be maintained during the discussions.
- Write or Print Handouts 3 and 4 on Chart Papers. Make copies of Handouts according to the number of groups that you are making.
- This Session is a preliminary session to be done as a precursor to the more advanced session on the same topic the following day – Session 10, Handout 12.

1. **Introduce** *handout 3: how do children react in a crisis situation?*

This has to be introduced in the plenary by the facilitator. This is a preliminary session to be done a day before the main session on the same topic – session number 12 and handout 16.

2. **Ask participants** to think of the children and share examples of their reactions, behaviours, needs and challenges. Discuss the possible differences between reactions of:

    i. the majority of children / a few specific children boys / girls
    ii. young children / older children and adolescents

3. **Introduce Handout 4 – Case study – Chandan's situation after his father's death**

Divide the participants in 4 group of 4-10 each. Ask each group to study Handout 4. The tasks for the 4 groups are –

Group 1 – Discuss and write down the steps to be taken by Chandan to stabilise his family after his father's death.

Group 2 – Discuss and write down the steps to be taken by Chandan to sort out the financial matters after his father's death.

Group 3 – Discuss and write down the steps to be taken by Chandan to reorganise his father's business and his and his siblings' studies.

Group 4 – Discuss and write down the Psycho-Social Support that may be required by Chandan and his family members.

All the groups then present in the plenary followed by discussion.

Handout 3: How do children react to a crisis situation?

Children are particularly vulnerable in a crisis situation. Crisis events disrupt their familiar world, including the people, places and routines that make them feel secure. Young children are often particularly vulnerable since they cannot meet their basic needs or protect themselves and their caregivers may be too overwhelmed to care for them.

How children react to the hardships of a crisis (for example the Pandemic of Covid-19, witnessing destruction, injury or death, lack of food or water) depends on their age, development stage and their personality. For example some children are naturally prone to be more fearful while other children may become immune to, or ignore the violence and suffering around them. Children and young people may experience similar distress reactions as adults do (e.g. feeling sad, fearful, depressed or anxious, having difficulties sleeping or losing appetite, physical symptoms such as fatigue, aches and pain). Young children may confuse facts with fantasies and fears of danger, and they may not have the ability to keep things in a perspective and to block troubling thoughts.

Children's reactions to a crisis situation:

Young children may return to earlier behaviours (for example bed-wetting or thumb sucking), they may cling to caregivers, confuse facts with fantasies and fears, and reduce their play or use repetitive play related to the distressing event.

School-age children may behave like much younger children, believe they caused the bad things to happen, develop new fears, may be less affectionate, feel alone and be preoccupied with protecting or rescuing people in the crisis, may have nightmares and sleeping difficulties.

Adolescents may feel "nothing", feel different from or isolated from their friends, or they may display risk taking behaviour, negative attitudes and increased aggression.

At the Community Centre, Community Level PSS Workers may notice the following:

- Difficulties with learning and concentration
- Social isolation (keeping quiet in the community centre/group, withdrawn, not participating)
- Increased aggressiveness and challenging behaviour
- Nervousness, sadness and fears
- Lack of confidence, courage and hope for the future
- Physical signs: fatigue, aches and pains, stuttering

While most children exposed to a crisis are likely to show some of these warning signs **not all children will be traumatized**! Children's reactions will vary and their resilience in situations of crisis will depend on a number of factors such as their previous experiences, their personality and the way their caregivers and other adults such as teachers interact with them. **In general, children cope better if they have a stable, calm adult around them**. Further a child's sense of control over his or her environment and opportunities for involvement in tasks such as reading, drawing or helping with chores at home will contribute to resilience and coping.

Community Level PSS Workers can help children recover from distressing events[7]:

- **Most children** (70-80%) will be resilient if their basic psychosocial needs are met through normal developmental activities such as schooling, recreation and play.

[7] "Psychosocial support for education in emergencies - training and resource package for teachers and counsellors", Department of Education, Draft June 2013

- **Some children** (20-25%) may need some additional support such as a person to talk to about their feelings, help with a difficult situation at home or group activities that help to build their coping mechanisms (e.g. expressive arts or life skills activities).

- **Only a few children** (<5%) may require specialized intervention (e.g. psychosocial counselling or mental health services) due to losses, trauma or unresolved grief. Although Community Level PSS Workers cannot provide such specialized interventions these children too will benefit from general group based supports. For details of Age-Wise reactions to grief please refer to Session Number 10, Handout 12.

Handout 4 – Case study – Chandan's situation after his father's death

Chandan is a 15 year old boy and lives in a village with his parents and a younger brother, Spandan and a younger sister, Vandana. Spandan is 11 years old and Vandana is 9 years old. Last year in 2020, his father had planned to start commercial farming at a big scale. He took loan from a scheduled bank for his new venture. But, soon after he started his business, Covid-19 induced pandemic struck, which affected his business adversely. Then soon afterwards the standing crops were severely affected by locusts. Chandan's father was in deep trouble as to supplement the loan from the bank he had also taken loan from the local moneylender. Chandan's mother fell very ill after contracting Covid-19 and the whole family went into a disarray. Chandan's mother recovered from the illness but had become very weak and was unable to do any household work. Everything fell upon Chandan's father and he could not cope up with the extreme stress and committed suicide.

Chandan was young but brave boy. He spoke to the village elders and met all the relevant government and bank officials and sorted out the matter.

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    a. .....
    b. .....

2. Were all the learning points covered? Provide examples
    a. .....
    b. .....

3. Reactions/Reflections of the participants
    a. .....
    b. .....
    c. .....

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. .....
    b. .....

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 5
Session Title: The role of Community Level PSS Worker in promoting psychosocial well-being

Time – 2 Hours 30 Minutes

Purpose	The purpose of the session is to understand the ways in which Community Level PSS Workers, through their daily interaction and activities in the community centre/group, can promote children psychosocial well-being.
Learning Points/Key Messages/Key Takeaways	1. All children have common basic psychosocial needs, that is, things they need for a healthy and balanced development and well-being. 2. There are many ways Community Level PSS Worker can respond to these needs through their group work practices and daily interaction with students. 3. In an emergency situation children may face uncertainty and many of their basic psychosocial needs may be unmet. 4. In an emergency situation it is of particular importance that Community Level PSS Workers find ways to promote the children's psychosocial well-being.
Resources	Handout 5: the role of Community Level PSS Workers in promoting psychosocial well-being Training activity 2: self-assessment checklist for supportive group interaction

Methodology

Focused Group Discussions

Group Work

Plenary Exercises

Notes for Facilitator/s

- Ensure that participants remain comfortable on talking about the issues (discussed in the session) in the group freely. Discuss with the participants that sensitivity and confidentiality should be maintained during the discussions.
- Write or Print Handout 5 and Training activity 2 on Chart Papers. Make copies of Handouts according to the number of groups that you are making.
- This Session prepares the Community Level PSS workers to use Activity Tools in Section 4 of this Manual. Introduce Section 4 of this Manual to the participants.
- This session also introduces the concept of Assessment of the child who are in need of PSS and/or advanced Psychological/Psychiatric Care and Support. Details of Assessment are dealt in Session Number 7 of this Section. Tools of Assessment are given in Section 5 of this Manual.

1. **Highlight that** for a healthy and balanced development and well-being, children need:

   i. to have a secure attachment with caregivers

   ii. to have meaningful peer relations and social competence to form a sense of identity and belonging

   iii. to develop a sense of self-worth and value, self-esteem to have access to opportunities

   iv. to be able to trust others

   v. intellectual and physical stimulation physical and psychological security

   vi. hopefulness / optimism about the future to develop responsibility and empathy to have adaptability and creativity

2. **Introduce** *handout 5: the role of Community Level PSS Worker in promoting psychosocial well-being,* and highlight that there are many ways Community Level PSS Worker can respond to children's basic psychosocial needs through their group practices and daily interaction with children.

3. **Discuss** the strategies given in the handout and ask participants to think about why they are important.

4. **Ask participants** to complete training activity 2: *self-assessment checklist for supportive group interaction,* to identify what they are already doing well in their groups and what they could improve on. Tell participants that you will not look at their answers but the checklist is for self-reflection.

5. **Ask participants** to select a number of items from the self-assessment checklist that they would attempt to improve on in their group practices and interaction.

Handout 5: The role of Community Level PSS Workers in promoting the Psycho Social wellbeing of Children

Children's Psychosocial needs:	How you as a Community Level PSS Worker can support	Suggested Exercises/Interventions for Community Level PSS Worker
Secure attachments with caregivers	▪ Form a caring relationship with the children. ▪ Establish stable and predictable routines in your group settings to make children feel secure. ▪ Discuss with parents the importance of showing love, care, and support to their children.	Meet the children regularly and be aware about them and their needs. Prepare a weekly routine for your Community Centre and

		follow them. Involve children in preparing this routine. Involve parents and caregivers in the discussions at the centres – one to one as well as in group activities.
Meaningful peer relations and social competence	▪ Have clearly established group rules that are discussed frequently with children. ▪ Teach children the boundaries of socially acceptable behaviour and how to interact with adults and each other. ▪ Offer group and team activities that require cooperation and dependence on each other. ▪ Teach ways of conflict resolution and tolerance	Make group rules with children's participation and display them prominently in a chart paper. Follow them. Practice Activities given in Section 4 of this Manual.
Sense of identity and belonging	▪ Make sure all children feel welcome and socially included in the group (being part of the group). ▪ Promote a strong child identity (feeling like a child and recognized as such). ▪ Engage children in dialogue, listening and sharing information. ▪ Promote children's identity and pride in their culture and heritage.	Practice Activities given in Section 4 of this Manual. Discuss local cultural festivals and practices of the children and their families. Discuss about their ancestors and local heroes. Ask children to narrate stories of their bravery and gallantry
Sense of self-worth And value, self-esteem	▪ Recognize, encourage and praise the children. ▪ Create opportunities for self-expression through individual/group discussions, drawing, writing, drama, music, poetry etc. activities that promote pride and self-confidence. ▪ Encourage children to form independent opinions.	Ask children to narrate stories of their bravery and gallantry. Involve the children in making rules and regulation concerning them at the Centre and for Group Activities.

	▪ Allow children to participate in decisions affecting their life (e.g. decisions on group rules).	
Trust in others	▪ Make sure the children know they can rely on you for some help and advice and that they can talk to you confidentially about their worries. ▪ Stand to your words and do not give false promises.	Practice Activities given in Section 4 of this Manual.
Access to opportunities	▪ Value each child's potential, equally regardless of their gender, abilities, disabilities or socio-economic status. ▪ Make sure all children have an equal chance to participate in ▪ Group activities – this does not mean all children have to do the same tasks at the same time or achieve the same results but all have to be supported to participate and benefit from learning	Practice Activities given in Section 4 of this Manual. Involve the children in making rules and regulation concerning them at the Centre and for Group Activities.
Intellectual and physical stimulation	▪ Provide a variety of active and motivating learning experiences - Children learn best by doing and when the given tasks provide them with a challenge that matches their abilities (sometimes you may need to provide different activities to different students based on their abilities). ▪ Engage the children in recreational and creative activities, both traditional and new through games, sports etc. ▪ Provide the children with opportunities for play and playful learning during the day.	Practice Activities given in Section 4 of this Manual. Involve the children in making rules and regulation concerning them at the Centre and for Group Activities.
Physical and Psychological Security	▪ Ensure children at your centre are protected from any forms of verbal and physical violence: - Use ways of positive discipline, do not use corporal punishment or any other kinds of punishments that ridicule or humiliate the student.	Practice Activities given in Section 4 of this Manual. Involve the children in making rules and regulation concerning them at the Centre and for Group Activities.

	- Let all children know you do not tolerate bullying. - Take prompt action if a child is exposed to bullying and violence (from peers or adults). ▪ Teach children how to protect themselves from dangers in their environment.	Ask children to narrate stories of their bravery and gallantry.
Hopefulness/optimism about the future	▪ Allow children to express their hopes and aspirations about the future. ▪ Encourage children to think of the future positively.	Ask the children to narrate stories of their aspirations. Design activities of drawing around aspirations in life. Ask children to tell about their future plan about their careers and dreams. Session 4 and Group Work around Handout 4 is helpful facilitating this.
Responsibility and empathy	▪ Set an example: demonstrate empathy towards the needs, rights and feelings of others. ▪ Discuss stories with a moral message /human rights concepts with the children. ▪ Talk about different feelings and emotions with the children. ▪ Teach children about their human rights and responsibility towards respecting the rights of others.	Practice Activities given in Section 4 of this Manual. Discuss stories of our National Heroes – Mahatma Gandhi, Netaji Subhas Chandra Bose, Sardar Vallab Bhai Patel. Involve children in discussing stories of the local heroes. Involve children in story writing competition on rights and responsibilities.
Adaptability and creativity	• Teach problem solving: allow children to imagine different alternatives and options in a given situation.	Practice Activities given in Section 4 of this Manual.

	▪ Allow children to suggest solutions to different practical challenges (e.g. how to make the environment group and community centre settings more attractive).	Involve the children in making rules and regulation concerning them at the Centre and for Group Activities.

Training Activity 2: Self-assessment questionnaire for stress

This short questionnaire will help you to evaluate your present stress level. Take the time to fill it out every three months in order to compare the scores. Rate each of the following items in terms of how much the symptom was true of you in the last month.

	NEVER (score 1)	ONCE A MONTH (score 2)	OFTEN/ONCE A WEEK (score 3)	ALWAYS (score 4)
1. I feel tense and nervous				
2. I have physical aches and pain				
3. I am always tired, physically and mentally.				
4. I cannot tolerate noises.				
5. My work no longer interests me.				
6. I act impulsively.				
7. I can't get distressing events out of my mind.				
8. I am sad and feel like crying.				
9. I am less efficient than I used to be.				
10. I have trouble planning and thinking clearly.				
11. I have difficulty in sleeping.				
12. Doing even routine things is an effort.				
13. I am cynical or very critical.				
14. I have bad dreams or nightmares.				
15. I am irritable, minor inconveniences or demands annoy me a lot.				
16. I am spending more time at work than initially.				
Total				

Add up your total score:

- Under 20: Your stress is normal, given the working conditions.
- From 21-35: You may be suffering from stress and should take it easy. Try to find ways of coping and reducing your stress.
- Above 36: You may be under severe stress. Ask for help from someone close to you.

