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“Prevalence of Mental Health Problems and Associated Psychosocial Factors Among Juveniles in Child Correction Homes in Nepal”

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LIST OF ABBREVIATIONS

ACEs: Adverse childhood experiences

ASEBA: Achenbach System of Empirically Based Assessment

ANOVA: Analysis of Variance

CBCL: Child Behaviour Checklist

YSR: Youth self-report

ADHD: Attention Deficit Hyperactivity Disorder

ODD: Oppositional Defiant Disorder

DSM: Diagnostic and Statistical Manual

SPSS: Statistical package of Social Sciences

WHO ACE-IQ: World Health Organization Adverse Childhood Experience International Questionnaire

BACKGROUND

Mental health problems in children and adolescents in conflict with law is found to be very common. Various social, economic and psychological factors are associated with children's involvement in committing crimes. Research related to mental health problems in this population has been carried out mainly in developed nations. There is, however very scant literature from developing countries and none from Nepal. Children in conflict with law being already vulnerable, ill understood and are often marginalized they are prone to mental health problems.[1] Research from the West shows that mental health problems may even predate the entry into juvenile system or may develop later.[2,3] The juvenile justice system must be able to identify youths with mental health needs as they enter and re-enter the system. Diversion, emergency responses, and long-range treatment planning can occur only if we have reliable ways to identify which youths have serious mental health needs, what those needs really are, and how they can be described in ways that promote rational responses to the youths' clinical conditions.[4] In addition, ACEs display a burden to children worldwide and it appears especially important in the context of juvenile delinquency. This study aims to estimate the prevalence of mental health problems in this population and explore ACE's. These findings would help us identify the magnitude of the problem, recommend and plan intervention for those in need.

This is an observational, cross sectional study at eight child correction homes across the Nepal. Children were interviewed and assessed using a semi structured proforma, child behaviour check list (Youth self-report) and WHO ACE- IQ. Since there has not been any study related to children in conflict with law, this study becomes very crucial to plan mental health services and train different stake holders in contact with this population according to the prevalence and different types of mental health problems.

Statement of the Problem

The prevalence rate of youth with mental disorders within the juvenile justice system is found to be consistently higher than those within the general population of adolescents.[4] The Criminal Codes of 2074 as well as the Children's Act, 2075 has defined children as those persons below 18 years. This has increased the number of children placed in the child correction home by 65% (the children from 16 to below 18 years) as per the research conducted by the Secretariat.[5] In the last fiscal year, there were 382 children in the eight child correction homes, whereas the number of such children increased to 821 (boys 798 and girls 23) in this fiscal year.[5]

This has resulted in the overcrowding of the child correction homes, the education, health and nutrition requirement of the children could be compromised and they may be more vulnerable to psychological distress leading to mental health problems. Given the growth of juvenile detainee populations, epidemiologic data on their mental health problems are increasingly important. Yet, there are no studies in Nepal in this regard. Until we have better epidemiological data, we cannot know how best to use the system's scarce mental health resources to meet the mental health needs of children in conflict with law.

Rationale/Justification:

Although extensive research on prevalence of mental health problems in juvenile offenders has been conducted in Western countries and few Asian countries, epidemiological research concerning this issue is non-existent. Due to the lack of research, inadequate models of care,

insufficient policy development, ineffective experience and training of staff, and inadequate practice has led to non-existent mental health services for the juvenile offenders with mental health concerns.

Prevalence studies have shown that here is a three to four-fold increase in the prevalence of psychiatric illnesses in juvenile offenders compared to the general population.[18,19] Furthermore, presence of more than one mental health problem is associated with a higher rate of repeat offending and recidivism. So, assessment of and intervention in mental health problems may also help prevent further offenses.[2]

In Nepal, there has been no study to explore mental health problems in juvenile offenders. To promote awareness of this issue, the magnitude of the mental health problems experienced by juvenile offenders must be investigated via epidemiological research. Finally, screening and recognition of mental health problems in juvenile offenders may help identify risk factors for continued criminal behaviours, facilitate treatment, and eventually lead to more positive outcomes.

Research Questions were as follows:

1. What is the prevalence of mental health problems in juvenile offenders residing in child correction homes of Nepal?
2. What are the factors associated with mental health problems in juvenile offenders?
3. What are the ACEs of juvenile offenders and is there any association of ACE with mental health problems in juvenile offenders?

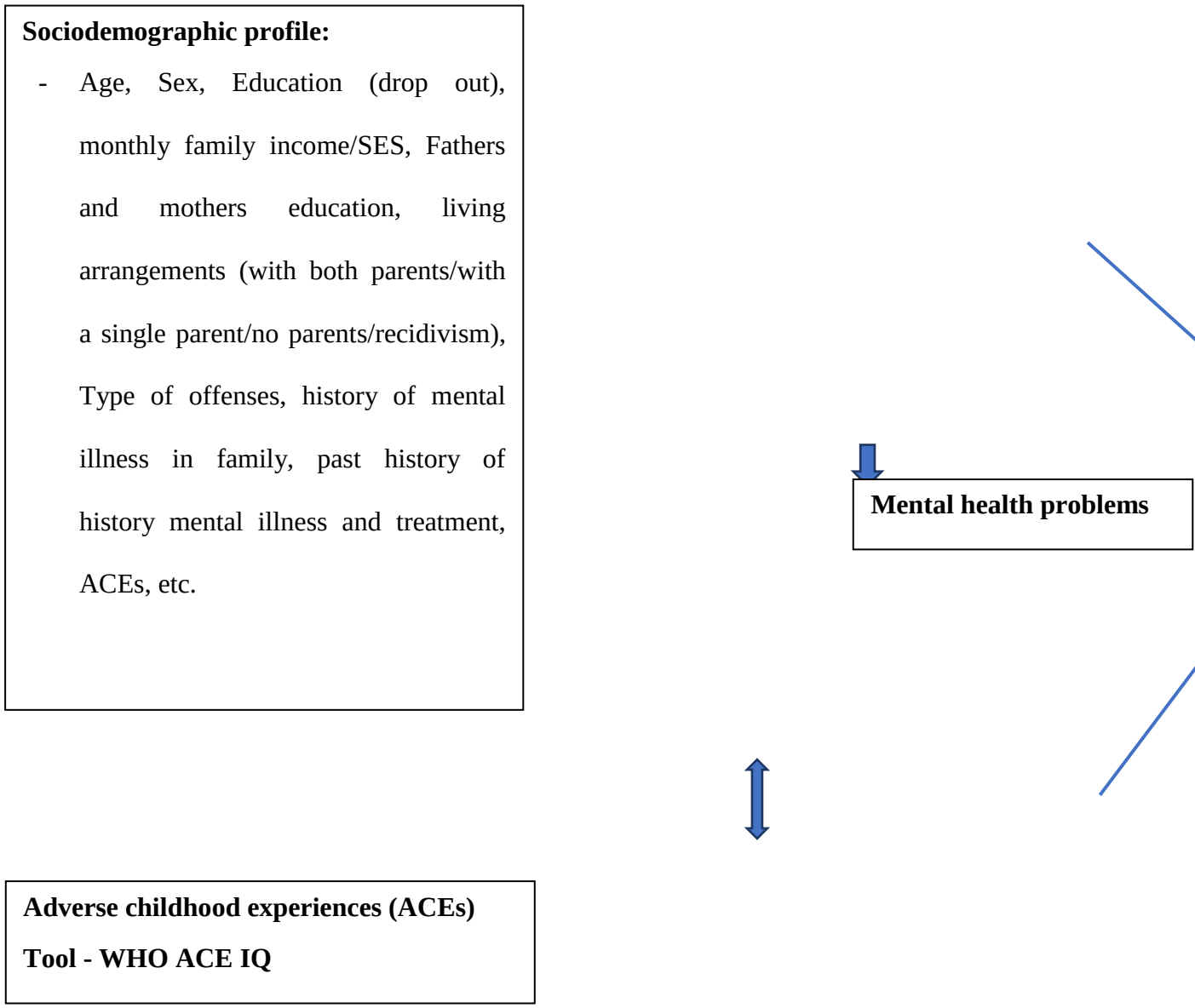
OBJECTIVES

The General objective of the study was to estimate the prevalence of mental health problems and associated factors in children and adolescents residing at various child correction homes in Nepal.

