Research On:

Examining the Impact of Adverse Childhood Experiences, Substance Abuse, and Mental Health among Young Adults in Don Bosco YaR Centres, India

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DON BOSCO NATIONAL FORUM FOR THE YOUNG AT RISK

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Young at Risk

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Don Bosco National Forum for the Young at Risk
Don Bosco House C-991, Sector -7, Dwarka, New Delhi-110077
info@dbyarforum.org +91 8851653538 www.dbyarforum.org

Compiled by : Ms. Moumita Roy Choudhury (National Project Coordinator)
Mr. Pratik Dhainje (Associate Project Coordinator)

Data Analysis by: Ms. Gayatri Menon (Independent Development Consultant)
Mr. Robert Richard (Independent Development Consultant)

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Design and Layout by :
Mr. Pratik Dhainje (Associate Project Coordinator)
Ms. Moumita Roy Choudhury (National Project Coordinator)
Mr. Raj Parit (National Data Management Coordinator and Trainer)

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*The names of children have been changed to protect their identity

Don Bosco National Forum for the Youth at Risk

Research on:

Examining the Impact of Adverse Childhood Experiences, Substance Abuse, and Mental Health among Young Adults in Don Bosco YaR Centres, India

Submitted by

Gayatri M.
Robert Richard
Independent Development Consultants
Researchers

Acknowledgement

The Don Bosco National Forum for the Young at Risk (DB YaR Forum) was established to reflect on, share, and coordinate services for at-risk children and young people in South Asia. We initiated this research as a timely requirement to better understand the realities of our young adults under our care and protection. The study has outlined necessary intervention plans for young at risk.

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Foreword

Childhood trauma or adverse experiences are difficult for growing children to handle. The negative impacts of such experiences manifest as emotional and psychological wounds, causing deep inner pain. These traumas embed themselves in the minds and hearts of children and dislodging them requires understanding their influence from the child's perspective. We, as parents and educators, must comprehend the nature of these adverse experiences and the ways children react or respond to them. The goal of this study is to help them develop resilience and transform negative experiences into positive connections that will prepare them for constructive and successful outcomes in their adolescence.

Often, children at risk may appear content with recreational activities and good food. However, some caregivers believe these children are dull or disinterested in academic pursuits. I believe it is their adverse childhood experiences that catch them off guard and affect their concentration. Their brains are not failing at school; rather, they are preoccupied with managing their physical survival and emotional shutdown. These children require external interventions to cope with their internal struggles.

Don Bosco's educational pedagogy, also known as the Preventive System, emphasizes a holistic approach to education based on reason, faith, and loving-kindness. It fosters a caring and supportive environment where children are seen as individuals with potential. This pedagogy aims to develop the whole person—not just intellectually but also emotionally, spiritually, and socially.

At Don Bosco YaR Centers, this educational system involves much more than merely imparting knowledge. We recognize the crucial role of caregivers as educators, mentors, and role models, fostering a sense of belonging and shared purpose. They help the youth become aware of their mental well-being and potential in various fields, whether literary, artistic, or sporting. By addressing their mental health issues, children learn to recognize their gifts and skills and then are guided to use these for the service of others.

Substance abuse or misuse is a discipline where the declared intentions of both individuals and organizations are most seriously tested. Maintaining a structured discipline in YaR Centers/Homes is essential; without it, managing a broad spectrum of activities would result in chaos. Our main concern is ensuring that our young people understand themselves as human beings and the reasons for their existence.

Our journey of accompaniment, caring presence, and attentive listening is aimed at the well-being of the young people and works towards helping them realize their mental wellness. Consistent counseling, guidance, and, when necessary, medical interventions create a safe environment for them to cope with their traumatic, abusive pasts and look forward to developing a better future.

This research serves as an eye-opener, convincing us that our approach to holistic education for young people at risk is a sacred and divine means for the positive and constructive transformation of human beings and for building a more just and humane society. Thus, we provide an effective care system and a healthy environment in our YaR Centers.

Fr. Joe Prabu
Executive Director

Abstract

Substance abuse and mental health issues are growing public health concerns, often linked to early life adversities such as Adverse Childhood Experiences (ACEs). This study examines the connection between the same, with an aim to explain how these factors are linked and influence each other throughout a person's life. The research focuses on how early adversities, such as physical, emotional, and sexual abuse, neglect, and other forms of trauma, contribute to mental health challenges and substance use disorders.

The study uses mixed method of research under which this study employs convergent parallel design to analyse data from young adults with a history of ACEs as well as counsellors working with Don Bosco Child Care Institutions and community Programmes. It also considers factors like social support and protective measures that reduces the negative effects of ACEs.

A key finding is that most young adults in the study are not addicted to substances. However, among the 30% of the respondents who consume some form of substance a few feel unsupported, while some receive coping support from parents and peers. A significant number of respondents reported substance use within their families. Peer pressure was the most significant socio-cultural influence, followed by mental health issues and unstable living conditions, showing that environmental and social factors contribute strongly to substance abuse. Mood swings, depression, and anxiety were the most common mental health issues reported among young adults. Here, the primary focus is to understand ACEs from the angle of mental health and substance abuse and reciprocate with intervention to curb any negative influence. Thus, the study highlights the need for intervention Programmes that address the complex link between mental health issues and substance use. It advocates for comprehensive approaches that recognize the lasting impact of trauma. These efforts aim to reduce trauma-related issues and build healthier, more resilient communities.