If possible talk with your supervisor, a doctor or counsellor.

Reference: Managing Stress in the Field - International Federation of the Red Cross and Red Crescent Societies (Link: www.ifrc.org/Global/Publications/Health/managing-stress-en.pdf)

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    a. .....
    b. .....

2. Were all the learning points covered? Provide examples
    a. .....
    b. .....

3. Reactions/Reflections of the participants
    a. .....
    b. .....
    c. .....

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. .....
    b. .....

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 6
Session Title: How to discuss a crisis with children?

Time – 1 Hour 30 Minutes

Purpose	The purpose of the session is to practice an appropriate way of talking with children about a crisis situation.
Learning Points/Key Messages/Key Takeaways	1. Children want and need as much factual information as possible – give simple answers without scary details. 2. Children may have feelings of guilt – emphasise that they are not solely responsible for the bad things that happened. 3. Do not ask children to disclose their individual experiences in front of the group – this may be very distressing and harmful! 4. Group discussions about the crisis and about children's feelings in third person as a group on general may help children feel less alone with their worries. 5. The first days after return to group/centre a time slot in the mornings may be used for group discussions
Resources	Handout 5: How to discuss a crisis with children

Methodology

Focused Group Discussions

Group Work

Plenary Exercises

Notes for Facilitator/s

- Ensure that participants remain comfortable on talking about the issues (discussed in the session) in the group freely. Discuss with the participants that sensitivity and confidentiality should be maintained during the discussions.
- Write or Print Handout 6 on Chart Papers. Make copies of Handouts according to the number of groups that you are making.
- Prepare and keep ready cut outs and placards for "Doctor" and "Patients".

1. **Introduce** *Handout 6: how to discuss a crisis with children?* Highlight the basic principles of talking to children about a crisis:

    i. Children want and need as much factual information as possible, give simple answers to their questions however without scary details.

    ii. Tell the children it is ok to feel sad, afraid, confused, angry and guilty. These are normal responses to a very abnormal crisis or tragedy.

    iii. Emphasize that they are not responsible for the bad things that happened.

    iv. Initiate group discussions about distressing events that many may – or may not – have experienced. Even those who would not have experienced the events are likely to have heard of them. This will help affected children feel less alone with their worries.

    v. Allow the children to share their own ideas about what happened so that they can begin to master the events.

    vi. Listen carefully to your children thoughts and fears without being judgmental.

    vii. Do not ask children to tell their own individual stories in front of the group- instead you can let students know that you are there for them and ready to listen any time later if they have worries which they would like to share with you confidentially.

    viii. Emphasize to the children that they are safe at the centre / that everything possible is done to make sure the centre is a safe space.

    ix. Emphasize that you care for your children's health and wellbeing.

2. **Arrange a role play** to practice a possible situation that may happen in a group activity at the community centre:

    - **The roles**: one participant will be 'the DOCTOR' and other participants will be 'the CHILDREN PATIENTS'.

    - **The scenario**: many of the CHILDREN have seen on TV or have heard stories about Covid-19 outbreak and overcrowding and emergency at the district hospital of infected patients. Some children may have relatives affected by the event. Other children may have witnessed a similar situation earlier. Children are anxious to discuss the event in group.

    - **The task**: *'the DOCTOR'* will lead a discussion on the event. *'CHILDREN'* may ask questions and raise their comments.

- **Time:** allow participants 10 minutes before the role play to read handout 5: How to discuss a crisis with children, then use 10 minutes for the role play and then 20 minutes for a discussion on how the role play went.

3. **Emphasize the key messages**:

i. Children want and need as much factual information as possible – give simple answers without scary details.
ii. Children may have feelings of guilt – emphasise that they are not responsibility for the bad things that happened.
iii. Do not ask children to disclose their individual experiences in front of the group – this may be very distressing and harmful!
iv. Group discussions about the crisis and about children's feelings may help children feel less alone with their worries. This has to be done in third person with generalised stories. Personal stories in first person are to be avoided.

Handout 6 - How to discuss a crisis with children – For Community Level PSS Workers

Returning to group activities following a crisis, such as a Covid-19 distress and lockdown often creates some nervousness for children and Community Level PSS Workers. In some situations children and Community Level PSS Workers may be displaced and reallocated into a temporary or new centre. For Community Level PSS Workers the task of leading group activities and answering difficult questions from children in such a situation can be understandably overwhelming.

Some children may have serious worries but refrain from talking about them, sometimes out of shame, or because they are not used to talking about themselves with an adult. Many children may share similar fears and experiences without realizing it, because no one is talking about his or her concerns. It is extremely important for children to have a chance to openly discuss common problems. This might mean for instance that the first few days upon entry to Community Centres will be used for these discussions, together with some creative and recreational activities before assuming regular interactions and sessions. The discussion should be taken up through generalised stories narrated in third person.

When talking with children about a crisis remember the following:

1. Children want and need as much factual information as possible, give simple answers to their questions however without scary details
2. Tell the children it is ok to feel sad, afraid, confused, angry and guilty. These are normal responses to a very abnormal crisis or tragedy.
3. Emphasize that they are not responsible for the bad things that happened
4. Initiate group discussions about distressing events (like Covid – 19 related illnesses or deaths in the family) that many may – or may not – have experienced. Even those who would not have experienced the events are likely to have heard of them. This will help affected children feel less alone with their worries.
5. Allow the children to share their own ideas about what happened so that they can begin to master the events
6. Listen carefully to the children's thoughts and fears without being judgmental
7. Do not ask children to tell their own individual stories in front of the group - instead you can let children know that you are there for them and ready to listen any time later if they have worries which they would like to share with you confidentially
8. Emphasize to the children that they are safe at Community Centre / that everything possible is done to make sure the Community Centre is a safe space
9. Emphasize that you care for the children's health and wellbeing

While many children begin to heal by talking about the distressing events, for some children, especially younger ones, it may be more appropriate to use other ways to deal with the events such as through play, drawings or other expressive activities.

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    a. .....
    b. .....

2. Were all the learning points covered? Provide examples
    a. .....
    b. .....

3. Reactions/Reflections of the participants
    a. .....
    b. .....
    c. .....

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. .....
    b. .....

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 7
Session Title: Identifying children who may need more advanced support and assisting them with Referrals

Time – 3 Hour 30 Minutes

Purpose	The purpose of the session is to learn how to identify children who may need advanced support in addition to what Community Level PSS workers can provide in the groups / community centres.
Learning Points/Key Messages/Key Takeaways	1. Most children will be resilient if their basic psychosocial needs are met through normal developmental activities such as schooling, recreation and play. 2. Some children may need some additional support such as a person to talk to about their feelings, help with a difficult situation at home or group activities that help to build coping mechanisms. 3. Only a few children may require specialised intervention due to losses, trauma or unresolved grief. 4. It is important to practice using the Assessment Tool given in Section 5 of this Manual
Resources	Handout 7: Basic understanding on identifying and assisting children who may need more advanced support Handout 8: Section 5 of this Manual - PSYCHOSOCIAL SUPPORT ASSESSMENT AND REFERRAL PATHWAYS

Methodology

Focused Group Discussions

Group Work

Plenary Exercises

Notes for Facilitator/s

- Ensure that participants remain comfortable on talking about the issues (discussed in the session) in the group freely. Discuss with the participants that sensitivity and confidentiality should be maintained during the discussions.
- Write or Print Handout 7 on Chart Papers. Make copies of Handouts according to the number of groups that you are making.
- Prepare and keep ready print out of PSS Assessment Tools and Referral Pathways as detailed out in Section 5 of this Manual.
- Ideally this Session will require 3 Facilitators. One of the facilitators must be an expert in Psychological Assessment.

1. **Introduce** *Handout 7: identifying and assisting children who may need more advanced support*, and highlight the key messages:

   Most children will be resilient if their basic psychosocial needs are met through normal developmental activities such as schooling, recreation and play.

   Some children may need some additional support such as a person to talk to about their feelings, help with a difficult situation at home or group activities that help to build coping mechanisms.

   Only a few children may require specialised intervention due to losses, trauma or unresolved grief.

2. **Highlight that** all children benefit from the support Community Level PSS workers can provide in the group/community centre. However some children may, in addition, need more advanced support. This includes:

   i. children who continue to show signs of distress for a lengthy time / when others in the class already begin to heal (note that distress signs during the first month upon return to Community Centre following a crisis are a part of the normal healing process)

   ii. children whose signs of distress are much more severe /whose behaviour differs significantly from others in the group: e.g. completely refusing to talk or not able to interact with others at all due to fears, despite being in a safe and protective environment

   iii. children who have been directly exposed or forced to witness acts of violence including rape, torture and killing

   iv. children whose parents or caregivers are too sick or distressed to be able to care for them

3. **Ask participants to** share their experiences and observations of children in their group who may have shown such signs. Ask participants how they dealt with the situation.

4. **Ask participants to** identify available sources of additional and more extensive supports (Save the Children staff and other individual people, organizations and services).

5. Introduce Handout 8: Section 5 of this Manual - PSYCHOSOCIAL SUPPORT ASSESSMENT AND REFERRAL PATHWAYS

6. Divide the Participants into 3 Groups. Give the 3 Groups following tasks after thorough explanation of the Assessment Tools in Section 5.

   STEP 1:

   Group 1 – From amongst the group members any 5 will become dummy children. These dummy children to be given brief by the facilitators. The rest of the group members to carry out assessments on CBCL and Participatory Assessment.

   Group 2 – All the group members to carry out assessments on CBCL and Participatory Assessment of the 5 dummy children.

   Group 3 - All the group members to carry out assessments on CBCL and Participatory Assessment of the 5 dummy children.

   STEP 2:

   All Groups to do the scoring and detailing separately.

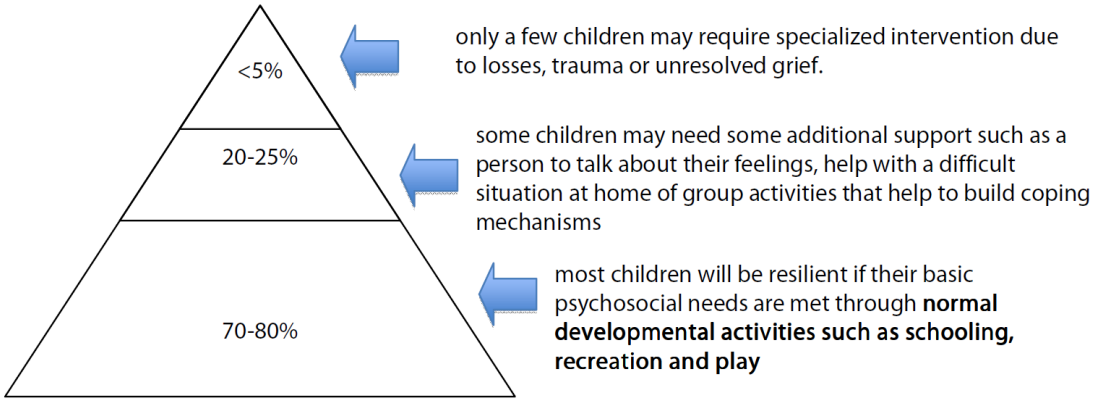
   STEP 3:

   All the Groups to make recommendations for care plan and/or Referral

   STEP 4:

   All the Groups to make presentations in the Plenary

Handout 7 - Identifying and assisting children who may need more extensive support[8]



While all children will benefit from the support Community Centres and Community Level PSS Workers can provide, some children may, in addition, need some more extensive support. This support can be for example designated group activities that help deal with emotions and build coping mechanisms, home visits from a social worker and psychosocial counselling or therapy.

Identification could also happen with extended support from CPCs, peer/ children groups, local service providers, Childline, local NGOs, CBOs, local Clubs, any individuals, parents, children themselves, CWC, etc. Hence, it is very important for Community Level PSS workers to establish a working relationship with these stakeholders on frequent basis.

Children who are likely to need more advanced support include (Assessment to ascertain the children showing signs of distress are to be done as per Tools and Exercises mentioned in Section 5 of this Manual):

1. children who continue to show signs of distress for a lengthy time / when others in the group already begin to heal (note that distress signs during the first month upon return to Community Centre following a crisis are a part of the normal healing process)

2. children whose signs of distress are much more severe /whose behaviour differs significantly from others in the group: e.g. completely refusing to talk or not able to interact with others at all due to fears despite being in a safe and protective environment

3. children who have been directly exposed or forced to witness acts of violence including rape, torture and killing

4. children whose parents or caregivers are too sick or distressed to be able to care for them

[8] "Psychosocial support for education in emergencies - training and resource package for teachers and counsellors", Department of Education, Draft June 2013

Make sure you have the contact details of a counsellor, social worker or any other instance to which the child may be referred to for further support. While the more advanced support may not always be available immediately give the child your additional attention and ensure the child can feel safe and protected in the group.

Handout 8: Section 5 of this Manual - PSYCHOSOCIAL SUPPORT ASSESSMENT AND REFERRAL PATHWAYS

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    a. .....
    b. .....

2. Were all the learning points covered? Provide examples
    a. .....
    b. .....

3. Reactions/Reflections of the participants
    a. .....
    b. .....
    c. .....

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. .....
    b. .....