The Specific objectives were as follows:

1. To estimate the prevalence of mental health problems in children and adolescents living at child correction homes
2. To identify factors associated with mental health problems in juvenile offenders
3. To explore adverse childhood experiences (ACEs) in children and adolescents living at child correction homes.
4. To identify association between ACEs and mental health problems in juvenile offenders

Figure 1: Conceptual Framework



METHODS

Research Method: This is a quantitative, cross sectional study with census method at eight child correction homes across the country.

Study Site and its Justification: Eight child correction homes in eight districts were Morang, Parsa, Makwanpur, Bhaktapur, Kaski, Rupandehi, Banke and Doti. This study was proposed by the "Secretariat of Central Child Justice Committee", Ministry of Women, Children and Senior Citizens, the Government of Nepal Pulchowk, Lalitpur where the expectations from the study were to assess the status of mental health problems in all child correction homes run by the Government of Nepal. Therefore, the study intends to screen and assess the status of mental health status of all the adolescents residing in all child correction homes run by the Government of Nepal.

Exclusion criteria were any participant (study subject) who refuses to give assent and who were severely ill.

Sample Size

All children resided in child correction homes during the study period and who had given the assent (**N=670).**

Study variables

Dependent Variable were Mental health problems.

Independent Variables were Age, Sex, Education (drop out), monthly family income/SES, Fathers and mothers education, living arrangements (with both parents/with a single parent/no parents/recidivism), Type of offenses, history of mental illness in family, past history of history mental illness and treatment, ACEs, etc.

STUDY INSTRUMENTS

I. A semi-structured proforma – Age, Sex, Education (drop out), monthly family income/SES, Fathers and mothers education, living arrangements (with both parents/with a single parent/no parents/recidivism), Type of offenses, history of mental illness in family, past history of history mental illness and treatment, ACEs, etc.

II.Youth Self-Report (YSR) - Nepali version

The Achenbach System of Empirically Based Assessment (ASEBA) for school-age children includes three instruments for assessing emotional and/or behavioural problems: Child Behaviour Checklist (CBCL), completed by parents, Youth Self-Report (YSR), completed by adolescents between 11 to 18 years of age and Teacher's Report Form (TRF), completed by teachers. CBCL - YSR is already validated in Nepalese culture and language.

YSR covers eight domains of mental health.

1. Anxious/Depressed
2. Withdrawn/Depressed
3. Somatic Complaints
4. Social Problems
5. Thought Problems
6. Attention Problem
7. Rule-Breaking
8. Aggressive Behaviour

Internal Consistency: .76 - .95

Construct Validity: Thousands of studies related to association of scale scores and other variables - like DSM diagnoses, other similar scales (Conners, BASC), Genetic factors, Neurophysiological factors and other outcomes in adult

III. WHO Adverse Childhood Experiences International Questionnaire (WHO ACE-IQ)

The consequences of adverse childhood experiences (ACEs) such as child maltreatment and other traumatic stressors for health risk behaviours and long-term chronic diseases has been the focus of a growing number of studies. However many countries have yet to appreciate the major public health implications of ACEs and their lifelong consequences. For this recognition to spread requires that data on ACEs are collected as part of broader health and health risk behaviour surveys, and that the findings are used to advocate for and inform policies and programmes designed to reduce ACEs and promote safe, stable and nurturing relationships between children and their parent or caregivers.

The International ACE Research Network has produced the ACE-IQ which enabled the measurement of childhood adversities in all countries and comparisons of such adversities between them; the drawing of associations between childhood adversities and health risk behaviours and health outcomes in later life; advocacy for increased investments to reduce childhood adversities, and scientific information to inform the design of prevention programmes. ACE-IQ should always be integrated into broader health surveys. Although data about adversities on their own may be useful for some purposes, the real value of ACE-IQ lies in demonstrating the associations between early exposures to ACEs and subsequent risk behaviours and health outcomes. It is only by integrating ACE-IQ into broader health surveys that such associations can be measured. When the ACE-IQ is administered as part of broader health surveys it should be included in the middle of the instrument to ensure that an adequate level of rapport between the interviewer and respondent can be established before asking the sensitive questions it contains. As some of the questions in the ACE-IQ may cause upset for a

participant it is strongly recommended that wherever the ACE-IQ is implemented a list of reputable, reliable and responsible local services should be available, so that the interviewer can direct the participant to the appropriate source of help or support. The ACE-IQ can be translated into the appropriate language for use in the country where it's being delivered, but the normal procedures of translation and back translation must be followed in order to ensure the fidelity of the translation.

PERMISSION, TRANSLATION AND BACK TRANSLATION

The permission was obtained from the Authors to use both tool in this research. CBCL is already translated and validated in Nepalese population. ACE-IQ was translated in Nepalese language. Two experts translated the original English questionnaire to Nepali. Two professional translators then independently translated the Nepali version back to English. Finally, two investigators were discussed the differences and a consensus were reached for the final Nepali version.

Pre-testing the Data Collection Tools

Pretesting of the WHO ACE-IQ was done with 10% sample with the similar setting.

Data Management

The collected data was reviewed, organized and coded. Data were checked for its completeness and accuracy. Each collected data was coded, categorized and kept in researcher's locked archive. After completion of data collection, those data were entered and analyzed by using Statistical Package of Social Sciences (SPSS) version 26. Data was analyzed by using descriptive (mean, standard deviation, frequency, percentage) and inferential statistical method (chi-square test and bivariate analysis) were done. The findings were presented in tables and figures.

DATA ANALYSIS

The ASEBA data management and SPSS statistics version 26.0 for Windows were used for all analyses. Descriptive analysis was carried out using mean and standard deviation with range for continuous variables including socio-demographic profile. Statistical data was analyzed by percentage, median, mean and standard deviation. Pearson's chi-square test was done for categorical variables. Analysis of variance (ANOVA) was used for continuous variables. Multiple linear regression analysis was carried out to estimate the association between childhood adverse experience and mental health problems. Statistical significance was defined at 0.05 level.

Plan for Dissemination of Research Results

It will be published in the peer-reviewed journal. Possible attempt will be made to get it published in international journal with high impact factor.

Plan for Utilization of the Research Findings (optional)

The findings can be used for policy making for effective dissemination of mental health services for this marginalized and ill understood population.

ETHICAL CONSIDERATION

Ethical approval was obtained from the Ethical Review Board (ERB) of Nepal Health Research Council. Before enrollment in the study, all participants received an explanation of the aims, objectives and background of the study. They were also be informed regarding the risks and benefits from the study. The participants were children under 18 years old. Legal Gurdian were asked to provide written informed consent prior to data collection. Assent was taken with all participants. Anonymity and confidentiality of the participant was maintained throughout the study. They had the right to withdraw from the study at any point, if they wished, without any negative repercussions.

REFERRAL SYSTEM FOR THE ADOLESCENTS WHO HAVE SUICIDE AND SELF-HARM

Identification of the problem according to the Youth self -rating forms (YSR) rating done by the participants. Further risk assessment of the participants who had suicidal ideas and self-harm behaviours were done by the counsellors. The In charge of the respective CCH was informed if the participants needed further evaluation & counselling. Asked for referral to nearest medical college & hospital with psychiatry services or Tele video consultation with Kanti Children's Hospital was planned if the participants needed advance level of management.