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List of Abbreviations

ACE - Adverse Childhood Experience
ASPD - Antisocial Personality Disorder
APA - American Psychological Association
BPD - Borderline Personality Disorder
CCI - Child Care Institution
CWC - Child Welfare Committee
DB YaR - Don Bosco National Forum for the Young at Risk
DID - Dissociative Identity Disorder
FGD - Focus Group Discussion
HPA - Hypothalamic-pituitary-adrenal
ITI - Industrial Training Institute
LSD - Lysergic acid diethylamide
MI - Motivational Interviewing
NIDA - National Institute on Drug Abuse
PTSD - Post-traumatic stress disorder
PhD - Doctor of Philosophy
SUD - Substance Use Disorders
SWOT - Strengths, Weaknesses, Opportunities, and Threats
TF-CBT - Trauma - Focused Cognitive-Behavioural Therapy
UNCRC - United Conventions on the Rights of the Child
WHO - World Health Organization

CHAPTER 1 - INTRODUCTION

Understanding Adolescents and Young Adults in the Context of Adverse Childhood Experiences

Adolescents and their transition to young adulthood is a major aspect of a human life cycle. According to UNCRC, a child is any person below the age of 18 years. It also defined young adult as a person between the age group of 18 to 29 years. World Health Organization (WHO) categorizes young adults as those between the ages of 18 and 25, considering this stage as part of the broader "adulthood" phase where individuals begin to establish stable careers, families, and long-term relationships (World Health Organization, 2020). The American Psychological Association (APA) also recognizes 18 to 29 years as the period of emerging adulthood, a time marked by identity exploration, self-focus, and changes in personal roles and responsibilities (Arnett, 2000). This is supported by several fields, including psychology, sociology and public health and varies with context.

In the context of health and social studies, young adulthood at this stage are more vulnerable and can fall into prey of mental health challenges, substance abuse, and the enduring effects of adverse childhood experiences (ACEs).

In the context of this research, it is important to understand the concept of Adverse Childhood Experiences (ACEs). Close (2024) stated that ACEs are defined as traumatic experiences that take place between the age group of 0 - 17 years which can sometimes be extended to adulthood if not addressed. He further said that ACEs have a severe and long-term impact on adolescents especially during their transition to adulthood. ACEs are stressful or traumatic events that can have a profound impact on a child's development and long-term well-being. Understanding the different types of ACEs and how they affect young adults is crucial for the foundation’s work in providing effective interventions, support, and healing (Protsahan Foundation, 2024).

Types of ACEs:

1. Abuse

Abuse in this context, refers to the critical and negative experiences that results in harm causing emotional, physical and psychological long-term damage in the individual.

Types of Abuse:

- Physical abuse like hitting, kicking, burning, or other forms of violence.
- It may also include belittling, threatening and neglect which harms the self-worth and well-being of individuals from a very young age. This can lead to harmful mental health concerns as well.
- Sexual exploitation of children can often lead to long-lasting trauma.

Types of Neglect:

- Inaccessibility to food, clothing, shelter and medical needs.
- Not catering to the emotional needs of children by failing to provide love, affection and medical attention.
- Lack of education and irregularity in going to schools.

Types of Household Dysfunction:

- Parent or caregiver who has mental illness which are left untreated, causes unsafe environment for children.
- Parental drug or alcohol abuse can lead to neglect, emotional abuse, or even physical abuse, impacting the child's safety and emotional well-being. Substance use or alcoholism among parents is another critical aspect that affects the well-being of children within their households.
- When children witness violence between caregivers or parents is a cause of trauma.
- Separation or divorce of parents causing conflict, neglect or instability can emotionally impact the children.
- Incarcerated parents or close family members can leave the emotional well-being of children behind.

Other aspects of ACEs also include –

- Physical or emotional bullying by peers
- Exposure to violence in neighbourhoods, schools, or other public settings
- Events like floods, earthquakes, or accidents leading to trauma can affect children’s mental health and development.

Most of the impacts of ACEs are long lasting. Children who undergo ACEs are at a higher physical health risk leading to heart related diseases, obesity and even diabetes. Mental health constraints like depression, anxiety and PTSD are other emotional concerns causes.

They can be impacted by substance abuse, criminal behaviour and relationship concerns also. They underperform in schools and will not have clear career prospects later in life (Protsahan Foundation, 2024).

Sl. No	**Typology of ACEs**
1.	Natural Disaster
2.	Domestic Violence
3.	Shootings
4.	Bullying
5.	Accidents
6.	Sexual Abuse
7.	Living in war prone areas
8.	Witnessing injuries or death of another person
9.	Loss of a family member
10.	Parental death / separation

Table 1 - Typology of ACEs
Source: cdc.gov

Introduced in the late 1990s, ACEs encompasses a range of traumatic experiences that an individual face before they turn 18 years. It can sometimes include personality disorders as well. It can be strongly associated with usage of drugs during adolescence and young adulthood leading to behavioural disorders. This connect between substance abuse, mental health and ACEs is contributing as a concern in the area of public health as well. So, it may be noted that early life adversities can cause concerns on the mental and physical health of adolescents and later the same is reflected in their adulthood. This study aims to explore the intricate ways in which ACEs, including trauma, abuse, neglect, and household dysfunction, interact with substance abuse and mental health challenges throughout the life course.

Substance abuse can cause problems in the mental health conditions, creating a vicious cycle of addiction, emotional concerns which leads to trauma. Individuals with a past of childhood trauma can lead them to use substance as a coping mechanism leading to dependence and an increased risk of developing chronic mental health issues. This relationship leads to the dire need of prevention and affirmative interventions to reduce the impact of the same on their lives.

On analysis of the pathways through which childhood trauma contributes to substance misuse and mental illness, this study aims to highlight the importance of integrated approaches to treatment and prevention. Through this study, the comprehensive report seeks to provide actionable insights into how early intervention and trauma-informed care can mitigate the long-term effects of ACEs and break the cycle of substance abuse and mental health disorders.

The next chapter will take the reader through the literature around the area of ACEs, Mental Health and Substance Abuse. It also aims to show the linkage between traumatic childhood experience and its link to substance abuse and mental health.

Chapter 2

A walk through the literature

In 2007, the Ministry of Women and Child Development's statewide study in context of child abuse found that the children between the ages of 5 to 12 years had high frequency intake. These children were more vulnerable towards getting exploited and abused. One of the significant findings of the research was that sixty nine percent of the fifty percent of the victims were males when it came to parents as a typical abuser (Trivedi et al., 2021). It was also found that found that one in seven Indian suffered from a mental illness and this number has multiplied since 1990. The striking rise of the percent is alarming enough for considering it as a public health issue faced by the nation.