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 8
Session Title: Psychosocial Interventions - Coping and Resilience

Time – 1 Hour 30 Minutes

Purpose	By the end of this session, participants should be able to – (a) Define coping and resilience, (b) Explain factors affecting coping and resilience, (c) Examine the link between coping and resilience
Learning Points/Key Messages/Key Takeaways	Coping refers to dealing with a new situation, for instance, a behaviour that people develop to deal with a new and challenging experience. Coping can be both negative and positive. Negative coping involves people promoting an unpleasant experience or creating new problems, while positive coping involves adjusting positively to the situation or trying to eliminate it. Resilience refers to the process of adapting well while experiencing difficult circumstances. It can be described as "bouncing back" from difficult experiences. Research has shown that resilience is normal or ordinary and not extraordinary. All people can demonstrate resilience. **Distinction between resilience and coping** Coping and resilience are often used to mean the same thing. Though they are similar, the two need to be treated distinctly. As explained above, coping refers to the different strategies that a person will try in order to deal with the difficult experience. These can be positive or negative. Resilience is the ability to recover and return to normal functioning after a difficult experience.
Resources	Handout 9: Case Study – Neha's Story

Methodology

Focused Group Discussions

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Sub – Session 8.1
Discussing Coping and Resilience

Notes for Facilitator

- Ask participants to brainstorm on the concepts of coping and resilience.
- Write down or Print Handout 9: Case Study – Neha's Story. Make copies as per group needs. Present the case study ("Neha's Story") and discuss the questions and answers.
- Ask participants to share similar stories from their community.
- Summarise discussions and make key conclusions.

Possible answers for Neha's Story Questions:

- Her close relationship with her mother; her relationship with friends, relatives, neighbours and community.
- She talked about her problem; she joined a VLCPC; she built new relationships; she got involved with her new family; she maintained her focus.
- Ensuring that her schooling continued; having a family adopt her; taking part in a child/youth centre; having someone to talk to.
- Neha's story presents a good example of a child who copes with the challenges she faces and develops resilience. We will now look more closely at what we mean by coping and resilience.

Handout 9

Case study: Neha's Story

Neha comes from a family of four children, three girls and one boy. Her parents, Mr. and Mrs. Pawar died of Covid-19 when she was thirteen years old. As the youngest child, Neha used to spend a lot of time with her mother, who taught her much about life. Her mother always spoke about how she believed in her heart that Neha would grow up to be a successful. She also always encouraged her to have a relationship with her peers, relatives, neighbourhood and community who would always be there for her. Neha treasured her relationship with her mother dearly and told herself that she would live to be very successful as per her mother's wishes.

When Mr. and Mrs. Pawar died, they left behind three houses, two of which had always been rented out. However, soon after their death, relatives came and took two of the houses away from them. Neha and her siblings were left with one very small house to live in and no money for food and other basic necessities. Life for Neha, who was the youngest of the four children, was very tough. Her eldest sister, who was in her early twenties, soon got married and left home. The relatives decided that Neha and her brother should go and stay with an uncle in another town. The uncle was sometimes rude and used abusive words for Neha and her brother. Neha explained her situation to one of the elders, who encouraged her to the VLCPCS (Village Level Child Protection Committee). This provided her with the opportunity to share her problems with others child and learnt that many children are experiencing similar difficulties in life. Through the VLCPC, she befriended a girl, Kavita, who told Neha's story to her parents. Kavita's parents, who were both moved and worried with Neha's situation, decided to talk to Neha's uncle and help the family. Their offer came at a very good time because Neha's uncle now go reformed. Now Neha and her brother also got the opportunity to attend school.

Neha now takes part in all aspects of their family life and aims to study social science at university so that she can become a social worker and reach out to children and families facing difficulties in life.

Questions

1. What made Neha respond in a different way from her siblings following the death of their parents?
2. What actions did Neha take that demonstrated her resilient qualities?
3. What role did the community play in encouraging or enhancing Neha's resilience?
4. Do you have similar stories from your families and communities about children like Neha who show the ability to stand, survive, and fight on despite difficulties?

Sub Session 8.2
Understanding Coping among Vulnerable Children

Facilitator tips

- Ask participants to discuss the following question: What are the positive and negative things that Vulnerable Children (VC) do to deal with their difficult experiences?
- Summarise the responses and supplement missing answers from the notes below.

Start the Session with the following talk (indicative) –

Factors affecting coping

Two people who have experienced the same traumatic event may not necessarily cope in a similar way. One may cope positively while the other copes negatively. One may take a shorter period to recover while the other takes longer. People have different coping styles because each individual is unique, with a different personality, experiences, and resources, all of which influence their coping abilities. Therefore, caregivers need to understand the factors that influence coping so that they are able to help children rebuild their lives. These factors include an individual's level of self-esteem, as well as the availability of community protective factors, such as social services and supporting institutions. Most of the factors that influence resilience are the same as those that influence coping.

Other factors that influence coping include:
• Availability of resources like land, property, income, and community support structures.
• Meaning of the experience to the victim (For instance, how the individual perceives an event will affect both the level of stress she experiences and her coping effectiveness. An individual who believes she was at fault at the time of the event may suffer severe guilt feelings and depression.)
• Past experiences in dealing with problems
• Magnitude and context in which the experience occurred. For example a worldwide Pandemic like Covid–19 Vs. a more local event like a flash flood Vs. an even more local event like a family's loss of partial income
• State of the person's health (For instance, he may have pre-existing stress.)
• Ethnic and cultural differences, which may endanger individuals as well as interfere with their ability to obtain or use services and supplies during a traumatic event. Like a family belonging to a Scheduled Caste may face discrimination in obtaining support and supplies from the Government programmes and schemes. Or a family belonging to Minority Community may face discrimination in obtaining their entitlements, which may hamper their coping up and recovery after a disaster.

1. Divide the participants in groups of 10 – 20 each (depending on the total number of participants). Try making a maximum of 6 groups.
2. Give the groups the following tasks –

- From your past experience of working with vulnerable children, discuss in the group a situation where a child has lost one of the parents due to Covid-19. What are the different ways (Positive and Negative) the Child may respond. List the positive and negative ways of responding in a Tabular form on Chart Papers.
- From your past experience of working with vulnerable children, discuss in the group a situation where a child has lost both of the parents due to Covid-19. What are the different ways (Positive and Negative) the Child may respond. List the positive and negative ways of responding in a Tabular form on Chart Papers.
- From your past experience of working with vulnerable children, discuss in the group a situation where a child's family has lost all sources of income and livelihood due to Covid-19 and has been discontinued from education. What are the different ways (Positive and Negative) the Child may respond. List the positive and negative ways of responding in a Tabular form on Chart Papers.

3. All the Groups to present in the Plenary and in the plenary discuss about the Social factors of promoting Coping in Children.

Possible ways of responding to a difficult situation (Positive and Negative)

Positive	**Negative**
Talking to other children	Blaming people
Participating in community activities	Exhibiting denial
Seeking advice from adults	Doing nothing about the problem
Keeping busy	Isolating themselves
Playing games and interacting with children	Abusing substances
Getting involved in recreation activities	Demonstrating suicidal behaviour
Seeking counselling	Running away to live on the street
Following normal daily routine	

Sub – Session 8.3
Understanding Resilience among Vulnerable Children

1. **Rubber band exercise:**

   Take a rubber band and stretch it as far as possible, then bring it back to its original size.

   Repeat the exercise several times and then relate it to a person's experience by asking:

   − What happens when we stretch the rubber band?

   − What happens when we let go?

   − What happens when we stretch it too far?

   − How does this relate to resilience?

Possible answers as discussion points with the participants (Hints for the facilitator/s)

The rubber band changes shape when it is stretched. It adapts to being pulled. When I let go, it snaps back but it may not look exactly the same as before. (It can be longer or have a slightly changed colour.) When I pull it too much, it can break. This is similar to resilience in that people can recover from stress and difficulties (being "stretched") and "bounce back" to their original shape. However, this does not mean that they are just like they were before the experiences. The difficulties can leave their mark on their emotions, behaviour, and abilities. And just like the rubber, if people are "stretched" too far, they may not be able to cope. No one is infinitely resilient. This means that they need support to become more resilient.

2. **Additional notes (Discuss with the Participants in the Plenary)**

When we use the term resilience in psychology:

- Resilience means the ability to recover quickly from severe events, especially if there is a supportive environment.
- This does not mean that after being "stretched" by an adverse event, there are no effects. Individuals experience all the reactions to stress that we spoke about, but they are able to quickly adapt and solve the problem or adapt to the new situation.
- Just as the elastic band snaps when it is stretched too far, it is important to remember that nobody is infinitely resilient. Without proper support and with prolonged exposure to adverse situations, even the most resilient person can "snap".
- Good news about resilience: Almost anybody can build and cultivate it. (Katey Hurley, Medically reviewed by Allison Young); What Is Resilience? Your Guide to Facing Life's Challenges, Adversities, and Crises)

Facilitator notes

Resilience involves behaviour, thoughts, and actions that can be learnt and developed in anyone. A combination of factors contributes to resilience. According to Dr. Amit Sood,

known as the "**Happiness Doctor**", who is the Founder and Executive Director of the Global Center for Resiliency and Wellbeing (formerly, he was a professor of medicine at Mayo Clinic College of Medicine, Rochester, Minnesota, and chair of the Mayo Mind Body Initiative), the primary factor in resilience is having caring and supportive relationships within and outside the family. Relationships that create love and trust, provide role models, and offer encouragement and reassurance help strengthen a person's resilience. Factors that influence resilience can be categorised as either external or internal.

External	**Internal**
Support of caregivers	Intellectual maturity
Quality of family life	Self-esteem
Positive role models in the community	Coping style
Degree of community social support	Capacity to manage strong feeling
	Sense of purpose and optimism

Source: Author's collation from various sources. Please refer to the references in the endnote for the sources from where the collation has been done.

Being resilient does not mean that a person does not experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major painful experiences in their lives. The road to resilience often involves considerable emotional distress.

3. Group tasks and exercises – Discussion on Social Support that promotes resilience among Children

i. Divide the participants in groups of 10 – 20 each (depending on the total number of participants). Try making a maximum of 6 groups.

ii. Give the groups the following tasks –

- From your past experience of working with vulnerable children, discuss in the group a situation where a child has lost one of the parents due to Covid-19. What are the different ways the family, community and government may support the Child. List the means of support by (a) Family, (b) Community, and (c) Government in a Tabular form on Chart Papers.
- From your past experience of working with vulnerable children, discuss in the group a situation where a child has lost both the parents due to Covid-19. What are the different ways the family, community and government may support the Child. List the means of support by (a) Family, (b) Community, and (c) Government in a Tabular form on Chart Papers.
- From your past experience of working with vulnerable children, discuss in the group a situation where a child's family has lost all sources of income and livelihood due to Covid-19 and has been discontinued from education. What are the different ways the family, community and government may support the Child. List the means of support by (a) Family, (b) Community, and (c) Government in a Tabular form on Chart Papers.

iii. All the Groups to present in the Plenary and in the plenary discuss about the Social factors of promoting resilience among Children.

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    c. ……
    d. ……

2. Were all the learning points covered? Provide examples
    a. ……
    b. ……

3. Reactions/Reflections of the participants
    a. ……
    b. ……
    c. ……

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. ……
    b. ……

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 9
Session Title: Communicating with Children

Time – 1 Hour 30 Minutes

Purpose	By the end of this session, participants should be able to – (a) List the principles of communicating with children, (b) Demonstrate skills of communicating with children, (c) Identify potential barriers and the consequences of such barriers in communicating with children, (d) Utilise relevant skills and techniques to overcome communication barriers.
Learning Points/Key Messages/Key Takeaways	Our words, actions, facial expressions, and body language (verbal and non-verbal communication) convey many messages to children. The following principles are important when communicating with children: • Trust: Trust is important. The child needs to be able to trust those who are caring for them. Similarly, the parent/guardian/caregiver needs to be able to trust the child. • Honesty: Never lie to a child! Lying can destroy a child's trust in those who are caring for him, causing him to fear future care and increasing his anxiety! • Respect: Respect children for who they are with a non-judgmental attitude. Do not ignore the child's viewpoint and feelings. • Attitude: Speak with the child, not to the child. • Unconditional care: Treat children equally regardless of gender, background, or socio-economic status. Treat each child as an individual. • Confidentiality: Avoid disclosing private information about children and their caregivers. • Patience: Communicating well with children takes time. Develop patience and make the time you have with the child count. • Our own feelings: Be careful of your own feelings: Children are very perceptive to the attitudes of those around them. They pick up on the distress and anxiety of those around them. • Freedom to express: Allow children to express their worries and anxieties through play, drawing, songs, or other activities. • Information needs: These are often neglected, sometimes on the pretext that understanding is limited. • Active Listening: It has 9 Elements - 1. Attentive focus 2. Paraphrasing 3. Encouragement 4. Questioning and clarifying 5. Summarizing 6. Normalization 7. Generalization

	8. Triangulation 9. Stabilization
Resources	**Handout 10 – Group Tasks (Case Scenarios)** **Handout 11 - Practical ways of communicating with children – Drawings (Exercises)**

Methodology

Focused Group Discussions

Group Work

Plenary Exercises

Notes for Facilitator/s

- Ensure that participants remain comfortable on talking about the issues (discussed in the session) in the group freely. Discuss with the participants that sensitivity and confidentiality should be maintained during the discussions.
- Write or Print Handout 10 on Chart Papers. Make copies of Handouts according to the number of groups that you are making.
- Ideally this Session will require 2 Facilitators. One of the facilitators must be a male and the other a female.

This session is designed to make the participants understand that to communicate with children, you must be able to speak and understand their language. Children speak 3 languages:

1. The Body language: One has to be very observant to see and interpret this.
2. The language of play: Children love this language and use it most. It includes games, drawing, and singing.
3. Spoken language: This is usually the least used and the least expressive language (depending on the age).

In order to effectively communicate with children, we need to know the language that children speak and also note that children are different from adults.

1. Ask participants to think of a favourite song and game from their childhood.
2. Divide participants into 5 groups and ask them to prepare one favourite game and song from childhood for presentation in plenary.
3. After the plenary, ask participants to share the importance of games and songs when communicating with children.
4. Ask participants to discuss the principles of communicating with children. Then ask them to:
    a. Discuss the barriers they have experienced in communicating with children

b. Identify an event that happened in their lives that illustrates one of these communication barriers
c. Form 5 Group and give them tasks as per Handout 10 and ask them to share in the plenary.