FINDINGS OF THE STUDY

Part I: Demographic Information

Table 1: Distribution of participants in eight centres

Site	Number of participants	Percent (%)
Morong	168	25.1
Bhaktapur	121	18.1
Banke	102	15.2
Kaski	84	12.5
Rupandehi	72	10.7
Parsa	46	6.9
Doti	41	6.1
Makwanpur	36	5.4
Total	**670**	**100%**

Above table shows that highest number of participants were from Morong center (i.e.25.1%) followed by Bhaktapur(i.e.18.1%), Banke(i.e.15.2%), Kaski(i.e.12.5%), Rupandehi(i.e.10.7%),Parsa (i.e.6.9%), Doti(i.e.6.1%) and Makwanpur centers(i.e.5.4%).

Table 2: Types of Crime

Types	Frequency	Percent (%)
Sexual Harassment/ Rape	218	32.5
Property Destruction/Stealing	177	26.4
Murder/ Attempt to murder	65	9.7
Substance use/ Driving	62	9.3
Small Crime	15	2.2
Others	24	3.5
Total	**670**	**100%**

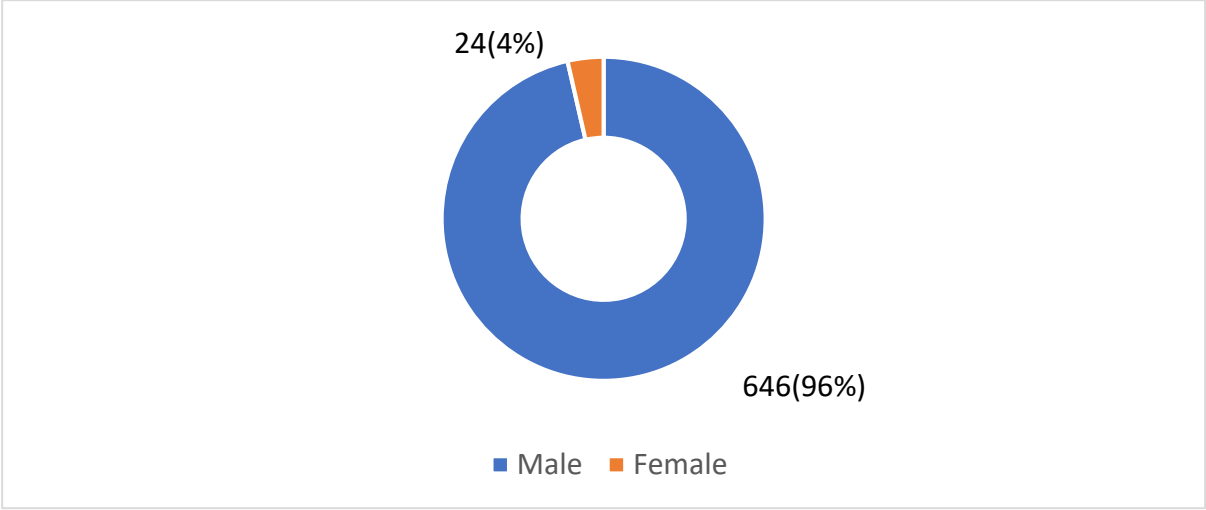
Above table indicates that the highest number of participants (i.e., 32.5%) were accused of Sexual Harassment/ Rape followed by Property Destruction/Stealing (i.e., 26.4%), Murder/ Attempt to Murder (i.e., 9.7%), Substance Use/ Driving (i.e., 9.3%), Small Crime (i.e., 2.2%), Others (i.e., 2.2%), Serious Crime(i.e., 0.7%) and Extreme Form of Crime (i.e., 0.6%).

Table 3: Distribution according to age

Age	Frequency	Percent (%)
Below 15 (11-14yrs)	45	6.96
Above 15 (15-18yrs)	601	93.04
Total	**646**	**100%**

Above table shows that 93.04% participants were above 15 years old. However, 24 (3.6%) did not disclose their actual age and those were not included in the analysis.

Figure 2: Distribution according to Gender



Above pie chart shows that 96% participants were boys.

Table 4: Family Income of Participants

Income	**Frequency**	**Percent (%)**
Less than Rs10000	295	46.03
More than Rs 10000	346	53.97
Total	**641**	**100%**

Above table shows that 53.97% participants were reported more than 10,000 monthly family incomes and 46.03% participants were reported less than 10,000 monthly family incomes. However, 4.3% did not disclosed their actual monthly family income and those were not included in the analysis.

Table 5: Prevalence of self-harm (suicidality)

Site	**Frequency (%)**
Bhaktapur	30 (4.47%)
Rupandehi	19 (2.83%)
Banke	19 (2.83%)
Morang	13 (1.94 %)
Kaski	12 (1.79%)
Doti	12 (1.79%)
Makwanpur	11(1.64%)
Parsa	4 (0.59%)
Total	**120 (17.9%)**

Above table exhibits that altogether 17.9% (N=120) participants had reported suicidality.

Table 6: Availability of counselling services

Present	Absent
Bhaktapur	Parsa
Banke	Doti
Kaski	Makwanpur
Rupandehi	Morang

Above table indicates that Bhaktapur, Banke, Kaski and Rupandehi centers had counselling services.

Table 7: Total reaches of counselling services (According to number of participants residing on those centres)

Counselling services	Frequency	Percent (%)
No	291	43.4
Yes	379	56.6
Total	**670**	**100%**

Above table shows that 56.6% participants were on the reach of counselling services as counsellors were available in the four centers of child correction homes.

Table 8: Findings of ACEs Scale

a.		**Frequency**	**Percent (%)**
Community Violence	No	198	30.09
	Yes	460	69.91
	Total	**658**	**100%**
	missing	**12**	**1.8**
b.		**Frequency**	**Percent (%)**
Collective violence	No	355	54.2
	Yes	301	45.8
	Total	**656**	**100%**
	Missing	**14**	**2.1**
c.		**Frequency**	**Percent (%)**
Someone chronically depressed, mentally ill, institutionalized or suicidal	No	605	93.6
	Yes	41	6.4
	Total	**646**	**100%**
	Missing	**24**	**3.6**
d.		**Frequency**	**Percent (%)**
Alcohol and/or drug abuser in the household	No	507	78.1
	Yes	142	21.9
	Total	**649**	**100%**
	Missing	**21**	**3.1**
e.		**Frequency**	**Percent (%)**
Bullying experience	No	165	25.03
	Yes	494	74.97
	Total	**659**	**100%**
	Missing	**11**	**1.6**
f.		**Frequency**	**Percent (%)**
Sexual contact or sex abuse	No	524	79.04
	Yes	139	20.96
	Total	**663**	**100%**
	Missing	**7**	**1.0**

g.		Frequency	Percent (%)
Physical abuse	No	423	63.80
	Yes	240	36.19
	Total	**663**	**100%**
	Missing	**7**	**1.0**
h.		**Frequency**	**Percent (%)**
Emotional abuse	No	342	51.50
	Yes	322	48.49
	Total	**664**	**100%**
	Missing	**6**	**0.9**
i.		**Frequency**	**Percent (%)**
Emotional Neglect	No	35	5.34
	Yes	620	94.65
	Total	**655**	**100%**
	Missing	**15**	**2.2**
j.		**Frequency**	**Percent (%)**
Household member treated violently	No	371	56.04
	Yes	291	43.95
	Total	**662**	**100%**
	Missing	**8**	**1.2**
k.		**Frequency**	**Percent (%)**
Parental loss, separated, divorced	No	420	63.54
	Yes	241	36.45
	Total	**661**	**100%**
	Missing	**9**	**1.3**

Interpretation of above table:

a. There were 69.91% participants had experienced community violence whereas 30.09% had never experienced such violence in the community. However, 1.8% did not provided information regarding the issues and those were not included in the analysis.