The interconnections between Adverse Childhood Experiences (ACEs), substance abuse, and mental health are increasingly recognized as central to understanding the long-term effects of childhood trauma on individuals' well-being. Literature on this topic spans multiple disciplines, including psychology, psychiatry, social work, and public health, offering diverse insights into how these factors interact. This review aims to synthesize the key findings from empirical studies, theoretical frameworks, and clinical evidence to explore how ACEs contribute to the development of mental health disorders and substance abuse problems across the lifespan.

2.1 Understanding ACEs

In general, children have the capacity to perceive and remember traumatic events in their lifetime. It can be physical, emotional, sexual abuses or neglect and household dysfunction (De Young et. al., 2011). A 1994 epidemiological study published in the American Journal of Public Health found that children who experienced physical abuse by their parents were more likely to develop alcohol and drug disorders. The study established a connection between parental substance use and child abuse (Barth, n.d.).

A longitudinal study conducted by Zucker et al. (2016) on the relationship between family environment and substance abuse found that children raised in such environments are vulnerable to both genetic and environmental factors, increasing their risk of developing

substance use disorders later in life. The study revealed that children exposed to these conditions are three times more likely to experience substance-related issues by late adolescence.

Adverse Childhood Experiences were defined in the original investigation by Anda and Felitti (1998) ***as childhood experiences that were judged to be stressful for the developing child.*** This landmark study conducted by Felitti et al. (1998) stated a vital link between ACEs and mental or physical health conditions of adolescents who transition to adulthood. Two thirds of the adults reported at least a type of ACEs in their lives. These adversities were reflective for individual's physical and mental health.

The Bernalillo County Behavioural Health Business Plan (CPI, 2015) goes on to state that *"prevention and early intervention Programmes for this population need to have a wide scope and include efforts such as age-appropriate assessments, dyadic therapy, trauma informed care, play therapy and wrap-around services to support families/caregivers (adapted from Pacheo, 2016)."*

The above figure stratifies the aggravating impacts that are caused by ACEs in the lifespan of an individual. With the occurrence of ACEs, an individual can slowly develop disrupted neurodevelopment, social – emotional – cognitive impairment, health risk behaviours and disease – disability – social problem susceptibility and even can cause early death.

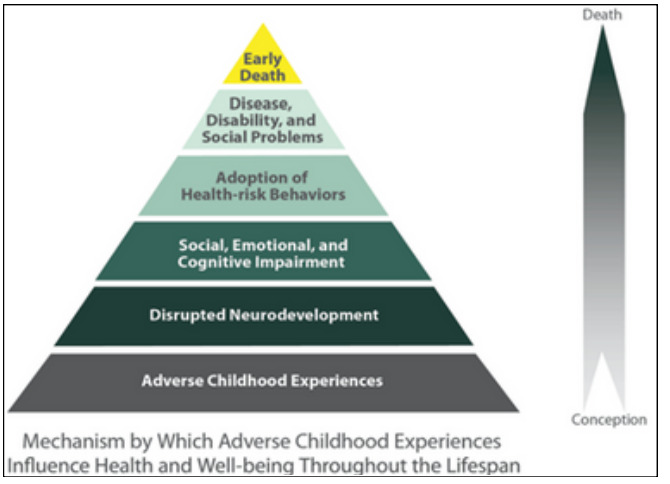

Figure 1 – Mechanism by which Adverse Childhood Experiences Influence Health and Well-being throughout the Lifespan - Adapted from Pacheo (2016),
Source: https://www.cdc.gov/violenceprevention/acestudy/about.html

Newbury-Birch et al. (2017) found in their study that 62% of adolescents cited curiosity as the primary reason for trying substances for the first time. Similarly, research by Gardner and Steinberg (2023) indicated that youth are more likely to engage in substance use and risky behaviors under peer influence.

Additionally, a meta-analysis of 37 studies conducted by Hughes et al. (2017) revealed that children exposed to multiple adverse childhood experiences have a higher likelihood of developing anxiety, depression, and self-harming behaviors.

2.2 Impact of ACEs on Mental Health

Researchers have found that there is a strong connection between mental health disorders and ACEs among different age groups. Early life traumas can lead to lack of neurological development, emotional irregularity and negative coping mechanism. ACEs can cause a range of mental health concerns like depression, bipolar, suicide and substance use (Fuller-Thomson et al., 2016)

Several studies have found a strong association between ACEs and mood disorders. Individuals with high ACE scores can have depression and anxiety. The biological mechanisms underlying this association include alterations in the hypothalamic-pituitary-adrenal (HPA) axis, which regulates stress responses, and the impact of chronic stress on brain areas involved in emotional regulation (e.g., the amygdala and prefrontal cortex) (Teicher et.al, 2006).

The social relationship building and individual functioning runs is closely related to ACEs and poor mental health (Herrenkohl et al., 2016). Those who have undergone ACEs will have their peers to experience People who are subjected to ACEs are more likely than their peers to experience difficulty developing healthy relationships due to lack of trust, poor emotional regulation skills, and maladaptive coping strategies (Poole et al., 2018)

ACEs, particularly sexual abuse and domestic violence, are significant predictors of PTSD in adulthood. Trauma during childhood can lead to hypervigilance, emotional dysregulation, and difficulty trusting others, all of which contribute to the development of PTSD. Studies indicate that childhood trauma, including emotional abuse and neglect, increases the likelihood of developing borderline personality disorder (BPD), antisocial personality disorder (ASPD), and dissociative identity disorder (DID). The emotional dysregulation and dysfunctional coping strategies seen in individuals with personality disorders are often rooted in early experiences of maltreatment and neglect (Teicher et al., 2006).

2.3 Substance Abuse and ACEs: A Vicious Cycle

The relationship between ACEs and substance abuse is one of the most concerning outcomes of childhood trauma. Studies show that children who experience trauma are more likely to engage in substance use during adolescence and adulthood as a coping mechanism for emotional pain, anxiety, and depression.