5. **The Communication during Initial Contact with Distressed Children should also have "Gender Awareness".[9]**
   a. Consider Gender issues when communicating with children and their families.
   b. Try to have a colleague of the other gender nearby or as your co-facilitator, in case his or her support is needed or is more appropriate.

6. After the presentations in the plenary, send the participants back in their respective groups and give the task to discuss and fill the details in a tabular form (with examples from the previous group exercise) –

Skills and techniques of communicating with children	**Barriers to effective communication with children**	**Consequences of communication barriers**

7. From the following list, supplement the information provided by the participants (this list is only indicative)

Skills and techniques of communicating with children

• Stop what you are doing, and pay attention to what the child is saying and doing.

• Use simple language: Think about the words you use. Long sentences will confuse children.

• Use a child's experience to explain things.

• Be friendly and approachable. Do not look bored, angry, or worried while a child is talking because this will stop him/her from talking.

• Actively listen and respond to the child. Try to answer his/her questions as honestly as possible.

• Provide adequate time and space.

• Provide an appropriate and conducive environment.

• Use a moderate dress code.

• Observe confidentiality.

• Be empathetic.

• Be polite and helpful.

[9] Practising PFA Action Principles, Save the Children

- Maintain eye contact.
- Use minimal encouragers.
- Use silence.
- Comment on the process.
- Ask open-ended questions and answering questions.
- Summarise and clarify.
- Repeat things frequently.
- Seek to understand what the child understands about any given information or situation.
- Seek to understand what the child means.
- Be sensitive to cultural norms.
- Sit at the same level as children.
- Do not rush children. Be patient, go at their pace, and allow them to express their emotions.

Barriers to effective communication with children:

- Language used
- Use of adult methods
- The size and height of an adult compared to a child
- Children identifying more with peers
- Attempting to handle everything yourself
- Getting emotionally involved
- Not listening effectively
- Blaming and judging the child or barking at the child
- Disability-related barriers (e.g., the child is dumb and deaf)
- Adult may symbolise another abusive adult that the child knows
- Use of formal roles, titles, and social standing

Consequences of communication barriers

- Miscommunication: The child cannot convey what he/she thinks and feels, and the adult cannot make the child understand what he/she is trying to say.
- Mistrust: The child feels that he/she cannot trust the adult.
- Anger and frustration: Both the child and the adult may feel these emotions.
- Isolation and withdrawal: The child feels that no one understands him/her and begins to withdraw from engaging socially with others.
- Blame: The child and the adult can blame one another for failed communication and behaviour that is not understood.

Handout 10 – Group Tasks (Case Scenarios)

Group participants into five and allocate a case study to each group. Then ask the group to discuss for 10 minutes and then report their responses in plenary.

- Group 1: You are taking care of a 3-year-old child. He/she is misbehaving and having an outburst. How do you communicate with the child to change his/her behaviour?
- Group 2: Your 9-year-old nephew has been telling you a lot of lies about many things, and you are beginning to feel that you cannot believe anything he says. How can you address this with him?
- Group 3: You are passing the school, and you notice that children are teasing another child and calling him/her names. You know the child's father had died of Covid-19 and mother does household work in other people's house after that, and you perceive that this may be the reason for the teasing. How would you deal with this situation?
- Group 4: Three children, ages 3, 5, and 7, are playing a hide and seek game. The 3-year-old asks you, "Aunt, can you play with us?" You get very tired after a little physical work after recovering from Covid-19. What do you do?
- Group 5: A 12-year-old child who used to tell you a lot of things has lately been very quiet and gives one-word answers to your questions. He seems to have become withdrawn in relation to adults, but you see him talking with his friends. Recently his father had lost job due to the Covid-19 pandemic, and his mother also remains mostly ill after recovering from Covid-19. What – if anything – do you do?

Communication with children is the use of age-appropriate language to facilitate both the passage of information to the child and the expression of their feelings. Communication is a two-way process and can be learnt.

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    a. ……
    b. ……

2. Were all the learning points covered? Provide examples
    a. ……
    b. ……

3. Reactions/Reflections of the participants
    a. ……
    b. ……
    c. ……

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. ……
    b. ……

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

Session Number: 10
Session Title: Problems associated with Adversity (Covid-19)

Time: 2 Hours 30 Minutes

Purpose	By the end of this session, participants should be able to – (a) Explain grief and bereavement in children of different ages (b) Recognise the signs of grief and bereavement in children of different age group (c) Elaborate how to provide care and support to children of different age group experiencing grief and bereavement
Learning Points/Key Messages/Key Takeaways	Loss refers to deprivation of something valuable to an individual, group or community. It can involve moving to a new place, changing schools, ending a friendship, or watching parents separate or die. All of these can bring sadness and grief to a child's life. Bereavement is a state of loss due to the death of a loved one. The death of a loved one is one of the greatest losses that can occur. Bereavement includes the period of adjustment in which the bereaved learns to live with the loss. The root word for "bereaved" means to be robbed or deprived of something valuable. **The five stages of grieving are:** **Denial**: In this stage, we basically refuse to believe that someone is terminally sick or has died. **Anger**: Anger can be directed toward the sick or dead person or even at oneself. We can blame others for the sickness, or we can blame God, higher powers, or ourselves. We can also experience angry emotional outbursts. **Bargaining**: We can bargain with ourselves or, if religious, with God. We may ask God to take away the reality of what has happened. **Depression**: This is characterised by extreme sadness, lack of sleep, lack of concentration, lack of interest in life and in activities that have previously given us delight, feeling hopeless and worthless, and, in extreme cases, thoughts of suicide. **Acceptance**: Here one realises that despite what has happened, one has to go on. Thoughts of loss may still come, but they are less intense and less disabling. There is energy to go on and what happened is taken as a fact of life.
Resources	Handout 11 – Story of Reenu – the Little Girl and her pet dog Handout 12 - Developmental Stages of Grief (by age)

Methodology

Focused Group Discussions

Group Work

Plenary Exercises

Notes for Facilitator/s

- Ensure that participants remain comfortable on talking about the issues (discussed in the session) in the group freely. Discuss with the participants that sensitivity and confidentiality should be maintained during the discussions.
- Write or Print Handout 11 and 12 on Chart Papers. Make copies of Handouts according to the number of groups that you are making.
- Ideally this Session will require 2 Facilitators. One of the facilitators must be a male and the other a female.

Activity 1:

Divide the participants in 5 Groups and give each group Handout 10 - Story of Reenu – the Little Girl and her pet dog.

1. Ask groups to discuss the following point around the Story.

   a. On bereavement and grief:
   - Definition of loss, bereavement, grief, and mourning
   - Stages of bereavement
   - How do children react to grief and bereavement?
   - What are the factors that lead to complicated grief?
   - What are the care and support options for grieving children?

   b. Discuss through Interaction

   - Grief is a normal, dynamic response that takes place after any type of loss. The process involves physical, emotional, cognitive, and spiritual responses to a loss. It is highly individualised and depends on the individual's perception of loss.

   - Mourning is used interchangeably with grief and specifically refers to a public expression of grief. Mourning is usually related to cultural and religious values and encourages social support for the mourner.

2. Ask the groups to present their understanding of grief among children on the basis of the story and any other examples from their lives and professional practice.

Activity 2 – Mourning Process among children

Read Out the following –

The mourning process for children has been described as involving four tasks:

1. Helping them to accept the reality of the loss
2. Assisting them to experience the pain or the emotional aspects of the loss
3. Aiding them to adjust to an environment where the deceased is missing
4. Supporting them to find ways of remembering the person and give them a "place" in their memory and life story.

Research[10] suggests that children may initially appear to be coping with the bereavement and may continue with their daily tasks, but that grief may re-emerge at a later stage of their life.

Discuss the following in the plenary –

1. **Stages of Bereavement**

It is generally agreed that people go through five stages of grief when they experience loss or are diagnosed with a life-threatening illness. However, it is important to point out to participants that there can be "rebounds" where the bereaved person moves from one stage to another and back again before reaching the final stage of acceptance.

2. **Children and mourning**

The process of grief among children can be different from that of adults. Young children who experience the death of a loved one often ask themselves three questions:

1. Did I cause this to happen?
2. Will this happen to me?
3. Who will take care of me?
4. Because of the loss (the person), will I be able to do anything or not be able to do anything in life?

Depending on the child's developmental stage, the child may not accept the irreversibility of death, especially if death is not explained properly to the child.

[10] Bereavement: Reactions, Consequences, and Care, CHAPTER 5 Bereavement During Childhood and Adolescence, Institute of Medicine (US) Committee for the Study of Health Consequences of the Stress of Bereavement; Osterweis M, Solomon F, Green M, editors. Washington (DC): National Academies Press (US); 1984.

1. **Divide the participants into 5 Groups**

Also give them Handout 12. Before presenting the table below, ask participants to consider how the following change as children become older: physical appearance and physiological maturity, motor skills, cognitive maturity, and social and emotional maturity. How might each of these factors affect how children grieve? Ask each group to discuss from their past experiences grief and morning among children (of different age groups) and how they find them similar and/or different from the details in Table of Handout 12.

Instructions and guidance given to all the participants in the Plenary before Group Work -

Common Reactions to Grief (not age specific):

We can categorise common grief reactions into four main areas: how the death affects our thoughts, emotions, behaviour, and physical reactions.

Thoughts	Emotions	Physical reactions	Behaviour
• Preoccupation with the death • Disbelief • Confusion • Hallucinations • Absentmindedness	• Guilt • Shock • Anxiety • Irritability or anger • Numbness • Loneliness • Relief • Fatigue	• Dizziness • Tightness in throat/chest • Breathlessness • Hollowness in stomach	• Sleep disturbances • Lack of appetite • Social withdrawal • Crying • Restlessness

There are other common reactions to grief. It is important to note that these are normal reactions and almost everyone feels them following the death of a loved one. These reactions will pass after some time. How long this takes depends on the individual.

2. Ask each Group to make presentation in the plenary – the similarities and differences between what has been mentioned in Handout 12 and what has been their real life experiences.

3. After the Groups' presentation discuss the following with the participants -

A. Complicated grief and bereavement

Grief is a reaction to loss, while bereavement is the process of dealing with the loss. Grief is complicated when the symptoms of grief (refer to the table on children developmental stages of grief in Handout 16) persist for at least six months and especially if it goes on for over two years, leading to notable functional impairment (psychological, physical, and social).

The grieving process can take time and should not be hurried. However, if it takes too long, usually more than two years, then it raises concern. Some people may be unable to move on from grief, making it impossible to rebuild their lives.

Factors leading to complicated bereavement:

• Several previous bereavements resulting from multiple losses
• A history of mental illness, such as depression, anxiety, or a previous suicide attempt
• A dependent relationship with someone who has died or a relationship where one had troubled or negative feelings about the deceased
• Low self-esteem, especially if a person's esteem depended on the dead person
• Lack of support from family and friends
• Sudden or unexpected death, for example, from suicide or an accident
• Death of a parent when one is a child or an adolescent
• Death of a cohabiting partner or a partner from an extramarital relationship where the relationship may not be legally recognised or accepted by family and friends
• Death involving murder, legal proceedings, or media coverage
• Death where the bereaved may be responsible
• Death from a quarantined disease like Covid-19
• Death where a post-mortem or an inquest is required

Other factors leading to complicated bereavement:
• The nature of cultural and religious beliefs: Some cultural and religious beliefs and practices may aid or complicate the process.
• Personality traits: Some people express emotions and look for support from similar individuals, while others may find this does not work for them.
• Substance abuse: In some communities, drugs and/or alcohol are used as coping mechanisms during bereavement. Such a method of coping often leads to complicated grief because it masks the actual grief response and limits opportunities for the bereaved to deal fully with their grief issues.

B. How children react to grief and bereavement

Children have some responses to illness and death that are similar to adults'. But they also have some very specific issues based on their developmental capacity to understand what is happening to them and their loved ones. Caregivers need to appreciate and understand the various stages of development in children in order to appropriately respond and support them. Children are often neglected when it comes to dealing with grief because they are considered "too young" to understand what has happened. Children "act out" in a bid to get attention. Even if a child is too young to comprehend, he or she can respond to changes in the emotional status of the family. Children may be dealing with the death of family members — and they may also have HIV. The caregiver must be given a sense of where the child is on his/her developmental trajectory. Four streams of development are usually presented:

• Physical growth and physiological maturation
• Motor skills development
• Cognitive maturation
• Social and emotional maturation.

C. Anticipatory grief in children during a parent's illness

It is important for caregivers to note that children begin grieving well before the death of their parents, so there are early opportunities to begin helping the children to avoid later complications. Children may experience various symptoms of grief as they watch their parents or siblings get very sick. Using stories about death and dying may be one way in which children can express their feeling and think about the death of a loved one. Below is a story of a sparrow that experiences loss. The story can be used to discuss feelings of grief with children and young people. It weaves a tale of nature, trees, and animals to discuss death, dying, and change.

Additional information for the facilitator

Tell the Trainees (Community Level PSS Worker) that when a child shows any of the symptoms discussed, refer to child organisations if there are any in your area. You may also refer the child to your local psychiatric unit in case of a suicide attempt or depression. Psychiatric services exist in every district in India. If the child has a serious emotional or psychological problem, it is best to refer to a trained person. However, it is also important to encourage the caregivers to show love and support to the child throughout the mourning period.

Refer to Referral Pathways and Psychosocial Support Assessment mentioned in Section 5 of this Manual.

Handout 11 – Story of Reenu – the Little Girl and her pet dog

Once upon a time, Reenu, a little girl, lived in a village. Her mother and father had built a house there, and when she opened her eyes for the first time in her life, the house and the household items were the first thing she saw. She loved to go up and down the stairs in the house and play in the courtyard. Many of her friends came to visit her in the courtyard — the butterflies, the bees, and other little children like her. As she grew up, she sometimes went to spend some time with her grandparents, who lived in the nearby village. Reenu was also very fond of her pet dog – "Veeru".