b. Above table indicates that 45.8% adolescents had experienced collective violence whereas 54.2% never experienced such violence. However, 2.2% did not provide information regarding the issues and those were not included in the analysis.

c. Above table shows that 93.6% participants reported that there were no chronically depressed, mentally ill, institutionalized or suicidal in the family. However, 3.6% did not provide information regarding the issues and those were not included in the analysis.

d. Above table demonstrates that 21.9 % participants reported problem of alcohol and drug abuser in the household. However, 3.1% did not provide information regarding the issues and those were not included in the analysis.

e. Above table shows that more than half (i.e., 74.97%) of participants reported bullying experienced in their childhood period. However, 1.6 % did not provide information regarding bullying experiences and those were not included in the analysis.

f. Above table shows that 20.96% of participants reported having any experiences **of Sexual contact or sex abuse** in their childhood period. However, 1.0% did not provide information regarding sexual contact or sexual abuse experiences and those were not included in the analysis.

g. Above table shows that 36.19% of participants reported having experiences of **Physical abuse** in their childhood period. However, 1.0 % did not provide information regarding physical abuse and those were not included in the analysis.

h. Above table shows 48.49% of participants reported having experiences of **Emotional abuse** in their childhood period. However, 0.9 % did not provide information regarding emotional abuse and those were not included in the analysis.

i. Above table shows that 94.65 % participants reported experiences of Emotional neglect in their childhood period. However, 2.2 % did not provide information regarding emotional neglect and those were not included in the analysis.

j. Above table demonstrates that 43.95% of participants reported having experiences of their Household member treated violently. However, 1.2 % did not provide information regarding Household member treated violently and those were not included in the analysis.

k. Above table exhibits that 36.45% adolescents reported that there were Parental loss/ separated /divorced in their childhood period. However, 1.3 % adolescents did not provide any information regarding parental loss/ separation and divorced in their family and those were not included in the analysis.

Part II. Prevalence of Mental Health Problem

Table 9: Mental Health Problems according to YSR- broadband (Externalizing& Internalizing) criteria and their Gender

	Gender		Total
	Female N=24	Male N= 646	N=670
Externalizing problems			
Normal	21(87.5%)	455 (70.4%)	476 (71.0%)
borderline	1 (4.2%)	40 (6.2%)	41 (6.1%)
clinical	2 (8.3%)	151 (23.4%)	153 (22.8%)
Internalizing problems			
Normal	8 (33.3%)	248 (38.4%)	256(38.2%)
borderline	5 (20.8%)	108(16.7%)	113 (16.9%)
clinical	11 (45.8%)	290 (44.9%)	301 (44.9%)
Total Problems			

Normal	12 (50%)	346 (53.6%)	358 (53.4%)
borderline	6 (25%)	99 (15.3%)	105 (15.7%)
clinical	6 (2.9%)	201 (31.1%)	207 (30.9%)

Table 1 shows the number of girls were very less in number (N=24) in comparison to boys (N= 646). Regarding the Total problems, 2.9 % girls and 31.1 % boys scored in the clinical range whereas in the Externalizing problems, 8.3% girls and 23.4% boys scored in the clinical range. However in the Internalizing problems, 45.8% girls and 44.9% boys scored in the clinical range.

Table 10: Mental Health Problems according to DSM oriented scales and eight syndrome scales of YSR

DSM oriented scales			
T scores	**Normal (<64 t score)**	**Borderline (65-69 t score)**	**Clinical (>70 t score)**
ADHD	636 (94.9%)	20 (3.0%)	14 (2.1%)
ODD	642 (95.8%)	1(0.1%)	27 (4.0%)
Somatic	484 (72.2%)	84 (12.5%)	102 (15.2%)
Conduct	555 (82.8%)	37 (5.5%)	78 (11.6%)
Affective	473 (70.6%)	90 (13.4%)	107 (16.0%)
Anxiety	537 (80.1%)	65 (9.7%)	68 (10.1%)
Total		**297 (44%)**	**396 (59%)**
Eight syndrome scales			
T scores	**Normal (<64 t score)**	**Borderline (65-69 t score)**	**Clinical (>70 t score)**
Anxious depressed	454 (67.8%)	91 (13.6%)	125 (18.7%)
Withdrawn	537(80.1%)	50 (7.5%)	83 (12.4%)
Somatic	514(76.7%)	35 (5.2%)	121 (18.1%)
Social	430 (64.2 %)	134 (20.0%)	106 (15.8%)
Thought	544 (81.2%)	58 (8.7%)	68 (10.1 %)
Attention	602 (89.9%)	45 (6.7%)	23 (3.4%)
Rule Breaking	538 (80.3%)	64 (9.6%)	68 (10.1%)
Aggression	563 (84.0%)	47 (7.0%)	60 (9.0%)

The prevalence of emotional/behavioural problems was calculated according to the YSR manual (Achenbach & Rescorla, 2001), that is, based on cut-off points indicating normal, borderline or clinical range of emotional/behavioural problems.

Anxious depressed, Withdrawn, Somatic, Social, Thought, Attention, Rule Breaking and Aggression are the different emotional and behavior problems identified in the Eight Syndrome Scale according to the YSR Manual. According to this scale findings, 18.7% of adolescents had the problem of Anxious depressed, 12.4% of adolescents had the problem of withdrawn, 18.1% adolescents had reported somatic problems, 15.8% of adolescents had social problems, 10.1% of adolescents had thought problem and rule breaking problems, 3.4%

of adolescents had attention problem and 9% of adolescents had reported aggression problem were in the clinical range.

However, in the DSM oriented scales, 2.1% of the adolescents had attention-deficit/hyperactivity problems (ADHD), 4% of the adolescents had oppositional defiant problems (ODD), 15.2% of the adolescents had Somatic problems, 11.6% of the adolescents had conduct problem, 16% of the adolescents had affective problems and 10.1% of the adolescents had anxiety problem which all were in the clinical level. The six DSM-oriented scales of YSR are: (1) affective problems (2) anxiety problems (3) somatic problems (4) ADHD (5) ODD and (6) conduct problems.

Table 11: Adverse Childhood Experience (ACE) with Total problems

ACE Score	N %
<4	184 (28.4%)
>4	464 (71.6%)
Total	**648 (100%)**

Table 11 indicates that participants who scored <4 scores on ACE scale were 28.4% and participants who scored >4 scores on ACE scale were 71.6%.However, 22 (3.28%) did not provide overall information regarding their childhood adverse experiences and those were not included in the analysis.

Table 12: Diagnosis according to DSM oriented Scale of YSR

DSM Diagnosis	Frequency	Percent (%)
Normal(No diagnosis)	474	70.7
One diagnosis	152	22.7
Two diagnosis	37	5.5

Three diagnosis	6	.9
Four diagnosis	1	.1
Total	**670**	**100%**

Above table indicates that 196(670-474=196 i.e. 29.2%) participants met the at least one of the clinical diagnosis according to DSM criteria where 22.7% adolescents met one diagnostic criteria, 5.5% met the two diagnostic criteria,0.9% met the three diagnostic criteria and 0.1% met the four diagnostic criteria.

Table 13: Diagnosis according to Broad band (Internalizing and externalizing problem) Scale of YSR

Problems	Frequency	Percent (%)
No diagnosis	336	50.2
1 Diagnosis	214	31.9
2 Diagnosis	120	17.9
Total	**670**	**100%**

Above table suggested that 334 (214+120=334, i.e. 49.8%) participants had either of the internalizing and externalizing problems in the clinical rage.