Adolescents with a history of ACEs, particularly physical and emotional abuse, are more likely to start using substances at an earlier age. The experience of trauma leads many individuals to turn to alcohol, nicotine, or illicit drugs as a way to self-medicate and numb their emotional distress.

The National Institute on Drug Abuse (NIDA) highlights that individuals with ACEs are not only more likely to use substances, but they also face a higher risk of developing substance use disorders (SUDs). The self-medication hypothesis suggests that individuals may use drugs or alcohol to alleviate the psychological pain and emotional dysregulation caused by unresolved trauma.

Substance use disorders frequently co-occur with mental health disorders in individuals who have experienced ACEs. This phenomenon is referred to as comorbidity, where mental health problems (e.g., depression, PTSD) and substance use disorders interact and exacerbate each other. Individuals with both conditions may experience a cycle of emotional distress, substance use, and further mental health deterioration, making treatment more complex.

The existing literature underscores the profound and lasting impact of Adverse Childhood Experiences (ACEs) on an individual's mental health and susceptibility to substance abuse. Studies have consistently demonstrated that early trauma disrupts neurological development, impairs emotional regulation, and fosters maladaptive coping mechanisms, increasing the risk of mood disorders, personality disorders, and post-traumatic stress disorder (PTSD). Additionally, the strong correlation between ACEs and substance use highlights the role of childhood trauma in shaping future behavioral patterns, where individuals often resort to self-medication to manage emotional distress. This vicious cycle of trauma, poor mental health, and substance abuse presents a significant public health concern that requires a multidimensional approach for intervention.

Addressing the impact of ACEs necessitates the adoption of trauma-informed care strategies that integrate mental health support, early intervention, and substance abuse prevention. Comprehensive programs focusing on resilience-building, social support networks, and therapeutic interventions can help mitigate the long-term consequences of childhood trauma. As research continues to evolve, future efforts should aim to develop targeted policies and holistic care models that prioritize early screening, psychological support, and community-based initiatives. By fostering awareness and promoting accessible mental health services, it is possible to break the cycle of adversity, ensuring that affected individuals receive the support needed for healing and recovery.

The interconnectedness between ACEs, mental health disorders, and substance abuse highlights the urgent need for integrated, trauma-informed approaches to treatment and prevention. Recognizing the lifelong consequences of childhood adversity, interventions must be holistic, addressing both the psychological and behavioral aspects of trauma. Strategies such as early screening, access to mental health services, and resilience-building programs can help mitigate the negative effects of ACEs and reduce the likelihood of substance use disorders. Schools, healthcare systems, and community organizations must collaborate to create supportive environments that foster emotional well-being and provide early intervention for at-risk individuals.

As the understanding on the complex relationship between ACEs, mental health, and substance use continues to evolve, future interventions can be refined to target specific vulnerabilities and risk factors. Trauma-informed care, personalized therapeutic approaches, and policy-driven initiatives should be prioritized to ensure long-term recovery and well-being. By investing in research and implementing comprehensive support systems, society can work toward breaking the cycle of adversity, ultimately improving the life outcomes of those affected by early trauma.

In this light, this study ideally looks at how traumatic experiences in childhood can lead to drug consumption and its impact. The next chapter explains the process employed describing the research methodology and the ethical concerns are explained.

Chapter 3

Research Methodology

The study examines the complex relationships between Adverse Childhood Experiences (ACEs), substance abuse, and mental health concerns. The theoretical framework for this research integrates developmental psychology, trauma theory and social ecological theory to address the study's objectives. These theories together offer a holistic understanding of how ACEs contribute to mental health and substance use disorders, the underlying factors driving their co-occurrence, and the societal influences that further exacerbate these relationships.

3.1 Research Questions

1. What is the relation between adverse childhood experiences, substance abuse and mental health issues?
2. What is the impact of ACEs on habituating substance abuse?
3. How can comprehensive, integrated treatments be designed and executed to meet the diverse needs of persons and communities impacted by these interconnected issues?

3.2 Objectives

1. To document the socio demographic details of the young adults
2. To understand the role of adverse childhood experiences in predisposing young adults to both substance abuse and mental health concerns.
3. To the potential factors contributing to the correlation of mental health concerns and substance abuse.
4. To know the influence of societal factors on the relationship between substance abuse and mental health concerns.

3.3 Research Design

The research brings in a mixed methodology of research with a convergent parallel research design. The study collected and analysed quantitative and qualitative data simultaneously.

Figure 2 - Design adapted from Harvard Catalyst
Source: https://catalyst.harvard.edu/community-engagement/mmr/

3.4 Universe

The study population included young adults with a history of adverse childhood experiences in thirty Child Care Institutions and other community Programmes under the umbrella of Don Bosco National Forum for the Young at Risk [DB-YaR Forum].

3.5 Sampling

The study's participants are recruited through non - probability, purposive sampling assuring variety in terms of age, gender, and geographical region. Data will be collected from childcare centres and community-based Programmes under DB-YaR Forum Centre. Qualitative data will be collected through collectively administered focus group discussions, case studies, and success stories with participants and key stakeholders.

3.6 Tools of Data Collection

Questionnaire for quantitative data and in-depth interviews was conducted with the help of Interview Guides (Annexure 1 and 2) and Focused Group Discussions are conducted through FGD Guides in the process (Annexure 3). The tools of data collection were reviewed by independent researchers, PhD Scholars and Academicians in this domain.

3.7 Ethical considerations

The study follows ethical principles and norms, included informed written consent from all participants, maintaining confidentiality, anonymity and limiting potential risks or harms (Annexure 3). Prior to collecting data, the Child Care Institution’s or service provider’s approval was requested.