Reenu's mother and father were out for a whole day for work, and they wanted Chintu to be safe. The pet dog – "Veeru" was always there for Reenu's company and reassured Reenu's parents of her safety.

One day, Reenu found her pet dog - Veeru drooping and his eyes looking dull. She kept asking Veeru what was wrong. Veeru said that he was feeling very weak and tired. Reenu ran to her grandfather. He knew a lot of things and would surely help Veeru. He took some herbs, but they did not help. Finally, he consulted his friends. They had a meeting, but nothing seemed to help. Reenu became sad and curled up with him. She did not know what to do now. She stayed there quiet and not moving.

Reenu went to her grandmother. She was feeling very sad. Her grandmother told her to be kind to Veeru and to call her friends to cheer him up. She called the butterflies, bees, and the little birds and every day they would go and play with Veeru to make him happy. Sometimes Reenu did not feel like playing, but would go to Veeru and hold on to him and sleep. Veeru was feeling very sad and Reenu would talk to him and remind him of all the lovely times they had: when Reenu was born, the day she fell down and he protected her by calling the neighbours.

One day Veeru did not respond. He was too tired and sick and one day he drooped and fell silent on the ground forever. Reenu and her friends felt very sad. Reenu's parents buried Veeru in the courtyard and made a toy house over it. The rains came and all around the toy house beautiful flowers and green grass began to grow. The butterflies came and sat on them, and Reenu felt that although Veeru had gone away, he was still there for her.

A few guideline questions have been provided below:
- What did Reenu do when she was happy? Sad? Helpless? Ask a volunteer to demonstrate it through their voice and body.
- Did they think Reenu would have an appetite? Sleep? Would her body feel tense? Tired? Achy? Would she have a headache? Body ache?
- If children are willing, the facilitator can ask if they have ever felt like Reenu. When? What did they feel?
- What did Reenu do to feel better (sing, play, talk)? Who did she go to for help?
- The facilitator should ask volunteers to share what they do when they feel like that. Who can help?
- How did Reenu feel later? Why?
- How do children suggest that their friends be comforted? What can young people do? What about adults?

Handout 12 - Developmental Stages of Grief (by age)[11]

Age	Thoughts	Feelings	Actions	Interventions
0-3 years			• Cries • Exhibits clinging behaviour • Exhibits regressive behaviour	• Hold the child. • Offer words of reassurance in a calm tone of voice.
3 – 5 years	• Believes loved one will return • Believes loved one is just away	• Confused • Anxious • Fearful of separation • Sad or angry	• Cries • Has temper tantrums • Has nightmares • Exhibits regressive behaviour • Exhibits clinging behaviour	• Provide attention. • Offer reassurance calmly; don't worry about the "right words".
6- 9 years	• Wonders if loved one will return • Believes deceased can still function • Believes their actions or words caused death	• Confused • Anxious • Fear of separation • Sad and angry • Fearful they might die too	• Cries • Has temper tantrums • Has nightmares • Exhibits regressive behaviour • Exhibits clinging behaviour • Has difficulty concentrating	• Provide extra attention. • Tell the truth; give appropriate information. • Reassure the child they were not responsible for the death. • Encourage physical or artistic expression.
9 – 12 years	• Understands finality and irreversibility of death • Believes their actions or words caused the death	• Sad • Confused • Anxious • Withdrawn • Lonely • Guilty	• Exhibits and engages in risky or dangerous behaviour • Shows decline in grades • Has difficulty concentrating	• Provide extra attention. • Tell the truth; give appropriate information. • Reassure the child they were not responsible for the death. • Encourage physical or artistic expression of grief. • Maintain structure, limits, and rules.
12 – 18 years	• Understands finality, irreversibility, and non-functionality of death • Believes their actions or words caused death	• Sad • Confused • Anxious • Withdrawn • Lonely • Guilty	• Exhibits and engages in risky or dangerous behaviour • Shows decline in grades • Has difficulty concentrating	• Seek community and school support. • Maintain structure, limits, and rules. • Encourage physical or artistic expression of grief.

[11] Source: US Department of Health and Human Services.

My Session Reflection

(To be filled by the trainer after the completion of the training. This is for self-learning and improvement. This will also help in revising the manual later on.)

1. Broad observation about how the session went by:
    a. ……
    b. ……

2. Were all the learning points covered? Provide examples
    a. ……
    b. ……

3. Reactions/Reflections of the participants
    a. ……
    b. ……
    c. ……

4. Did the session achieve its objective? If no, what are the aspects to be taken up again with the participants?
    a. ……
    b. ……

5. Your current feeling and why so: (Emoji of tired, happy, satisfied, exited to be put)

SECTION 4 - ACTIVITY SESSIONS TO BE PRACTICED WITH CHILDREN BY COMMUNITY LEVEL PSS WORKERS – PSYCHOSOCIAL INTERVENTIONS

Practicing tools for community level PSS worker

These tools are designed to be used by PSS workers in community. The tools presented look at the following areas:

1. Strengthening relationships
2. Relaxation
3. Ice Breaking, bonding, Psychosocial Assessment (for drawing out care plan and/or referral). To be used along with PSS Assessment Framework and Referral Pathways discussed in detail in Section 5 of this Manual.

GENERAL SAFETY TIPS: Key considerations

• Activities could remind people about difficult experiences they have had and could cause distress. It is important that you tell the participants this and let them know that they don't have to talk about anything they don't want to talk about, and can stop the activity at any time.

• Pay close attention to the participants. If they show signs of discomfort you should gently tell them that if they want to leave it there and stop that is fine with you.

• Make sure referral pathways are in place and you are ready to refer people for further support if needed. Refer to Section 5 of the Manual for PSS Assessment and Referral Pathways

• Make sure participants have your contact details (or contact details for your organisation) so that they can follow up if they need further support between meetings. This is over and above the regular follow up the Community Level PSS worker has to maintain at the community as well as at the Community Centre/Children's Group Level.

• You should prepare a list of contacts that you can give to participants, and bring them to every meeting.

Activity Tool Number: 1
Activity Tool Title: How to Strengthen Relationships and respond to challenges collectively

Time: 15-20 Minutes (for small group of people)

The following tool encourages participants to look at their relationships and to respond to challenges collectively. They help them to find different ways in which they can build and strengthen their relationships and support systems.

Purpose	To share positive traits and cultural similarities and differences. To respect and embrace the diversity in their community/society.
Age Group	6 years and older children
Group Size	5-40 people. If larger than 15 people, break into groups for small group sharing.
Resources	Paper and pen/pencil (possible to use a stick and draw the diagram on the ground).

PROCESS:

STEP ONE: ACTIVITY

- Ask children to draw a circle in the middle of the paper.
- Ask them to write their name in the middle of the circle.
- From that, draw 6 lines from the middle of the circle outward.
- On each of the lines, ask them to write a word that positively describes who they are and then to circle the one that is most important to them.

Sharing

- If you have a group of more than 15 children, each child can briefly say their name and then say the word they circled and why.
- If fewer than 15 people, they may briefly say their name, say all the words they wrote, then share the word they circled and why.

STEP TWO: CULTURAL SHARING

- Ask all children to share something about their culture (if it is pre-planned you may ask children to bring something from their culture.)
- Take time (3-5 minutes per person) for children to tell about what they shared or brought and why.

STEP THREE: DEBRIEF

- Ask children if they learned something new about someone.
- Ask if it was difficult to think of 6 different positive things that described them.
- Facilitator can add on questions as per their requirement.

SAFETY:

- This activity does not pose any safety issues.
- Make sure referral pathways are in place and you are ready to refer people for further support if needed. Refer to Section 5 of the Manual for PSS Assessment and Referral Pathways
- Make sure participants have your contact details or contact details for your organization so that they can follow up if they need further support between meetings. This is over and above the regular follow up the Community Level PSS worker has to maintain at the community as well as at the Community Centre/Children's Group Level.

Activity Tool Number: 2
Activity Tool Title: Identifying supportive people and relationships (Social Mapping)

Time: 45 Minutes

Purpose	How to identify supportive people and think about those relationships.
Age Group	8 years and older children
Group Size	Can be done with one child, or in a group if there is trust within the group.
Resources	Stone, flowers, leaves, twigs and any other objects around you.

PROCESS:

STEP ONE: PREPARATION

- Gather stones, flowers, leaves, twigs and other objects.

STEP TWO: WARM UP

- Begin with a warm-up activity/ group song/ energizer/ focuser.

STEP THREE: RELATIONSHIP CONNECTIONS

- Ask every child to place an item on the ground that represents them.
- Ask them to use the remaining objects to show the people they have relationships with or who are in their life. There are three levels: “Close”, “Closer” and “Closest”.
- Give time to allow the participant to add their friends, family, neighbours, people they work with, schoolmates, religious leaders and any other important people in their lives.
- Ask the following questions:

Heart connected:
Who is closest to you? Who do you really care about?

Mind connected:
Who do you learn from? What are you learning? Who do you teach?

Body connected:
Who gives you with food and shelter? Who is your blood relative?

Inside connected:
What makes you feel good inside? Who shares your values?

STEP FOUR: SHARING

- Once the picture is completed: ask them some questions about the map they have created so they can share more with the group.

Sample questions:

- Can you tell me a bit more about X (person in the closest circle)?
- What kinds of things do you do together?
- What things do you have in common?
- Who else is in your picture?
- Can you tell me a bit more about your picture? About all the other persons in the picture.
- Is there anyone in the picture that you have a different kind of relationship with since the crisis happened, either good or bad? (This point can be taken off-group in one to one sessions if there is any discomfort.
- Have there been any changes in your relationships?

STEP FIVE: HEART CONNECTION VISUALISATION

- Grounding – Ask everyone to breathe, and imagine tree roots attaching the feet to the ground. (5 minutes)
- Ask them to focus on their heart, have them think of what it looks like, then have them see a strong cord. Attach this cord to their heart and then attach the other end of the cord to who/whatever else they want to connect with.
- Have them imagine that their heart is beating at the same time as the attached heart. Allow a few minutes to enjoy this connection.
- End by saying "whenever you are ready you can slowly and gently come back into the room"

STEP SIX: DEBRIEF

- Did you learn something new about yourself or others?
- I am still here to help. If you would like to talk to me or someone else about how you are feeling just let me know and I will try to get you some more support.
- Clean-up. Return objects to where you found them. Keep written material (notes, drawing etc.) safe and secure.

SAFETY:

- This activity might remind people about difficult and/or distressing experiences. You should not probe about these events in detail in the Group if there is any discomfort in the child. All discomforting situations need to be taken off – group in one to one sessions. Use PSS Assessment and Referral Pathways. Refer to Section 5 of this Manual.

Activity Tool Number: 3
Activity Tool Title: Analysing relationship within family, peers and community.

Time: 1 Hour

Purpose	How to map communities, think about relationships, and talk about what people appreciate and find challenging in their communities.
Age Group	8 years and older children
Group Size	5-25
Resources	• Space where everyone can sit together in groups • A3 paper • Drawing material (markers, pastels, crayons, or charcoal) for everyone • Masking tape

PROCESS

STEP ONE: MAPPING

Ask the participant children to draw the following:

- Draw what you see in your community.
- Draw the things you like as well as those things you wish to be different and label them accordingly.
- Draw some things or people that you appreciate, care about, and are grateful for.

STEP TWO: CHANGES

Now start a new paper and ask the participant children to draw the following:

- Draw what you want to see in your community: hopes, changes etc.
- Draw yourself and anyone else you would like in this new community.

STEP THREE: SHARING

- Have everyone share the community maps.

STEP FOUR: DEBRIEF

- What effect do you think your community/family/ peers has on you?
- How do some people in the community/ family /peer bring you closer to some people and farther away from others?
- What did you learn about someone else's community?
- Why do you think we did this exercise? What do you think we can learn from this?

ALTERNATIVES:

- Group participants by communities.
- Along with mapping, they could make a **collage** with imagery and words.
- The exercise could also be a personal map or a map about their families/peer groups.
- For children you can use the idea of animals.

SAFETY:

- Little to no safety issues to flag. Drawing maps collectively works best when participants trust each other and there are not significant power differences (age, gender, social location).

Activity Tool Number: 4
Activity Tool Title: Changing Perspectives and understanding alternatives

Time: 30 Minutes

Purpose	Help people understand different alternatives.
Age Group	8 years and older children
Group Size	5-25
Resources	• A space where participants can sit together in, either groups on the floor or benches, or around tables. • A3 paper • Drawing media (markers, pastels, crayons, or charcoal) for the entire group. • Masking tape

PROCESS:

STEP ONE: COLOUR FINDING

- Ask participant children to tell you the main colour found in the room. All should agree on what that is.
- Ask them to look for another specific colour. Allow them some time to find it in different places in the room.
- Ask them to choose another colour and look for it.
- Ask them if they were able to find all the colours in the room.
- Explain that just because we noticed the first colour first, that doesn't mean it is the only colour that exists.
- Ask them if they noticed many other colours when they were looking for the colour requested.

STEP TWO: CONNECTION WITH EMOTIONS

- Make the connection between emotions in their life. All of the emotions are there but we can choose which ones we want to focus on, and what we choose defines what we are going to see.

STEP THREE: DEBRIEF

Debrief by asking the following questions:

- Why do you think we did this exercise? What do you think we can take away from this?
- Was there ever a time you thought one way about somebody, and something happened to make your thinking change?
- Has someone in your life ever helped you to think differently about a certain situation?
- What factors around us make us think the way we do?

SAFETY:

- Little to no safety issues to flag.

Activity Tool Number: 5
Activity Tool Title: Gratitude Pairs

Time: 15-20 Minutes

Purpose	Talk about forgiveness
Age Group	8 years and older children
Group Size	5-25
Resources	Open Space

PROCESS:

STEP ONE: Gratitude Pairs

- Pair children up, either asking them to pick someone, or counting them off in pairs.
- Have one child tell the other person three things that they are grateful for about that person.
- Have them look into the child's eyes and tell them something specific for which they are grateful, and then have them wait at least three seconds before going on to the next thing they are grateful for. These may be for different situations requiring support and care.
- The child receiving the compliment must only say, "Thank You".
- After the first child says three things they are grateful to their partner for, they switch roles.