Part III. Association between Total Problem Scores (YSR) and ACEs Scale

Table 14: Association between Total Problem Scores and ACE Variables

Variable	B	SE	Partial eta squared	Significance
Emotional abuse in child A1 A2 (Reference group: No)	0.164	0.069	0.008	**0.018**
Physical abuse in child A3 A4	0.157	0.072	0.007	**0.029**

(Reference group: No)				
Sexual abuse in child A5 A6 A7 A8 (Reference group: No)	0.044	0.085	0.000	0.602
Alcohol and drug abuse F1 (Reference group: No)	-0.049	0.088	0.000	0.581
Someone chronically depressed in family F2. (Reference group: No)	0.105	0.795	0.001	0.427
Incarcerated household F3 (Reference group: No)	0.122	0.126	0.001	0.332
One or no parents OR parents separated OR divorced F4 F5 (Reference group: No)	0.142	0.072	0.006	**0.050**
Violence in the family F6 F7 F8 (Reference group: No)	0.092	0.070	0.003	0.190
Emotional Neglect P1P2 (Reference group: Yes)	-0.309	0.155	0.006	**0.046**
Physical Neglect in child P3P4 (Reference group: No)	-0.039	0.070	0.000	0.573
Bullying and conflict of bullying (Reference group: Yes)	-0.155	0.080	0.006	**0.053**
Community violence V4 V5 V6 (Reference group: Yes)	-0.162	0.076	0.007	**0.032**
Collective violence V78910 (Reference group: No)	0.082	0.070	0.002	0.241
ACE total scores (Reference group: score >4)	-0.196	0.075	0.010	**0.010**
Environment				
Counseling service at correction home (Reference group: Yes)	-0.306	0.068	0.029	**0.000**
Age (Reference group: > 15 years)	0.080	0.098	0.001	0.417

The above table can be interpreted as:

- Adolescents who experienced emotional abuse in childhood had total problem score **0.164** times higher compared to Adolescents who never experienced emotional abuse and the difference was significant (p value **0.018**).

- Adolescents who experienced physical abuse in their childhood had total problem score **0.157** times higher compared to Adolescents who never experienced physical abuse and the difference was significant (p value **0.029**).
- Adolescents who had one or no parents or, parents separated or divorced had total problem score **0.142** times higher compared to Adolescents who were staying with their parents during their childhood and the difference was significant (p value **0.050**).
- Adolescents who never experienced emotional neglect in childhood had total problem score **0.039** times lesser compared to Adolescents who experienced emotional neglect in childhood and the difference was significant (p value **0.046**).
- Adolescents who never experienced Bullying and conflict of bullying had total problem score **0.155** times lesser compared to Adolescents who experienced Bullying and conflict of bullying and the difference was significant (p value **0.053**).
- Adolescents who never experienced community violence had total problem score **0.162** times lesser compared to Adolescents who experienced community violence and the difference was significant (p value **0.032**).
- Adolescents who had less than 4 ACE total scores has **0.196** times lesser total problem score compared to Adolescents who had more than 4 ACE total score and the difference was significant (p value **0.010**).
- Adolescents who had no counseling service at correction home has total problem score **0.306** times lesser compared to Adolescents who had counseling service at correction home and the difference was significant (p value **0.000**).

CONCLUSION

This study concluded that 334 49.8%) (i.e. 74.3%) participants had either of the internalizing and externalizing emotional and behavioral problems in the clinical rage. There were 29.2% participants who met at least one of the clinical diagnoses according to DSM criteria where

22.7% adolescents met one diagnostic criteria, 5.5% met the two diagnostic criteria, 0.9% met the three diagnostic criteria and 0.1% met the four diagnostic criteria. Moreover, 17.9% participants had reported suicidality. There is highly significant difference between adverse childhood effects (i.e., physical abuse, emotional abuse, be with one or no parents or, parents separated or divorced, emotional neglect, bullying and conflict of bullying, community violence and availability of counseling service) with total emotional and behavioral problems of participants as p value found as **0.029, 0.018, 0.050, 0.046, 0.053, 0.032** and **0.000** respectively. These all **p-values** were less or equal to **0.05**. However, correlation is weak on all domains except in relation to counselling services and total problem scores. More surprisingly, there is moderate negative correlation between availability of counselling services and having total emotional and behavioral problems. This could be due to more aware of mental health symptoms among who received counselling.

RECOMMENDATIONS

1. The overall prevalence of mental health problems in clinical range is between 29 to 49.8% %. To find out the exact prevalence we need to conduct detailed mental health survey that will include one to one clinical interview will be necessary by a child mental health consultant. So that their problems can be identified and managed on time.

2. As there are significant mental health problems in juveniles who are receding in correction facilities there is an urgent need to address this problem. Trained and competent mental health providers (counsellors/Psychologist/Psychiatrist) should be recruited

3. to address the problems.

4. Introduction of "Crisis Hot line" or other way to seek help inside the Child Correction Homes will also be valuable to increase the access to mental health treatment.
5. Environmental Changes such as reducing overcrowding, providing enough recreational and sufficient nutrition will be important.
6. Providing specialized intervention such as structured counselling/psychotherapy, motivational enhancement, "Life Skills Education" and substance abuse relapse prevention will be critical to promote overall well being and reduce future incarceration.
7. As significant number of youths in these correction homes are there due to sexual abuse offences, special program should be developed for treatment of these sexual abuse offenders to reduce future offences.
8. Community awareness is necessary regarding rearing and child protection.
9. School mental health promotion including "Life Skills Education" should be incorporated in schools to reduce overall mental health promotion and to reduce criminal offences.
10. As we have seen significant ACEs in these youths there needs to be psycho-social intervention in community/school to address these issues.

Limitation of the Study

1. Study technique: This study was a cross sectional study that was estimated of point prevalence.

2. Data collection: Due to the current situation of COVID-19 pandemic we were unable to complete the data collection on time because of participants themselves were infected in few centres. Some of socio-demographic data and other data that were missing on initial phase couldn’t be obtained with repeat visit due to travel restrictions.

3. Bias due to lockdown: Due to lockdown and restrictions being imposed due to COVID-19, the mental health problems of the children might be increased. However, couldn't able to assess those factors directly.

4. Reliability of information and Recall Bias: As parents/caregivers were not participated in the study, it has to be relied on children's information and there might be a chance of recall bias on ACE scale findings as they have to give the answers regarding to their early childhood experiences.

Appendix 1:

अध्यन सम्बन्धि जानकारी पत्र

शीर्षक

नेपालका बालसुधार गृहमा रहेका किशोर-किशोरीहरुमा मानसिक स्वास्थ्य समस्याहरुको परिणाम र सम्बन्धित कारकहरुको व्यापकता पता लगाउने "एक क्रस-अनुभागीय अध्ययन" **[Prevalence of mental health problems and associated factors among juveniles in child correction homes in Nepal: "a cross-sectional study"]**

अध्ययनको उद्देश्य

यो अध्ययनको उद्देश्य भनेको किशोर-किशोरीहरूको भावनात्मक र/अथवा व्यवहारमा देखिने समस्याहरू कस्ता खालका छन् भन्ने पता लगाउनु हो । यसले नेपाल भरिका वाल सुधार गृहमा रहेका किशोर-किशोरीहरूका समस्याहरूको परिमाणको बारेमा ज्ञान दिन सक्छ र यी किशोर-किशोरीहरूलाई कसरी सहयोग गर्ने भन्ने योजनामा हामीलाई सहयोग गर्छ । यस्तै खालका अनुसन्धान संसारभरि अन्य धेरै राष्ट्रहरूमा गरिएका छन् र जसले धेरै वालवालिकाहरूमा समस्याहरू छन् भन्ने देखाएको छ । यो स्वास्थ्य सेवाहरूको योजनामा महत्वपूर्ण हुन सक्छ ।

अध्ययन कसरी र को द्वारा गरिदैछ ?