3.8 Theoretical Framework

The Developmental Psychopathology Model by Thomas M. Achenbach and Dante Cicchetti were founded in 1974. It provides a foundational lens to understand how early-life adversities, such as abuse, neglect, and household dysfunction, lead to the development of mental health issues and substance abuse. According to this model, early childhood experiences have long-lasting effects on emotional, cognitive, and social development. Traumatic experiences disrupt normal development, leading to altered brain functioning, emotional dysregulation, and maladaptive coping strategies.

Trauma theory of Cathy Caruth (1995), as applied to ACEs, focuses on the psychological, emotional, and physiological impact of trauma on individuals. Trauma theory suggests that individuals who experience childhood abuse, neglect, or household dysfunction develop coping mechanisms to manage the emotional and psychological pain caused by trauma. In many cases, these coping strategies involve substance use to numb or manage negative emotions.

The Social Ecological Model (Bronfenbrenner, 1979) focuses on how different layers of a person's environment influence their development and Behaviour. This theory asserts that an individual's Behaviour and health outcomes are influenced by multiple systems, including the microsystem (family, peers), mesosystem (interactions between different contexts), ecosystem (indirect influences such as community support), and macro system (cultural norms, societal policies).

3.9 Operational Definitions

- As per the guidelines of DB-YaR Forum, Young Adults are defined as any individual between the age group of 15 – 29 years of age.
- Centres in this research refers to the provinces of DB-YaR Forum Centre across the country.

3.10 Institutional Framework

The study will be carried out in partnership with childcare centres and community-based programs which are dealing with children who face adverse childhood experiences, substance abuse and mental health issues.

3.11 Limitations of the Study: -

- Direct interviews were not done by the data analyzers. Both the data collection and analysis were not conducted by the same agency/individuals.
- Qualitative data in FGD collected and interpreted by the data collectors.
- Subjectivity of the data enumerators was significantly evident as they work with the respondents.
- The data enumerators were already dealing with the child respondents which leads to a sense of biasness in the study.

The following chapter will be the analysis and interpretations of the data collected during the study:

Chapter 4

Analysis and Interpretations

The research primarily focuses to examine and understand the effects of Adverse Childhood Experiences among the Adolescents and Young Adults up to the age of 29 years to see if it resulted in usage of substance abuse resulting in mental health concerns. This also looks forward to synthesis the data from young adults and counsellors to know the effectiveness of the basic foundation of habits and behaviour.

The analysis chapter is sub themed as following:

- Demographic Profiling
- ACEs among young adults
- ACEs and mental health
- ACEs and substance abuse

A total of **146 Adolescents and Young Adult** respondents were part of this research. Data was elicited from Panjim in Goa, New Delhi, Chennai and Trichy in Tamil Nadu, Shillong - Meghalaya, Dimapur - Nagaland, Kolkata – West Bengal and Bangalore - Karnataka. Along the same, the counsellors of the CCIs were also elicited data from.

A total of **31 Counsellors** participated in this research, representing various provinces. Among them, 7 were from Trichy, 6 each from Panjim and Chennai, 5 from New Delhi, 2 from Mumbai, and 1 each from Bangalore, Dimapur, Hyderabad, Kolkata, and Shillong provinces.

4.1 Profiling of the adolescent and young adult respondents

This section will introduce the background of the young adults and summarise their basic information based on age, gender, education, place of stay and the occupation of the parents. The purpose of this demarcation is to understand the background of the young adults from their perspective.

4.1.1 Basic demographic profiling of the young adults

The sample consisted of 146 young adults, with an age range of 11 to above 18 years. The following table shows the frequency of age from which young adults are included in this study.

29.5% of them are in their early adolescent period i.e., between 11 to 14 years of age. **62.3%** of them are part of the age group 15 - 18 years and only **8.2%** of them were above 18 years. So, a majority of 103 of them are young adults aged 15 years and above.

SI. No	Age (in years)	Number of respondents	Percent
1	11 to 14	43	29.5
2	15 to 18	91	62.3
3	Above 18	12	8.2
Total		**146**	**100.0**

Table 2 - Age of the respondents

In the figure 3, the gender of the respondents considered for this research is portrayed. The 146 adolescents and young adults had a maximum proportion of male respondents **65%** and **35%** female respondents.

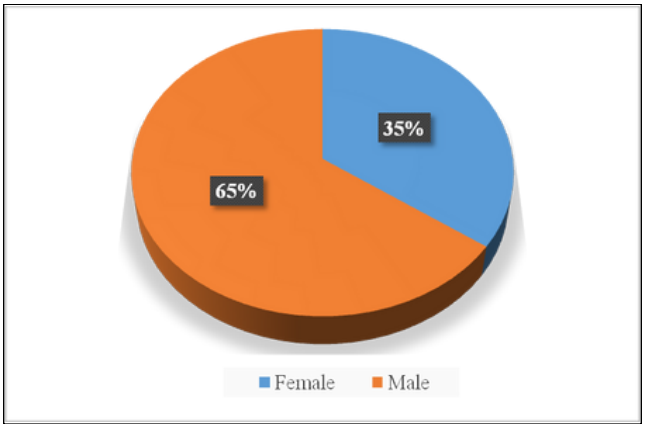

Figure 3 - Gender of the respondents

Examining their educational qualification, it was noted that there were adolescents and young adults whose qualification ranged from being out of school to higher education. **27.4%** i.e., 40 respondents had a qualification between 6 - 8 class; 57 of them i.e., **39%** were between 9 to 10 class; **19.9%** i.e., 29 of them were between 11 to 12th class and 18 of them i.e. **1.4%** have attained higher education.

Of the total respondents a majority of **133** respondents stay in Child Care Institutions (CCIs) in these provinces. As mentioned in the Institutional Framework in the methodology chapter, **13** of the respondents are selected from the community-based intervention programmes of DB-YaR Forum Centre. The duration of stay in the CCI of the reported **133** young adults ranged between less than 1 month to 10 years. The rest of the 13 respondents are connected with the organisation for more than 10 years through community-based intervention programmes.