STEP TWO: Debrief

Debrief by asking the following questions:

- How did it feel to be the person giving gratitude?
- How did it feel to receive the gratitude?

ALTERNATIVES:

- The activity can be done with children. They can say one thing they like about the other child. The child receiving the compliment can be asked to say thank you. After this is completed, the children can switch roles.
- This activity might remind people about difficult and/or distressing experiences. You should not probe about these events in detail.
- Ensure that participants are aware that they are free to leave at any time, not answer questions or not participate in activities they aren't comfortable with.
- Clarify that there is further support available should anyone experience distress.
- Remember that two facilitators should be present to ensure that support can be offered straight away.

Activity Tool Number: 6
Activity Tool Title: Cooperation and Shared Joy

Time: 15 Minutes

Purpose	Enhancing concentration and focus; exploring movement in a different way; developing cooperation and shared joy
Age Group	8 – 18 years children
Group Size	Any
Resources	Open Space

PROCESS:

- Divide the group into small groups of 5 and make a circle.
- Instruct that participants will think of one movement (i.e. jumping up and down, shaking their head, taking a deep breath) or a sound, and one person will try to remember everyone's moves by going in the circle and demonstrating them.
- Facilitator goes first, introduces movement/sound, and then steps out.
- Then the next child goes in the middle, demonstrates the facilitator's move, add their move/sound, and then steps out.
- Another child then steps in the circle, repeats the two previous movements, adds their movement, and then goes out of the circle.
- Repeat until everyone in the circle goes and tries to remember everyone's movements. If someone forgets a move, the group must begin again.

FACILITATOR TIPS:

- Encourage the group to refrain from helping the participant right away.
- Allow participants time to remember by themselves before assisting.
- Remind that help is always available.

DEBRIEF:

Ask participants the following:

- What was the experience like? Was it hard? Challenging?
- Were you able to remember everyone's' movements?
- Did everyone remember yours?
- Which movement was the hardest? Which movement was the easiest?

ALTERNATIVES:

- For children ages 12 and older: Form a larger circle with more children to see if the whole group can do it together.
- For children ages 12 and older: Have the whole group in a circle. Every child chooses something they like to do (e.g. play soccer, sing, dance, etc.) and takes turns going in the middle of the circle doing their movement. Then on a second round, a child will go in the middle, do their movement, and then call out someone's name and do that person's movement. Then the child whose name was called goes in the circle, does his/her

movement and calls out another child's name and does his/her movement. Repeat until everyone has gone.

SAFETY:

Little to no safety issues to flag.

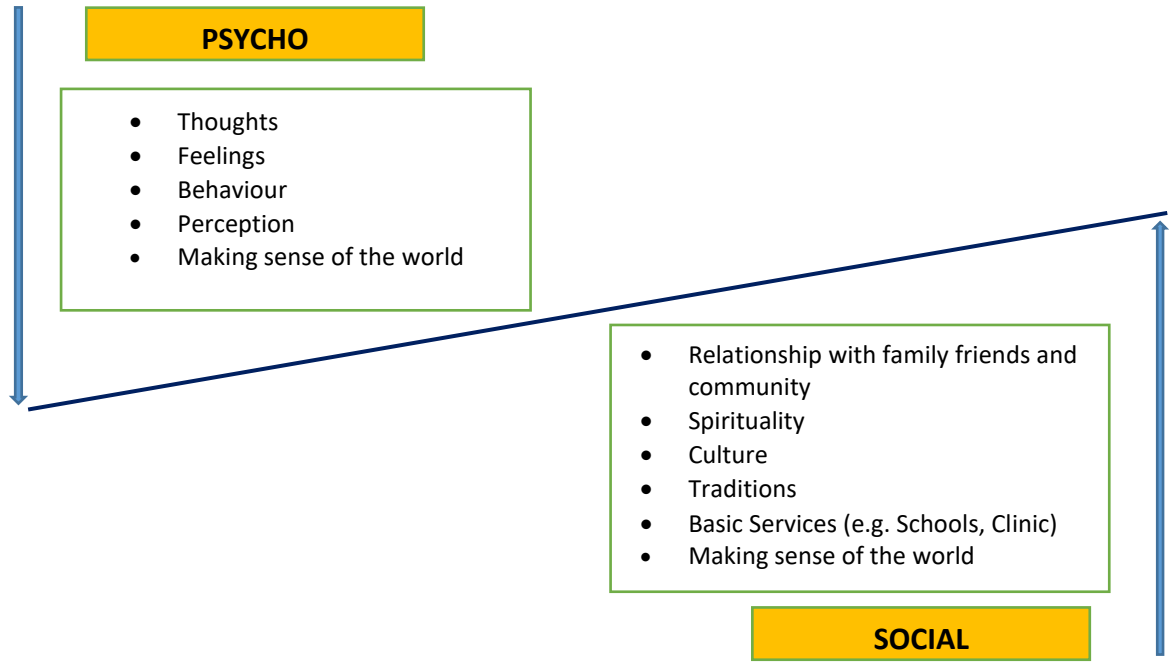
SECTION 5 - PSYCHOSOCIAL SUPPORT ASSESSMENT AND REFERRAL PATHWAYS

5.1 Who needs psychosocial support?

Everyone needs psychosocial support because we all have social, emotional, and psychological needs. However, we need to pay extra attention to people who have experienced grief, the death of a loved one, physical and sexual violence, displacement, or any of the other difficult situations we mentioned earlier. Others who need special attention are people who live in difficult circumstances, such as poverty; those who have a lot of stress; adolescents who are going through a challenging time; and people who may be involved in alcohol and substance abuse. Anyone who experiences the psychological, social, and physical reactions mentioned above will need psychosocial support.

Within above, children are often most vulnerable and helpless to deal with trauma and depression that leads to negative social, emotional, and psychological state of children.

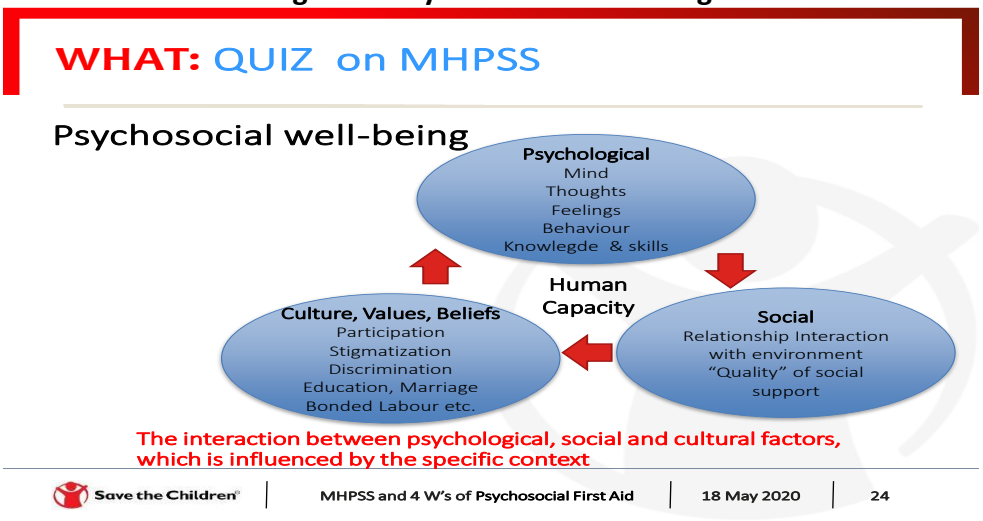
Figure 4: Elements of Psychological and Social in a Child's Life



Whenever there is an imbalance in these elements or there is any deficiency an intervention is required for correction. The stage in which focussed non-specialized intervention is done is – "Psycho – Social Support".

A pictorial depiction of elements of psychosocial well-being is also seen in Figure 5.

Figure 5: Psychosocial Well-Being



A decision on who should receive Focused Non Specialised Psycho Social Support is based on an assessment, which can be done as follows -

5.2 Basic Individual Assessment

PURPOSE: Understanding the views, issues and needs of a child and identifyingactions that respond to them.
TIME: 30-45 minutes
AGE: Up to 18 years
Materials: Tool 1 printed out, pen and notebook.

STEP ONE: PREPARATION

- Print out the tool that immediately follows after this section.
- Greet the child warmly and thank them for coming to see you (or welcoming you to their home).
- Explain and give an overview of what the interview will involve and complete informed consent of child and his/her parents/guardians.

STEP TWO: ACTIVITY
Complete the Participatory Assessment Tool that follows this summary.

STEP THREE: DEBRIEF

- Thank you for sharing your feelings. The information you have given me has been very useful and will help to identify what kind of support might be useful for you.
- Agree upon next steps.
- It is often difficult for children to seek help with emotional health and it is very important that we do everything possible to ensure that the child has a good

experience, feels good about their decision to seek help, and will feel comfortable returning to the service or group.

- If the child has come with a family member or elder, you should greet this person and show proper respect by saying "I appreciate you being here today Sir/Madam, and it is important for this kind of work that I talk directly to [name of child in difficulty] about how he/she is feeling, I hope that you will understand." You should then speak directly to the child who is experiencing difficulties ratherthan speaking to others about them.
- Remember to say that all information collected will be done in a confidential manner and that their participation is voluntary.
- If the child is at risk of harm, or of harming themselves or others you must immediately refer to the appropriate authorities.
- Give interviewees your contact details or contact details for your organization so that they can follow up with you for further support

5.3 Preliminary Referral Pathways

The following is a list of referrals that you can make based on the types of difficulties children are with you in the assessment. This is preliminary and indicative. Please refer to Figure 8.

- Difficulties sleeping: refer to the Mental Health Nurse for sleep hygiene psycho-educationwhile maintaining PSS support.
- Loss of interest in daily activities to a significant degree – not washing, dressing, etc.: refer toMental Health Nurse while maintaining PSS support.
- Seeing or hearing things that other people cannot – if the child is distressed by this and does not give it a religious or spiritual explanation, refer to the Mental Health Nurse while maintaining PSS support. If it is religious or spiritual in nature and causing distress, discuss coping strategies with them.
- Heavy alcohol or drug use: refer to Mental Health Nurse while maintaining PSS support.
- Sadness: if bereaved or grieving provide support with grief and loss, if no cause for sadness refer to Mental Health Nurse.
- Fright: if the child interviewed is afraid of someone or something in life, make attempts to get them to safety. If their fright has no current cause, provide basic support to promote safety. If their fright is severe and there is no apparent current cause, refer to the Mental Health Nurse.
- Risk (Self Harm, Safety, Suicide): "I understand that this is a difficult thing to talk about, but sometimes when children have been under a lot of stress and life is difficult they feel like hurting themselves or others in order to feel better. I was wondering if you have ever felt this way."

If the child is at risk of harm, or of harming themselves or others you must immediately refer to the appropriate authorities. In most cases, you will need to accompany the person to visit them. Don't leave them until they have received appropriate care and are safe.

5.4 Individual Child Behaviour Checklist[12]

Sl. No	Questions	Not at all	A little	Some-what	Quite a bit	A lot
1	Seems tense and nervous	1	2	3	4	5
2	Seems tired, physically and mentally	1	2	3	4	5
3	Not interested in study/work/games/other activity	1	2	3	4	5
4	Looks sad	1	2	3	4	5
5	Has Difficulty in sleeping	1	2	3	4	5
6	Bad dreams or nightmares.	1	2	3	4	5
7	Likes to live alone	1	2	3	4	5
8	Does not take lead or participate regular in group activities related to his/her hobby	1	2	3	4	5
9	Does not like to ask other people to get help to solve the problems.	1	2	3	4	5
10	Not punctual	1	2	3	4	5
11	Does not care about others	1	2	3	4	5
12	Tendency to hit other	1	2	3	4	5
13	Does not eat properly. Eats less or very slowly or leaves food	1	2	3	4	5
14	Seems helpless and hopeless	1	2	3	4	5
15	Has violent thoughts of harming self or another	1	2	3	4	5
16	Suicidal thoughts	1	2	3	4	5
17	Problems in relations with other people/family/ friends	1	2	3	4	5
18	Does not participate in cultural and religious activities in the family	1	2	3	4	5
19	Does not have understanding of the behaviour in different situations	1	2	3	4	5
20	Does not cooperate towards the people around him/her	1	2	3	4	5
21	Does not share feeling with parents/ caregivers	1	2	3	4	5
22	Does not get fairly treated by the family	1	2	3	4	5
23	Does not have a sense of belongingness with the family members	1	2	3	4	5

[12] Adapted from Child Behaviour Checklist (CBCL) The *Child Behaviour Checklist* (CBCL) is a widely used questionnaire to assess behavioural and emotional problems.

24	Does not have friends of same age	1	2	3	4	5
25	Is not comfortable to share problem with friends	1	2	3	4	5
26	Does not have sensitivity towards the friend's problem/need	1	2	3	4	5
27	Does not have good relation with teachers	1	2	3	4	5
28	Does not participate in community events	1	2	3	4	5
29	Has negative attitude in case of difficult circumstances	1	2	3	4	5
30	Gets angry and upset very easily	1	2	3	4	5

Scoring and Action
Score between 30 and 60 – The Child is fine
Score between 61 and 90 – The Child needs Psycho Social Support
Score between 91 and 120 – The Child needs to be assessed further Using Tool 2 and professional help should be sought
Score between 121 and 150 – The Child needs immediate professional help

5.5 Participatory Assessment

PURPOSE: Understanding the views, issues and needs of different children and identifying actions that respond to them
TIME: 1-2 days **AGES:** 1 up to 18 years
GROUP SIZE: 5 individuals should participate in total, in one-on-one interviews.