कान्ति बाल अस्पताल काठमाडौंको बाल तथा किशोर Outpatient Clinic (बाह्य रोगी परीक्षण क्लिनिक)का डा अरुण राज कुवर यो अनुसन्धान अध्ययको लागि उत्तरदायी हुनुहुन्छ । यसबाट यो कार्य उच्च स्तरको हुनेछ भन्ने सुनिश्चित हुनेछ । यस अध्ययनको परिणाम राष्ट्रिय, अन्तराष्ट्रिय वैज्ञानिक समाचार पत्रहरूमा प्रकाशित गरिनेछ । यदि तपाई यस अध्ययनमा सहभागी हुन चाहनुहुन्छ भने तपाईलाई प्रश्नावली भर्न दिइनेछ तपाइले अनुभव गरेको भावनात्मक अथवा व्यवहारसम्बन्धी समस्याहरूको बारेमा भएका प्रश्नहरू उत्तर दिन लगाइनेछ । तपाईले चाहेमा एउटा अनुसन्धान सहायकले तपाईलाई यो भर्न मद्दत पुऱ्याउनेछ । सबै अनुसन्धान सहायकहरू राम्रो ज्ञान भएका स्वास्थ्य कर्मीहरू छन् र सूचकहरूको सुपरिवेक्षण गर्न विशेष तालिम प्राप्त गर्नेछन् । तपाईलाई फारम भर्न करीब आधा घण्टा लाग्नेछ ।

गोप्यनियता

यस अध्ययनको अभिलेखहरू पूर्णतया गोप्य राखिनेछ । अनुसन्धान तथ्यांक कसैले खोल्न नमिल्ने गरी फाइलमा राखिनेछ र सबै इलेक्ट्रोनिक सूचना साङ्केतिक तथा गोप्य रुपमा पासवर्डद्वारा सुरक्षित फाइलमा राखिनेछ । यो तथ्यांङमा अनुसन्धान कर्ता र अनुसन्धान सुपरिवेक्षकहरू बाहेक अरु मानिसहरूको पहुँच हुनेछैन । हामीले प्रकाशित गर्ने कुनै प्रतिवेदनमा कुनै सूचना दिने छौंनौं ताकि कसैले तपाईलाई पहिचान गर्न सम्भव नहोस् ।

अध्ययनमा सहभागीताको लागि स्वास्थ हेरचाह लाभ

यस अध्ययनमा सहभागिताबाट हुने स्वास्थ हेरचाह लाभ भनेको तपाईको बच्चाको संवेगात्मक अथवा व्यवहार सम्बन्धी समस्याहरू पत्ता लाग्नेछ । यदि आवश्यक भएमा तपाईको बच्चालाई कान्ति बाल अस्पताल र कान्ति बाल अस्पतालमा कार्यरत बाल मनोचिकित्सक/बाल मनोवैज्ञानिकबाट स्वास्थ्य उपचार र/अथवा मनोवैनिक सहयोग प्रदान गरिनेछ । यो वास्तवमा अनिवार्य होइन, तपाईले निर्णय गर्न सक्नुहुनेछ । यदि तपाईको बच्चालाई केहि समयोग चाहिदैन भने तपाईको सहभागिता सधैंको लागि कदरयोग्य हुनेछ किन कि यसले अध्ययनलाई सफल बनाउनेछ र बालबालिकाको मानसिक स्वास्थ्य समस्याहरूको बारेमा विद्यालयमा सचेतना ल्याउन र रोकथाम गर्न सकिनेछ ।

अध्ययनमा सहभागिताबाट सम्भव जोखिम/असुविधा

यस अध्ययनको सहभागिताबाट खासै देखिने खालको अपेक्षित जोखिम छनै । हुन सक्छ कसैले आफूसँग भएको समस्याहरूको बारेमा सोचेर असुविधा महशुस गर्न सक्नेछन् । यदि त्यस्तो भएमा उहाँहरू अनुसन्धानकर्ता/अनुसन्धान सहायकसँग कुराकानी गर्न सम्पर्क गर्न सक्नुहुनेछ ।

अध्ययन अस्विकार गर्न अथवा अध्ययनबाट पन्छिने अधिकार

यस अध्ययनमा सहभागी हुने निर्णय पूर्णतय तपाईको हुनेछ । तपाईं कुनै पनि बेला यस अध्ययनको अनुसन्धानकर्तासँगको सम्बन्धलाई प्रभाव नपार्ने गरी वा यस अध्ययनबाट प्राप्त गर्ने लाभ नगुमाउने गरी यो अध्ययनमा भाग लिन अस्विकार गर्न सक्नुहुनेछ ।

प्रश्नहरू वा सम्बन्धित प्रतिवेदनको बारेमा सोध्ने अधिकार

यो अनुसन्धान अध्ययनको बारेमा अध्ययन अधि अध्ययन अवधिमा वा अध्ययन पश्चात् प्रश्न सोध्ने अधिकार हुनेछ । यदि तपाईलाई यस अध्ययनको बारेमा जिज्ञासा छ भने मलाई कुनै पनि बेला सम्पर्क गर्न सक्नु हुनेछः डा अरुण राज कुवर फोनः ९८५११०२३७८, इमेल इमेलः arunkunwar@yahoo.com या चिठ्ठिबाट सम्पर्क गर्न सक्नुहुनेछ ।

स्विकृति

तपाईको हस्ताक्षरले तपाईले यो अनुसन्धान अध्ययनमा सहभागी हुन निर्णय गर्नुभएको छ भन्ने दर्शाउँछ र तपाईले यहाँ दिइएको जानकारी पढ्नुभएको र बुझ्नुभएको छ भन्ने दर्शाउँछ ।

डा अरुण राज कुवर

बाल र किशोर बाह्य विरामी परीक्षण क्लिनिक कान्ती बाल अस्पताल, काठमाडौं

(फोन : ९८५११०२३७८ इमेलः arunkunwar@yahoo.com)

Appendix 2:Concent/Assent

INFORMED CONSENT FORM

सुसूचित मन्जुरीनामा

डा अरुण राज कुवर ले गर्न लाग्नु भएको "Prevalence of mental health problems and associated factors among juveniles in child correction homes in Nepal" शिर्षकको अनुसन्धान सम्बन्धी संलग्न 'जानकारी पत्र/पुस्तिका' सुनेर/पढेर र प्रश्नोत्तर समेत गरेर यो अध्ययन-अनुसन्धान सम्बन्धमा जानकारी प्राप्त भयो।

यो अनुसन्धान कार्यमा मेरो सहभागिता मेरो व्यक्तिगत इच्छामा भर पर्ने र मैले चाहेको खण्डमा कुनै पनि बेला यो अनुसन्धान प्रक्रियाबाट बाहिरिन पाउने भन्ने कुरा मैले बुझेको छु। यसको लागि मैले कुनै कारण दिनु नपर्ने र त्यसबाट मैले पाउने सेवा र मेरो कानुनी अधिकारमा असर नपर्ने समेत मलाई बुझाईएको छ।

यस अनुसन्धानको प्रतिवेदन वा सम्बन्धित प्रकाशित कृतिहरुमा मेरो कुनै व्यक्तिगत परिचय खुल्ने जानकारी प्रकाशित हुने छैन भन्ने कुरा मैले बुझेको छु।

यी सबै कुराहरु जानी-बुझी, म यस अध्ययन-अनुसन्धानमा सहभागी हुन स्वेच्छाले राजी भई यो सुसूचित मन्जुरीनामामा सहिछाप गरेकोछु।

सहभागीको सही_____

सहभागीको नाम थर

_____

मिति २०७७ / /

दायाँ	बायाँ

सहभागीको बुढीऔंलाको ल्याप्चे

साक्षी (बालसुधार गृहका इन्चार्ज) को सही _____

साक्षी (बालसुधार गृहका इन्चार्ज) को नाम थर _____

मिति २०७७ / /

Appendix 3:

१. बिवाह		
१.१ [एम १]	के तपाइको विवाह भइसकेको छ ?	हो/छ होइन/छैन (प्रश्न नं. एम ५ मा जानुहोस्) भन्न मन छैन
१.२ [एम २]	बिवाह हुँदा तपाइको उमेर कति थियो ?	उमेर [ ][ ] भन्न मन छैन
१.३ [एम ३]	के तपाइले पहिलो पटक बिवाह हुँदा आफ्नो श्रीमान /श्रीमती आफैले रोज्नु भएको हो?	हो (प्रश्न नं. एम ५ मा जानुहोस्) होइन थाहा भएन भन्न मन छैन
१.४ [एम ४]	पहिलो बिवाह हुँदा तपाइले आफ्नो श्रीमान /श्रीमती आफैले रोज्नु भएको होइन भने के तपाइले छनौट गर्ने अधिकार अरुलाई दिनु भएको थियो ?	हो होइन भन्न मन छैन
१.५ [एम ५]	यदि तपाई बाबु वा आमा बन्नु भएको छ भने कति वर्षको उमेरमा पहिलो बच्चा जन्मेको थियो ?	उमेर [ ][ ] लागु हुदैन भन्न मन छैन
२. बा-आमा /अभिभावकसंग को सम्बन्ध (तपाइको १८ वर्ष भन्दा मुनि हुर्कदै गरेको अवस्थामा ....)		
२.१ [पि १]	के तपाईका अभिभावकले तपाईका समस्या तथा पिरमर्काहरु बुझिदिने गर्नु हुन्थ्यो ?	सधैं धेरैजसो समय कहिले- काँही बिरलै मात्रामा कहिल्यै पनि गर्नु भएन भन्न मन छैन
२.२ [पि २]	के तपाई बिद्यालय वा कुनै काममा नभएको, फुर्सदको बेला के- कस्ता गतिविधि/क्रियाकलापहरु गर्नु हुन्थ्यो भन्ने कुरा तपाईका अभिभावकलाई सँधै थाहा हुन्थो ?	सधैं धेरैजसो समय कहिले- काँही बिरलै मात्रामा कहिल्यै पनि गर्नु भएन भन्न मन छैन
३.		
३.१ [पि ३]	के तपाईका अभिभावकहरुले प्रशस्त खानेकुरा दिन सक्ने स्थिति हुँदा हुँदै पनि तपाईलाई पर्याप्त खान नदिने गर्नु भएको थियो ?	धेरैजसो समय कहिले काँही एकपटक कहिल्यै पनि गर्नु भएन भन्न मन छैन
३.२ [पि ४]	तपाईको हेरविचार गर्ने बेलामा तपाईका अभिभावकले ज्यादै धेरै रक्सी तथा लागू औषध सेवन गर्ने गर्नु हुन्थ्यो ?	धेरैजसो समय कहिले काँही एकपटक कहिल्यै पनि गर्नु भएन भन्न मन छैन
३.३ [पि ५]	बिद्यालय उपलब्ध हुदा हुदै पनि तपाईका अभिभावकले तपाइलाई कत्तिको पढ्न नपठाउने गर्नु हुन्थ्यो ?	धेरैजसो समय कहिले काँही एकपटक कहिल्यै पनि गर्नु भएन

Nepalese Translated Version : Adverse Childhood Experiences International Questionnaire (ACE-IQ)

		भन्न मन छैन
४. पारिवारिक वातावरण तपाई १८ वर्षको उमेर ताका हुर्कदै गरेको अवस्थामा		
४.१ [एफ १]	तपाई जाँड रक्सी, मादक पदार्थ वा लागू औषध सेवन / दुरुपयोग गर्ने घर परिवारका सदस्यहरुसंग बस्नु भयो ?	थियो थिएन भन्न मन छैन
४.२ [एफ २]	के तपाई डिप्रेसन, मानसिक रोग भएका वा आत्महत्याका प्रयास गर्ने घर परिवारका सदस्यहरुसंग बस्नु भयो ?	थियो थिएन भन्न मन छैन
४.३ [एफ ३]	के तपाई जेल गएका घर परिवारका सदस्यहरुसंग संगै बस्नु हुन्थ्यो ?	थियो थिएन भन्न मन छैन
४.४ [एफ ४]	के तपाईका बा आमाहरु कहिल्यै छुट्टिएर वा सम्बन्ध बिच्छेद गरेर बसेका थिए ?	थियो थिएन लागू हुँदैन भन्न मन छैन
४.५ [एफ ५]	के तपाईका आमा, बा अथवा कोही अभिभावक बितु भयो ?	थियो थिएन थाहा छैन/ निश्चित छैन भन्न मन छैन
यी अर्को प्रश्नहरु तपाईले आफ्नै घरमा प्रत्यक्ष देखे - भोगेका केहि निश्चत कुराहरुसंग सम्बन्धित छन् । यी कुराहरु तपाईले नै मात्र भोगेको हुनुपर्छ भन्ने होइन,अन्य तपाईको परिवारका सदस्यहरुले भोगेको भोगाईसंग पनि सम्बन्धित छन् । तपाइको १८ वर्ष भन्दा मुनि हुर्कदै गरेको अवस्थामा		
४.६ [एफ ६]	के तपाईको बा-आमा वा घर परिवारका सदस्यहरुलाई ठुलो स्वरले चिच्याएर गालि गरेको, बलजफ्ती कसम खुवाएको, होच्याएको र अपमान गरेको देख्नु भयो ?	धेरैजसो समय कुनै कुनै बेलामा मात्र एक पल्ट कहिल्यै पनि भएन भन्न मन छैन
४.७ [एफ ७]	तपाईको बा-आमा वा घरमा परिवारका सदस्यहरुबीच थप्पड हानेको, लात्ताले हानेको र मुड्कीले कुटेको देख्नु भयो ?	धेरैजसो समय कुनै कुनै बेलामा मात्र एक पल्ट कहिल्यै पनि भएन भन्न मन छैन
४.८ [एफ ८]	तपाईको बा-आमा वा घरमा परिवारका सदस्यहरुबीच एक अर्कालाई कुनै वस्तु वा लठ्ठी, बोतल, चक्कु, खुकुरी जस्ता धारिला हतियारले हिर्काएको वा काटेको देख्नु भयो ?	धेरैजसो समय कुनै कुनै बेलामा मात्र एक पल्ट कहिल्यै पनि भएन भन्न मन छैन
५. तलका प्रश्नहरु तपाईले आफ्नै घरमा प्रत्यक्ष देखे - भोगेका केही निश्चत कुराहरुसंग सम्बन्धित छन् । तपाइको १८ वर्ष भन्दा मुनि हुर्कदै गरेको अवस्थामा		
५.१ [ए १]	तपाईलाई घरमा बा-आमा,अभिभावक वा परिवारका सदस्यहरुले ठुलो स्वरले चिच्याएर	धेरैजसो समय कुनै कुनै बेलामा मात्र एक पल्ट

Nepalese Translated Version : Adverse Childhood Experiences International Questionnaire (ACE-IQ)

किशोर किशोरीहरुको व्यवहार निरीक्षण सूची (CBCL - YSR)

तल किशोर किशोरीहरु लाई वर्णन गर्ने केही बुंदाहरु छन् । हाल वा गत ६ महिनाभित्र कुनै बुंदा तपाईंमा एकदम लागू हुन्छ भने २ मा घेरा लगाउनुहोस् । यदि केही मात्रामा लागू हुन्छ भने १ मा घेरा लगाउनुहोस् । यदि त्यो बुंदा पटृक्कै लागू हुदैन भने ० मा घेरा लगाउनुहोस् ।