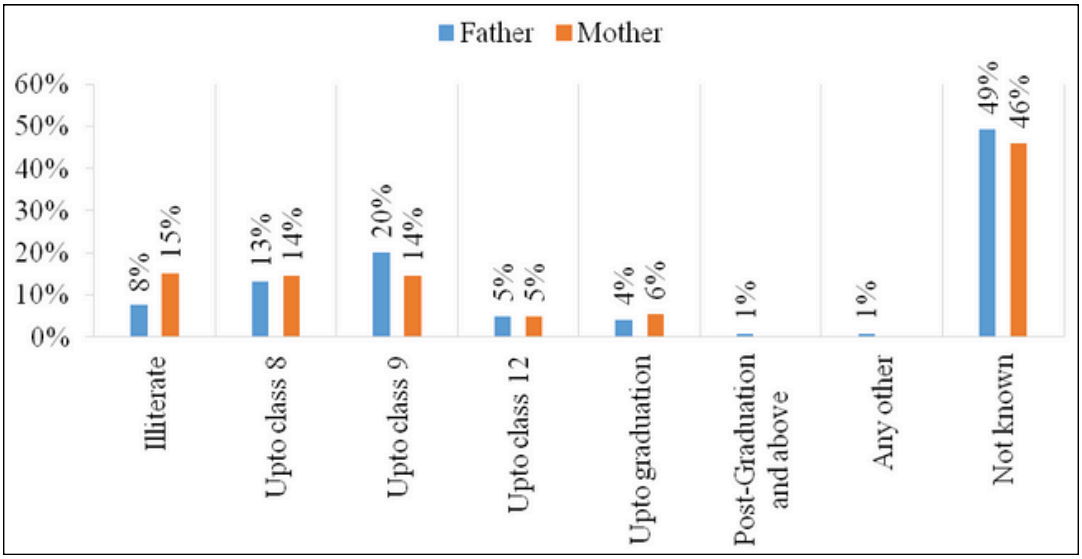

Figure 4 - Level of education amongst the mother and father of the young adults

Family education background plays a significant role in shaping a child's societal status and can have a profound impact on the trajectory of their life. **49%** of young adults were unawareof their father's educational qualifications, while **46%** were unaware of their mother's qualifications. **15%** of mothers are illiterate, compared to 8% of fathers. 14% of mothers completed up to the 8th grade, while **13%** of fathers reached the same educational level. **20%** of fathers completed their 10th grade and **14%** of mothers did the same. **5%** of both mothers and fathers completed their 12th grade. **4%** of fathers and **6%** of mothers completed their graduation. **1%** of each parent completed postgraduate studies, and **1%** of parents have other educational qualifications like ITI and diploma.

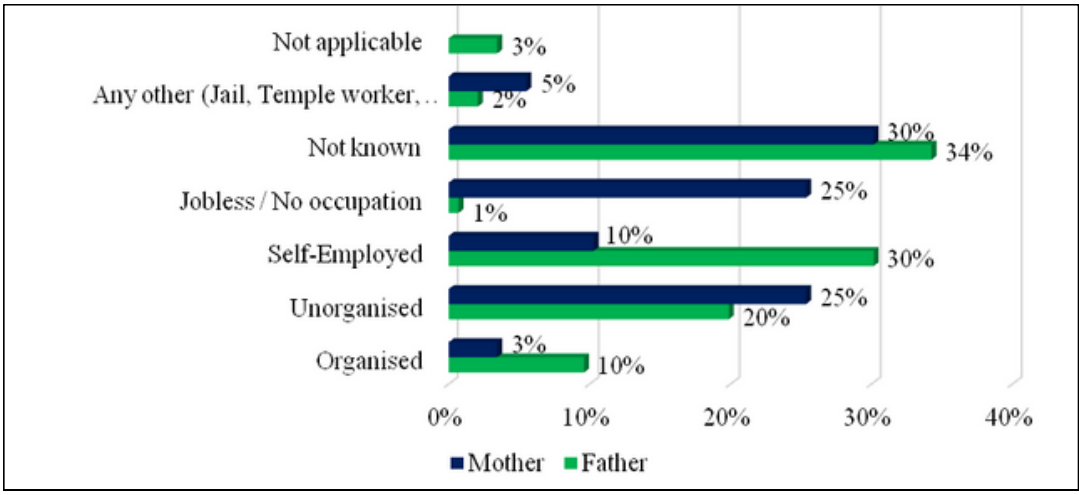

Figure 5 - Occupation amongst the mother and father of the young adults

In figure 5, over **30%** of young adults were unaware of their parents' occupations. **25%** of mothers were jobless compared to only **1%** of fathers. **30%** of fathers are self-employed, while just **10%** of mothers fall into this category. **25%** of mothers were in the unorganized sector, and **20%** of fathers were part of the same sector. Only **3%** of mothers were employed in the organized sector and **10%** of fathers were in the same sector. **3%** of parents did not fall into any of these categories unexplained by these children. About **7%** of parents were in jails, working in temples or as painters.

Adverse Childhood Experiences (ACEs) are often linked to family dynamics, as the family environment plays a crucial role in ensuring a child's safety and emotional well-being. The data reveals various family structures that could contribute to the presence of ACEs, as these conditions may increase the likelihood of stress, instability, and emotional distress for young adults.

As per this study, **22.6%** of the respondents live with both parents which indicates a better living environment. **9.6%** of them experience parental separation, which can potentially contribute towards emotional distress, confusion, and instability among them. **2.7%** of young adults live without their mothers, while **8.2%** live without their fathers. These situations can lead to feelings of abandonment or neglect, which are often associated with ACEs. **0.7%** of young adults live with their stepmothers, while **6.8%** of fathers are widowers, and **9.6%** of mothers are widows. The loss of a parent due to death

can have profound emotional impacts on young adults, making them more vulnerable to ACEs. **8.2%** of respondents live with stepmother or stepfather because of the death of a biological parent, which has the potent to initiate emotional challenges related to attachment and adaptation to new family dynamics. **2.7%** of them are in families where both parents are remarried, which can cause tension especially if young adults struggle to adjust to new caregivers or changes in family structure. **4.1%** of young adults are unaware of their parents' marital status, which could indicate a lack of communication or instability within the family, potentially leaving them feeling uncertain. **23.3%** of the young adults reported that their parents were incarcerated, or that they had no parents, with some experiencing the loss of their father after their mother's death.