RESOURCES:
Materials: Tool 2 printed out, pen, notebook.
Optional: Flip chart, markers, objects such as stones leaves etc. to use in ranking.
STEP ONE: PREPARATION
• Print out the tool that immediately follows after this section. Fill out the date, participant number, location and interviewer information on the tool. You can use a flip chart to write these details out on larger paper with the individual doing the assessment.
• Place out the flipchart and markers.
• When you meet the interviewee, introduce yourself, give an overview of what the interview will involve and complete informed consent of child and his/her parents/ guardians.
STEP TWO: ACTIVITY
• Complete the Participatory Assessment Tool that follows this summary.
STEP THREE: DEBRIEF
• Thank you for meeting with me today. The information you have given me has been very useful and will help us to plan our activities.
• What happens next: there will be a report and we will use it to plan our programmes in the future.
• Do you want to ask me any questions?

- Prompts:
  - Have we done anything that has not been good or that has made things worse?
  - Has anyone else done things that have not been good or have made things worse?
  - Is there anything you would like to talk about a bit more?
  - Is there anything else I can do differently?
  - I am still here to help, if you would like to talk to me or someone else about how you are feeling just let me know and I will try to get you some more support.

- It is important to obtain informed consent prior to interview from their parents/guardians.

PARTICIPATORY ASSESSMENT

Date:……Participant number[13]:……

Location:……..

Interviewer information:……..

SECTION 1: PROBLEM IDENTIFICATION

1. "What kind of problems do [GROUP OF INTEREST, e.g. Children, women, girls, young children, orphan and vulnerable children] have because of the [Covid, flood, other] situation? Please list as many problems that you can think of.''

2 "What other kind of problems do [GROUP OF INTEREST, e.g. Children, women, girls, young children, orphan and vulnerable children] have because of the [Covid, flood, other] situation? Please list as many problems that you can think of." The respondent may now list a few more problems. You would then continue with the question until the respondent gives no more answers.

3. "Do you have any personal problems because of who you are in the community? "(as a son, brother, sister, daughter, farmer, woman, elder, teenager, etc.)

Enter all problems into the table below with a short description for each problem:

Table 1.1: List of the problems (of any kind)	
Problem	Description

Section 2: PSS Areas

Classify the types of PSS problems

Table 2.1 : Problems and Corresponding PSS areas	
Problem (List problems from Table 1.1)	PSS Areas (e.g. problems related to relationship, feelings, thinking, behaviour etc.)

Section 3: Ranking

[13] Coding to be done Alphanumeric. Combination of alphabets and digits for location and child's unique number. Details to be mentioned in separate code book.

"You mentioned a number of problems, including [READ OUT ALL PROBLEMS NAMED IN Section 1 ABOVE]. Of these problems, which are the top three most important problems? Why?"

Table 3.1 Ranking of Top 3 Most Important Problems with Explanations	
Problem (List problems from Table 1.1)	Explanation (Write down what the reasons are for why each problem is so important
1.	
2	
3	

SECTION 4: DAILY FUNCTIONING AND COPING

''Sometimes [NAME A PROBLEM FROM TABLE 3.1] may make it difficult for a person to perform their usual tasks. For example, things they do for themselves, their family or in their community. If a [INSERT GROUP OF INTEREST] suffers from [NAME AGAIN THE PROBLEM LISTED FROM TABLE 3.1 ABOVE], what kind of tasks will be difficult for them?''

Table 4.1 Impairment of Daily Activities	
Repeat for each problem mentioned in Table 1.1	
Mental health/ psychosocial problems(as listed in Table 1.1)	Affected task
1.	
2.	
3.	
4.	

SECTION 5: PROBING

5.1 Have you experienced problems in your relations with other people? If yes, what type of problems? (e.g. do other people stigmatize you, do you not get support from others, are you not involved in community activities as you would like?)

5.2 Have you been experiencing problems related to your feelings? If yes, what type of problems? (e.g. sadness, anger, or fears)

5.3 Have you been experiencing problems related to the way you think? If yes, what type of problems? (e.g. concentrating, thinking too much, not remembering things)

5.4 Have you been experiencing any problems related to how you behave? If yes, what type of problems? (e.g. do things because you are angry, do things that others found strange, doing things you regret)

SECTION 6: SOCIAL SUPPORT AND COPING

"I am especially interested in learning more about [INSERT ANY RELEVANT PSYCHOSOCIAL AND MENTAL
HEALTH PROBLEMS MENTIONED ABOVE]. Can you please answer the following questions?"

6.1 Could you tell me how [INSERT PROBLEM] affects your daily life?

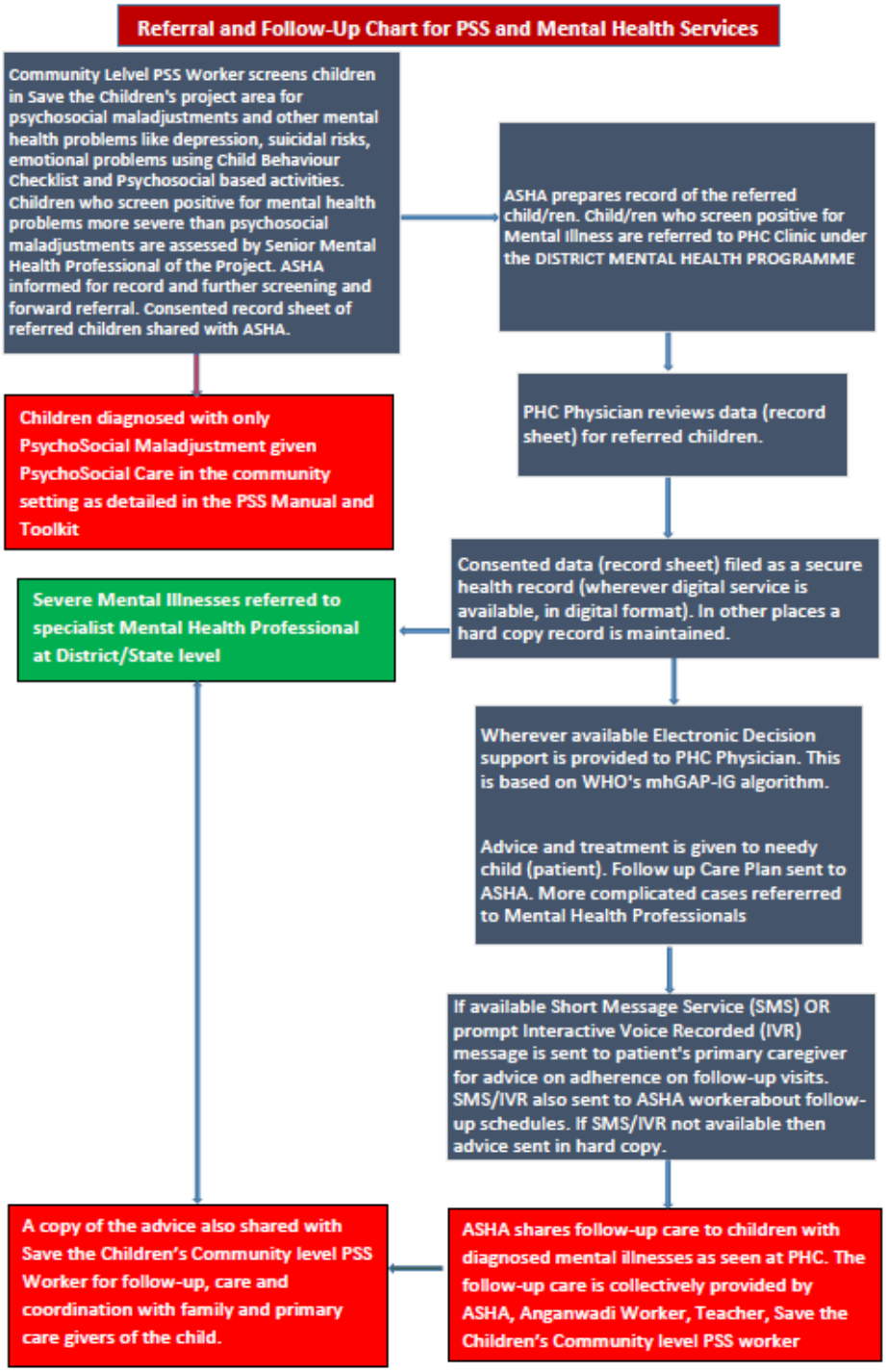
6.2 Have you tried to find support for this problem?

6.3 Could you describe how you have tried to deal with this problem? What did you do first? And after that?
6.4 Have you received support from others in dealing with this problem?
6.5 Who gave you this support?
6.6 What kind of support did you get?
6.7 To what extend did this help to deal with the problem?
6.8 Do you feel you need additional support with this problem?

Repeat for all mental health and psychosocial problems

REFERRAL PATHWAYS

Figure 6: Referral Pathways



5.6 District Mental Health Program (Under the National Mental Health Programme, GoI):

Envisages provision of basic mental health care services at the community level.

Objective: -

a. To provide sustainable basic mental health services to the community and to integrate these services with other health services
b. Early detection and treatment of patients within the community itself
c. To reduce the stigma of mental illness through public awareness.
d. To treat and rehabilitate mental patients within the community.

5.7 Mental health gap action programme (mhGAP)

In 2008, WHO launched the mental health gap action programme (mhGAP) in response to the wide gap between the resources available and the resources urgently needed to address the large burden of mental, neurological, and substance use disorders globally. Through mhGAP, WHO aims to provide health planners, policy-makers, and donors with a set of clear and coherent activities and programmes for scaling up care for mental, neurological and substance use disorders.

Read more at - https://www.who.int/mental_health/mhgap/evidence/en/

SECTION 6 - RECORD KEEPING AND REPORTING

6.1 First Intervention Report

Introductory Information about the Child

Name of the Child		Age	
Sex		Address	
Father's Name		Mother's name	
Family income		Family assets	
Date of Intervention			

Family Composition

S No.	Name	Age	Gender	Relation with Child	Education	Present Activity/ occupation
1.		-				
2.		-				
3.						
4.						

Objective of the Intervention with the Child	
Details of the Intervention	

Observations	

Need Assessment	
Physical Health	
Emotional/Psychological Condition	
Education Training and Occupation	
Economic Condition	

Proposed Action Plan	

6.2 Case Work Process Recording

Introductory Information about the Child

Name of the Child		Age	
Sex		Address	
Father's Name		Mother's name	
Family income		Family assets	
Date of Intervention			

Family Composition

S No.	Name	Age	Gender	Relation with Child	Education	Present Activity/ occupation
1.		-				
2.		-				
3.						
4.						

Intervention Details

Session	1
Date	
Time	
Place	

Session	2
Date	
Time	
Place	

Session	3
Date	
Time	
Place	

Session	4
Date	
Time	
Place	

Session	5
Date	
Time	
Place	

6.3 Group Activity Report

Introduction
Objectives:
Name of the Group:
Description of the Location:
Profile of Group Members: (for each member)

S. No	
Name	
Gender	
Age	
Educational Qualification	
Father's Name	
Father's Occupation	
Mother's Name	
Mother's Occupation	
Address	
Number of siblings	
Ordinal Position	
Brief About the child	

Details of Intervention

Intervention/ Visit / Activity No.	
Date and Day	
Venue	
Time	
Purpose of Activity	
Introduction of the activities	
Activities Undertaken	
Observation	
Assessment	
Conclusion	
Plan of Action	

Evaluation of members of Group (Each Member)

Conclusion

6.4 Follow Up Report

Name of the Child		Age	
Sex		Address	
Father's Name		Mother's name	
Family income		Family assets	
Date of Intervention			

Objective	

Details of Intervention	

Observations	

Need Assessment	
Physical Health	
Emotional/Psychological Condition	
Education Training and Occupation	
Economic Condition	

Proposed Action Plan	

6.5 Monthly Report - Format

Month: ……..

S. No	Name of the Child	Age of the Child	Nature of case (Problems/ Needs)	Address & phone no. of the Child	Economic condition of the family	Educational Status (Class)	No. of sessions conducted	Support Provided	Referral status	Current Status

Key resources

1. Bernard van Leer Foundation (2005). *Early Childhood Matters. Volume 104: Responding to young children in post-emergency situations*.
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2. Consultative Group on Early Childhood Care and Development (1996). *Children as Zones of Peace: Working with Children Affected by Armed Violence.*
http://www.ecdgroup.com/docs/Children_as_Zones_of_Peace;_Working_with_Children_Affected_by_Armed_Violence-13_05_2001-13_53_24.pdf
3. Emergency Nutrition Network Online (2006). *Infant Feeding in Emergencies*.
http://www.ennonline.net/ife/index.html
4. Human Sciences Research Council of South Africa (HSRC). Psychosocial Support Resources: Davids D. (Hesperian Foundation), *Emotional Behaviour Book*.
http://www.hsrc.ac.za/research/programmes/CYFD/unicef/other_resources.html
5. ICRC, IRC, Save the Children UK, UNICEF, UNHCR and World Vision (2004). *Inter-Agency Guiding Principles on Unaccompanied and Separated Children*. Save the Children UK.
http://www.unhcr.org/cgi-bin/texis/vtx/protect/opendoc.pdf?tbl=PROTECTION&id=4098b3172
6. INFO Reports/Johns Hopkins Bloomberg School of Public Health (2006).
Breastfeeding Questions Answered: A Guide for Providers.
http://www.infoforhealth.org/inforeports/breastfeeding/inforpt5.pdf
7. Save the Children UK (2006). *ECD Guidelines for Emergencies – the Balkans*.
http://www.savethechildren.org.uk/scuk/jsp/resources/details.jsp?id=4174&group=resources&section=policy&subsection=details&pagelang=en
8. UNESCO and IIEP (2006). *Guidebook for Planning Education in Emergencies and Reconstruction*.
http://www.unesco.org/iiep/eng/focus/emergency/guidebook.html
9. UNICEF and Macksoud M. (2000). *Helping Children Cope with the Stresses of War: A Manual for Parents and Teachers*.
http://www.unicef.org/publications/files/Helping_Children_Cope_with_the_Stresses_of_War.pdf
10. UNICEF (2002). *HIV and Infant Feeding*.
http://www.unicef.org/publications/files/pub_hiv_infantfeeding_en.pdf
11. WHO (2006). *Mental health and psychosocial well-being among children in severe food shortage situations*. Geneva: WHO. http://www.who.int/nmh/publications/msd_MHChildFSS9.pdf
12. Women's Commission for Refugee Women and Children (2005). *Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*.
http://www.womenscommission.org/pdf/EmOC_ffg.pdf