केही बुंदाहरु असम्बन्धित जस्तो देखिएता पनि, कृपया सबै प्रश्नको जवाफ तपाईंले जानेसम्म सही दिनुहोला ।

० = होइन (तपाईलाई थाहा भएसम्म) १ = केही हदसम्म ठीक हो २ = एकदम ठीक हो

१. म आफ्ना उमरकाभन्दा साना बच्चाहरुका जस्ता व्यवहार गछु ।	०	१
२. म बाबु आमाका अनुमात बगरपान राक्स पाउन गदछु ।	०	१
३. म धेर तर्क वा विवाद गछु ।	०	१
४. मल शरुगरका कामहरु पुरागन साक्दन ।	०	१
५. मल आनन्द लिन कुराहरु निक्क कम छन् ।	०	१
६. म जनावर मन पराउदछु ।	०	१
७. म बढा धाक लगाउछु	०	१
८. मलाइ ध्यान दिन वा एकाग्रता कायम गन समस्या छ ।	०	१
९. म कुन कुरा या साचाइ राक्न वा त्यसबाट ध्यान हटाउन साक्दन । (बणन गर्नुहोस् ।	०	१
१०. म शान्तसग बस्न साक्दन ।	०	१
११. म ठुला मान्छहरुसग बढा निभर हुन गछु ।	०	१
१२. म एकलापनका महशुस हुन्छ ।	०	१
१३. म अल्मालएका (हराएका जस्ता) लाग्छ ।	०	१
१४. म धेर रुन्छु ।	०	१
१५. म राम्रासग इमान्दार छु	०	१
१६. म निदया छु, वा छुच्चो व्यवहार गछु ।	०	१
१७. म दिवास्वप्न वा आफ्ना विचारमा हराउन गछु ।	०	१
१८. म जानाजान आफ्न हानी गन वा आत्म हत्याका काशिश गछु ।	०	१
१९. म अरुका ध्यान आफूप्रात आकाषत गन धेर काशिस गदछु ।	०	१
२०. म आफ्नै सामान विगार्ने/फोड्ने गर्दछु ।	०	१
२१. म आफ्नो परिवार वा अरुको सामानहरु विगार्ने/फोड्ने गर्दछु ।	०	१
२२. म अभिभावकले भनेको मान्दिन (घरमा अङ्गेरी छु) ।	०	१
२३. म स्कूलमा अङ्गेरी छु ।	०	१
२४. म आफ्ुल खानुपन जतापान खाना खान्न ।	०	१
२५. म अरु बच्चासग राम्रो मिल्न साक्दन ।	०	१
२६. म आफुल गन नहुन काम गदा वा काम विगादा पान आफूलाइ दोषा ठान्दन ।	०	१
२७. मलाई अरुको स–सानो कुरामा पनि डाह (डाडो) लाग्छ ।	०	१
२८. म नियम वा अनुशासन घरमा, विद्यालयमा र अन्यत्र पान पालना गादन ।	०	१
२९. म स्कूल बाहक कुन खास जनावर, पारास्थात वा ठाउसग डराउछु (वणन गर्नुहोस्)	०	१
३०. म स्कूल जान डराउदछु ।	०	१
३१. म आफ्ुल नराम्रा कुरा सोचुला वा गरुला भना डराउन गदछु ।	०	१
३२. म आफ्नो काममा एकदम ठिक (perfect) हुनु पर्दछ भन्ने ठान्दछु ।	०	१
३३. म कसबाट पान माया नपाएका महशुस गछु ।	०	१
३४. म अरुल आफुलाइ पछ्याएका महशुस गछु ।	०	१
३५. म आफुलाइ बेकम्मा या अरुभन्दा हीन सम्झन्छु ।	०	१
३६. मलाइ घाऊ चोटपटक लागी न रहन्छ ।	०	१
३७. म धेर झगडा पाररहन्छु ।	०	१
३८. म अरुबाट धेर जिस्क्याइन्छु ।	०	१
३९. म धेर झमलामा फासरहने साथीहरुका सगत गछु ।	०	१
४०. म अरुकालागि हुद नभएका आवाज सुन्न गदछु (वणन गनुहास्)	०	१

१. म अरुकालागि हुँदा नभएको आवाज सुन्न गदछु (बर्णन गर्नुहोस्)	०	१
२. म साच्चै नसाचा एक्कासी कामहरु गछु या झ्वाङ्ग उत्तेजनामा आउछु ।	०	१
३. म प्राय अरुसग भन्दा एक्ल बस्न रुचाउछु ।	०	१
४. म झुठा बोल्छु वा ठग्छु ।	०	१
५. म आलाका नङ् टोक्छु ।	०	१
६. म आत्तिन गछु वा तनावमा रहन गदछु ।	०	१
७. मेरा शरीरका मासपेशीहरु चलका वा कडा भएका महशुस गछु । (वर्णन गर्नुहोस्)	०	१
८. म डरलाग्दा सपना देख्छु ।	०	१
९. मलाई अरु कटाकटीहरुले मन पराउदैनन् ।	०	१
१०. म कोहि कुराहरु अरु धेर कटाकटीहरु भन्दा राम्रोगरि सक्दछु ।	०	१
११. म असाध्य डरपाक वा चिन्तित रहन्छु ।	०	१
१२. मलाई रिङ्गटा लाग्न गदछ ।	०	१
१३. म आफूलाई एकदम दोषी ठान्छु ।	०	१
१४. म धेर खान गदछु ।	०	१
१५. मलाई विनाकारण धेर थकाइ लाग्न गदछ	०	१
१६. म धेर मोटो छु ।	०	१
१७. शारीरिक समस्याहरु (कुन खास मेडिकल कारण नभएर)	०	१
क) पीडा वा कष्ट (पेट वा टाउको बाहेक)	०	१
ख) टाउको दुख्छ	०	१
ग) वाकवाकी, विरामी महसुस गछु ।	०	१
घ) आखाको समस्या छ (चश्मा लगाएर ठीक भएको भए उल्लेख नगर्ने)	०	१
ङ) डाडर वा अरु छालाको समस्या छ	०	१
च) पेट दुख्छ	०	१
छ) वान्ता गछु वा उकेल्छु ।	०	१
ज) अन्य (वर्णन गर्नुहोस्)	०	१
१८. म मान्छेलाई कुट्न पिट्न गछु ।	०	१
१९. म छाला वा शरीरका अन्य भागहरु काट्याउन गछु (बर्णन गर्नुहोस्)	०	१
२०. म राम्रोसग साथी बन्न सक्दछु ।	०	१
२१. म नया कुराहरु प्रयास गर्न मनपराउदछु ।	०	१
२२. मेरा स्कूलका काम कमजोर छ ।	०	१
२३. म राम्रोसग सन्तुलित छैन वा भद्दा छु ।	०	१
२४. म आफ्ना उमेरका भन्दा ठूला कटाकटीहरुसग बस्न रुचाउछु ।	०	१
२५. म आफ्नो उमेरका भन्दा साना कटाकटीहरुसग बस्न रुचाउछु ।	०	१
२६. म कुरागेन मान्दिन वा इन्कार गदछु ।	०	१
२७. म कुन खास काम बारम्बार दोहर्याई रहन्छु (वर्णन गर्नुहोस्)	०	१
२८. म घरबाट भाग्न गछु ।	०	१
२९. म धेर चिच्याउछु ।	०	१
३०. म कुरा लुकाउछु वा गाप्य राख्न गदछु ।	०	१
३१. म अरुमान्छेहरुले नदेखका वा हुँदा नभएका चिजहरु देख्दछु (वर्णन गर्नुहोस्)	०	१
३२. म धेक मान्छु वा चाडै न लाज्जत हुन्छु ।	०	१
३३. म आगलागी गराउ छु ।	०	१
३४. म मेरा हातले राम्रो कामगर्न सक्दछु ।	०	१

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