It is clear that 75.9% of them live in a family facing dysfunction which can cause behavioural, mental and social impairment in the child. These circumstances can be compelling to contribute to ACEs causing long term trauma and adverse health conditions too. The presence of parental separation, loss, remarriage, or instability can affect their sense of security and cause increased vulnerability.

As mentioned in the beginning of the report, this data looks into the equation between family dynamics and ACEs. Adolescents and young adults living witnessing parental dysfunction can have a sense of abandonment, neglect, and attachment issues. Living with step-parents can lead to challenges in creating trusting relationships in the social realm. Not knowing the marital status of parents is another aspect that paves way to child's vulnerability. These factors ideally have the power to cause sense of insecurity, loss, instability and can even disrupt attachment aggravating the effects of ACEs.

4.1.2 Basic profiling of Counsellors

31 counsellors of the CCIs and Outreach Programmes of DB-YaR Forum Centre were part of the research and out of which as per figure 6, a majority of **71%** were women and only **29%** were males.

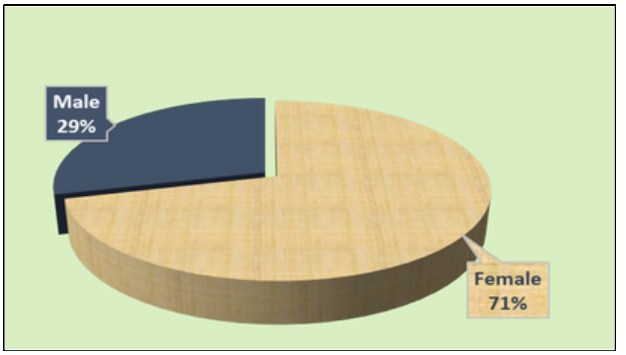

Figure 6 - Gender of the Counsellors

It is noteworthy that educated counsellors are recruited by DB-YaR Forum Centre for the mental health care of the young adults. **71%** of them were post graduates and the rest **29%** are graduates. The counsellor respondents of the study work in CCI, outreach or both under the aegis of DB-YaR Forum Centre. It was noted that **83.9%** of them were part of the CCIs, **6.4%** were in outreach and **9.7%** were part of both of the entities. Of them, **25.8%** were part of the organisation for 6 months to 1 year; **29%** of them were part for 3 - 5 years; **16.1%** served between 2 to 3 years; **16.1%** of them were having an experience for more than 5 years.

Examining their experience working with adolescents and young adults, it was identified that a remarkable **41.9%** have experience of 3 to 5 years; **12.9%** have more than 5 years of experience; **16.1%** has 2 to 3 years of experience; **9.7%** has 1 - 2 years of experience and **19.4%** has only 6 months to 1 year of experience. **These mental health professionals not only take up this role as counsellors, but also as psychologist, social worker, career counsellor, educator, caregiver/warden and home/CCI Warden.**

4.2 ACEs, young adults and adolescents

This section of the study delves into the long-term impact of Adverse Childhood Experiences (ACEs) on young adults and adolescents, focusing on the role of family structure, emotional distress, and the support systems available to help these individuals process their traumatic experiences. The results reflect both the challenges faced by the respondents with unfavourable childhood experiences and the interventions made by counsellors.

The structure of the family that the respondents come from, plays an innate role in understanding their surroundings and social circles. Figure 7 shows that more than **50%** of the respondents come from nuclear families. **15.8%** of the respondents are from joint families and **14.4%** of them are from single parent families. **8.2%** of them were unaware of their family structure, **2.7%** of them stated that they belong to extended family and **2.1%** stated foster family as their family ideation. Less than **1%** belonged to step family and adoptive families. **The lack of knowhow on the family structures, being part of step families or adoptive families also indicates a disruption in their biological family fabric to a large extend.**