Annexure 1
PSYCHO – SOCIAL SUPPORT (STATUTORY COMPLIANCES – INDIA)

Juvenile Justice Act, 2015

Sections	Details
18 - Orders regarding child found to be in conflict with law	(1) Where a Board is satisfied on inquiry that a child irrespective of age has committed a petty offence, or a serious offence, or a child below the age of sixteen years has committed a heinous offence, then, notwithstanding anything contrary contained in any other law for the time being in force, and based on the nature of offence, specific need for supervision or intervention, circumstances as brought out in the social investigation report and past conduct of the child, the Board may, if it so thinks fit,— (a) allow the child to go home after advice or admonition by following appropriate inquiry and counselling to such child and to his parents or the guardian; (b) direct the child to participate in group counselling and similar activities; (g) direct the child to be sent to a special home, for such period, not exceeding three years, as it thinks fit, for providing reformative services including education, skill development, counselling, behaviour modification therapy, and psychiatric support during the period of stay in the special home:
19 - Powers of Children's Court.	(1) After the receipt of preliminary assessment from the Board under section 15, the Children´s Court may decide that— (i) there is a need for trial of the child as an adult as per the provisions of the Code of Criminal Procedure, 1973 and pass appropriate orders after trial subject to the provisions of this section and section 21, considering the special needs of the child, the tenets of fair trial and maintaining a child friendly atmosphere; (ii) there is no need for trial of the child as an adult and may conduct an inquiry as a Board and pass appropriate orders in accordance with the provisions of section 18. (2) The Children's Court shall ensure that the final order, with regard to a child in conflict with law, shall include an individual care plan for the rehabilitation of child, including follow up by the probation officer or the District Child Protection Unit or a social worker. (3) The Children's Court shall ensure that the child who is found to be in conflict with law is sent to a place of safety till he attains the age of twenty-one years and thereafter, the person shall be transferred to a jail: Provided that the reformative services including educational services, skill development, alternative therapy such as counselling, behaviour modification therapy, and psychiatric support shall be provided to the child during the period of his stay in the place of safety.
35 - Surrender of children	(1) A parent or guardian, who for physical, emotional and social factors beyond their control, wishes to surrender a child, shall produce the child before the Committee. (2) If, after prescribed process of inquiry and counselling, the Committee is satisfied, a surrender deed shall be executed by the parent or guardian, as the case may be, before the Committee.
37 - Orders passed regarding a child in need of care and protection.	(1) The Committee on being satisfied through the inquiry that the child before the Committee is a child in need of care and protection, may, on consideration of Social Investigation Report submitted by Child Welfare Officer and taking into account the child's wishes in case the child is sufficiently mature to take a view, pass one or more of the following orders, namely:— (a) declaration that a child is in need of care and protection; (b) restoration of the child to parents or guardian or family with or without supervision of Child Welfare Officer or designated social worker; (c) placement of the child in Children's Home or fit facility or Specialised Adoption Agency for the purpose of adoption for long term or temporary care,

	keeping in mind the capacity of the institution for housing such children, either after reaching the conclusion that the family of the child cannot be traced or even if traced, restoration of the child to the family is not in the best interest of the child; (d) placement of the child with fit person for long term or temporary care; (e) foster care orders under section 44; (f) sponsorship orders under section 45; (g) directions to persons or institutions or facilities in whose care the child is placed, regarding care, protection and rehabilitation of the child, including directions relating to immediate shelter and services such as medical attention, psychiatric and psychological support including need-based counselling, occupational therapy or behaviour modification therapy, skill training, legal aid, educational services, and other developmental activities, as required, as well as follow-up and coordination with the District Child Protection Unit or State Government and other agencies;
53 - Rehabilitation and reintegration services in institutions registered under this Act and management thereof	(1) The services that shall be provided, by the institutions registered under this Act in the process of rehabilitation and re-integration of children, shall be in such manner as may be prescribed, which may include— (i) basic requirements such as food, shelter, clothing and medical attention as per the prescribed standards; (ii) equipment such as wheel-chairs, prosthetic devices, hearing aids, braille kits, or any other suitable aids and appliances as required, for children with special needs; (iii) appropriate education, including supplementary education, special education, and appropriate education for children with special needs: Provided that for children between the age of six to fourteen years, the provisions of the Right of Children to Free and Compulsory Education Act, 2009 shall apply; (iv) skill development; (v) occupational therapy and life skill education; (vi) mental health interventions, including counselling specific to the need of the child;

Juvenile Justice Rules, 2016

Rules	Details
11 - Completion of Inquiry	(5) Where the Board decides to release the child after advice or admonition or after participation in group counselling or orders him to perform community service, necessary direction may also be issued by the Board to the District Child Protection Unit for arranging such counselling and community service.
13 - Procedure in relation to Children's Court and Monitoring Authorities.-	(vi) When the child attains the age of twenty-one years and is yet to complete the term of stay, the Children's Court shall: (a) interact with the child in order to evaluate whether the child has undergone reformative changes and if the child can be a contributing member of the society. (b) take into account the periodic reports of the progress of the child, prepared by the Probation Officer or the District Child Protection Unit or a social worker, if needed and further direct that institutional mechanism if inadequate be strengthened. (c) After making the evaluation, the Children's Court may decide to: (ca) release the child forthwith; (cb) release the child on execution of a personal bond with or without sureties for good behaviour; (cc) release the child and issue directions regarding education, vocational training, apprenticeship, employment, counselling and other therapeutic interventions with a view to promoting adaptive and positive behaviour etc.;
19 - Procedure for inquiry	(9) Before the Committee releases or restores the child, both the child as well as the parents or guardians may be referred to the Counsellor.
21 - Manner of Registration of Child Care Institutions	(v) plan to provide services for children such as medical, vocational, educational, counselling, etc., in case of new applicants and details of such services provided in case of existing institutions ;

25 - After Care of Children Leaving Institutional Care	(iv) provision of a counsellor to stay in regular contact with such persons to discuss their rehabilitation plans ;
34 - Medical Care	(3) Every Child Care Institution may: (xi) provide or arrange for regular counselling of every child and ensure specific mental health interventions for those in need of such services, including separate rooms for counselling sessions within the premises of the institution and referral to specialised mental health centres, where necessary; and
35 - Mental Health	(5) Every institution shall have the services of trained counselors or collaboration with external agencies such as child guidance centres, psychology and psychiatric departments or similar Government and non-Governmental agencies, for specialised and regular individual therapy for the child, (7) No child shall be administered medication for mental health problems without a psychological evaluation and diagnosis by trained mental health professionals.
54 - Procedure in cases of offences against children	(10) An immediate need assessment of the child will be conducted in terms of the need for food, clothing, emergency medical care, counselling, psychological support and the same shall be immediately extended to the child at the police station. (18) During a trial involving children, as far as possible, the following norms may be followed to ensure a child-friendly atmosphere: (ii) Psychological counselling may also be provided to the child wherever necessary.
76 - Abuse and Exploitation of the Child	(2) In the event of any physical, sexual or emotional abuse, including neglect of children in an institution by those responsible for care and protection, the following action shall be taken namely: (iv) the Board or Committee shall take necessary steps to ensure completion of inquiry and provide legal aid as well as counselling to the child victim;
83 - Juvenile Justice Fund	(4) The Juvenile Justice Fund may be utilised by the State Government for the following purposes, namely:- (xiv) providing specialised professional services, counselors, translators, interpreters, special educators, social workers, mental health workers, vocational trainers etc. for the children covered under the Act;
92 - Inquiry in case of a Missing Child	(6) When a child is traced: (ii) the police shall send a report to the District Legal Services Authority which shall provide counselling and support services to the child and the family; and

POCSO Rules, 2012

4 - Care and Protection	(2) Where an SJPU or the local police, as the case may be, receives information in accordance with the provisions contained under sub-section (1) of section 19 of the Act in respect of an offence that has been committed or attempted or is likely to be committed, the authority concerned shall, where applicable, - (e) inform the child and his parent or guardian or other person in whom the child has trust and confidence of the availability of support services including counselling, and assist them in contacting the persons who are responsible for providing these services and relief; (5) In making determination under sub-rule (4), the CWC shall take into account any preference or opinion expressed by the child on the matter, together with the best interests of the child, having regard to the following considerations: (i) the capacity of the parents, or of either parent, or of any other person in whom the child has trust and confidence, to provide for the immediate care and protection needs of the child, including medical needs and counselling;
5 - Emergency medical care	4) The registered medical practitioner rendering emergency medical care shall attend to the needs of the child, including – (v) wherever necessary, a referral or consultation for mental or psychological health or other counselling should be made.

Convention on the Rights of the Child
Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989

Article 21	States Parties that recognize and/or permit the system of adoption shall ensure that the best interests of the child shall be the paramount consideration and they shall: (a) Ensure that the adoption of a child is authorized only by competent authorities who determine, in accordance with applicable law and procedures and on the basis of all pertinent and reliable information, that the adoption is permissible in view of the child's status concerning parents, relatives and legal guardians and that, if required, the persons concerned have given their informed consent to the adoption on the basis of such counselling as may be necessary;
Article 40	(3) (b) Whenever appropriate and desirable, measures for dealing with such children without resorting to judicial proceedings, providing that human rights and legal safeguards are fully respected. 4. A variety of dispositions, such as care, guidance and supervision orders; counselling; probation; foster care; education and vocational training programmes and other alternatives to institutional care shall be available to ensure that children are dealt with in a manner appropriate to their well-being and proportionate both to their circumstances and the offence.
Article 23	4. States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.
Article 39	States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child.

United Nations Standard Minimum Rules for the Administration of Juvenile Justice ("The Beijing Rules")

13 . Detention pending trial	13.5 While in custody, juveniles shall receive care, protection and all necessary individual assistance-social, educational, vocational, psychological, medical and physical-that they may require in view of their age, sex and personality.
26. Objectives of institutional treatment	26.2 Juveniles in institutions shall receive care, protection and all necessary assistance-social, educational, vocational, psychological, medical and physical-that they may require because of their age, sex, and personality and in the interest of their wholesome development .
18. Various disposition measures	18.1 A large variety of disposition measures shall be made available to the competent authority, allowing for flexibility so as to avoid institutionalization to the greatest extent possible. Such measures, some of which may be combined, include: (f) Orders to participate in group counselling and similar activities;

UN Guidelines for the Prevention of Juvenile Delinquency: the 'Riyadh Guidelines' (1990)

IV. Socialization processes	
A. Family	12. Since the family is the central unit responsible for the primary socialization of children, governmental and social efforts to preserve the integrity of the family, including the extended family, should be pursued. The society has a responsibility to assist the family in providing care and protection and in ensuring the physical and mental well-being of children. Adequate arrangements including day-care should be provided.
B. Education	21. Education systems should, in addition to their academic and vocational training activities, devote particular attention to the following: (b) Promotion and development of the personality, talents and mental and physical abilities of young people to their fullest potential;

	26. Schools should serve as resource and referral centres for the provision of medical, counselling and other services to young persons, particularly those with special needs and suffering from abuse, neglect, victimization and exploitation.
C. Community	32. Community-based services and programmes which respond to the special needs, problems, interests and concerns of young persons and which offer appropriate counselling and guidance to young persons and their families should be developed, or strengthened where they exist. 35. A range of services and helping measures should be provided to deal with the difficulties experienced by young persons in the transition to adulthood. Such services should include special programmes for young drug abusers which emphasize care, counselling, assistance and therapy-oriented interventions.
V. Social policy	45. Government agencies should give high priority to plans and programmes for young persons and should provide sufficient funds and other resources for the effective delivery of services, facilities and staff for adequate medical and mental health care, nutrition, housing and other relevant services, including drug and alcohol abuse prevention and treatment, ensuring that such resources reach and actually benefit young persons.

Annexure 2

General Notes for Facilitators

1. Since you will be dealing with community based workers as your trainees, please keep in mind that you are a trainer and not a preacher. Please keep your voice tones and pitch that of a friend and not someone with a higher status than your trainees. This is important as the trainees should not be in awe of your knowledge and personality. If the trainees are in awe of your knowledge and position, they will not share anything properly and only try to learn from you and it will become one way traffic.
2. Make the training as participatory as possible. You can only build on your participants' knowledge and skills as a trainer. In a 6 – 7 days training you will not be able to impart completely new knowledge and skill. This training manual will help you in building upon your trainees' knowledge and skills.
3. Always keep in mind that your trainees are community level workers who have immense knowledge and have high levels of coping and resilience capacity. You as a trainer are only building upon this capacity (that's why it is called capacity building). Never say anything or do any activity that looks down on them, their education, or their cultural practices.
4. Through this Training Manual and Activity Toolkit, you are only organising their work process and streamlining their professional tasks. The Training will build the capacity to organise and streamline their work.
5. The Sessions are built in a manner to build on the existing knowledge and skills.
6. The Sections on Assessment, Referral Pathways, Record Keeping and Reporting will have to be Project Specific. Involvement of the Project Staff along with the front line workers in transaction of this part of the training is crucial from the planning stage itself. This has to be negotiated and navigated very skilfully. These sections are practical in nature and pure theoretical application has every possibility of improper and undesirable results.

Session Plan

Day 1
Section 3 – Session 1, 2, 3, and 9

Day 2
Section 4

Day 3
Section 3 – Sessions 4. 5 and 6

Day 4
Section 3 – Sessions 8 and 10. Debriefing of 4 days

Day 5
Section 3 – Session 7. Section 5 – Assessment

Day 6
Section 5 – Assessment and Referral Pathways, Section 6 – Recording and Reporting