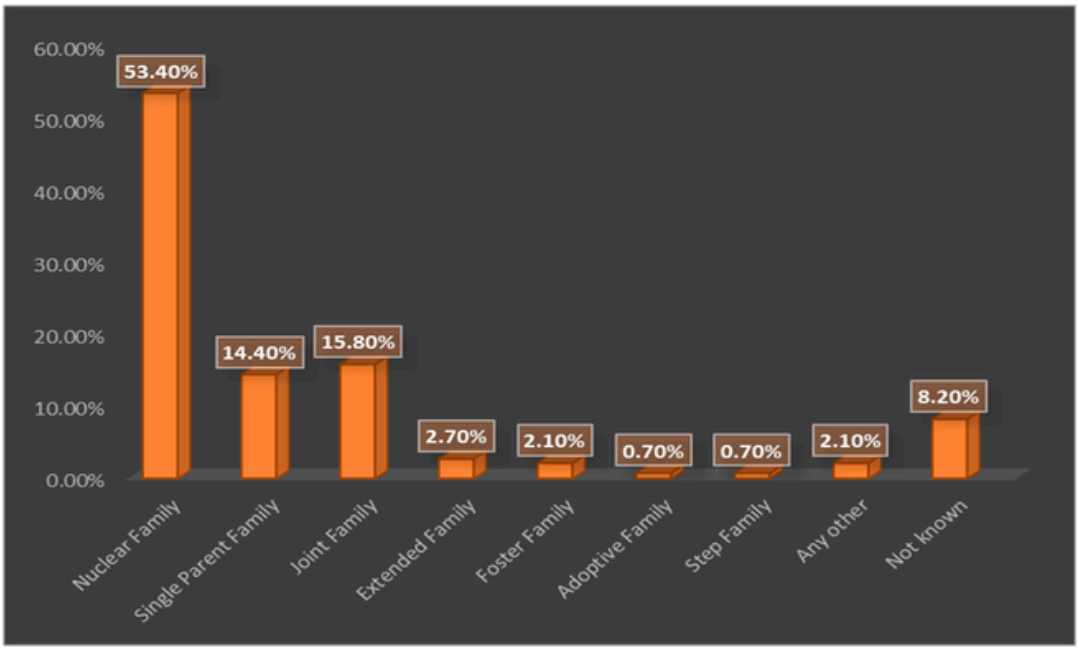

Figure 7 - Family Structure of the young adults

Sl. No	Relationship	Father /Male guardian	Mother/female guardian
1	Listening	15.7%	16.9%
2	Cordial	15.7%	14.4%
3	Loving	25.7%	24.7%
4	Happy	10.7%	23.4%
5	Non-Cordial	7.3%	3.1%
6	Rejection	5%	4.7%
7	Over Protection	3.4%	4.4%
8	Not Applicable	16.5%	8.4%

Table 3 - Cross tabulation on the relationship between the child and father / male guardian vs mother / female guardian

Examining the relation of parents and the respondents as per table 3, it was noted that **15.7%** of them have a cordial relation with their male guardian or father. They listen and understand the respondents. **25.07%** of them stated a loving relation with their fathers. Only **7.3%** of them had a non-cordial relation and **5%** were neglected. **3.4%** of them feel overprotected by fathers.

Observing the relation with mothers, **24.7%** of the respondents have a loving relation. 16.9% of them stated they were listened to by their mothers. **23.4%** of the young adults are happy with their mothers and **14.4%** of them have a cordial relation. Only **3.1%** felt a non-cordial relation and **4.7 %** of them feel neglected by their mothers or female guardians. **4.4%** of the young adults feel their mothers are overprotective. **24.9%** of them felt that there is no such relation with both their parents. **The data reveals that while a larger number of them experience love or affection, not all have a consistent rapport with their fathers. Mothers have a consistent role in nurturing children. Though they are found to be overprotective and sometimes neglect can cause a major factor to aggravate ACEs.**

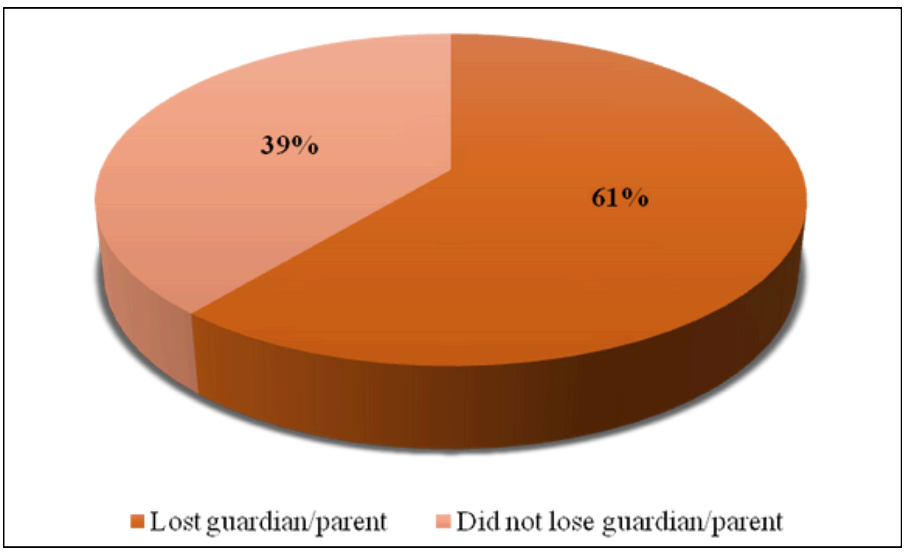

Figure 8 – Status on losing a parent or guardian

Losing parents at a young age is a major indicator of ACEs. As per figure 8, **39%** of the respondents did not lose their parents or guardians. Rest of the **61%** stated that they lost their parents.

SI. No	Type of feeling	Number of responses	Percent
1	Difficulty accepting the loss	51	15.0
2	Grief	42	12.4
3	Emotional distress	57	16.8
4	Guilt/Regret	11	3.2
5	Helplessness	39	11.5
6	Loneliness	51	15.0
7	Insecurity of Future	31	9.1
8	Suicidal Tendency	6	1.8
9	Any other	51	15.0

Table 4 - Feeling after the loss of parent(s) / loved one

As per table 4, significant portion of respondents i.e., **15%** expressed that they struggled with accepting the reality of the loss of their parents. Though it is a common response to loss, it sometimes stays unaccepted in the young minds. This indicates difficulty in accepting the loss of their parents and their grieving process. The largest portion of respondents i.e., about **16.8%** selected emotional distress, encompassing a wide range of negative emotions such as anxiety, confusion, frustration, and sadness. Around a meagre **3.2%** expressed feelings of guilt or regret after the loss. This could include feelings of responsibility for the death, regret about things left unsaid, or even a sense of failure in their relationship with the deceased. **11.5%** stated helplessness showcasing the feeling of loss and despair. **15%** of them stated loneliness and **9.1%** felt insecure due to loss of dear ones. **1.8%** stated that they developed suicidal tendencies. This is a serious concern that needs a preventive intervention as well. **15%** of them stated that they underwent inexplicable emotional experiences (any other). It is noted that more than **50%** of the respondents' stated feelings that directly connected to mental health concerns. **These indicators included – loneliness, helplessness, suicidal thoughts, despair, guilt and regret which directly shows unhealed mental health challenges in the respondents. These attributes are directly linked to ACEs.**

In the context of controlling the adolescents and young adults, **37.7%** of their guardians or parents have kept rules and regulations within the household. Another **37.7%** sometimes have a few rules that they have followed in their household. **11.6%** have been under regulations often and **13%** never had any such regulations. One such strong regulation is keeping a tap on their whereabouts. **41.8%** of the young adults reported that they always had to inform their parents or guardians on where they are. **29.5%** of them felt only at times this regulation is followed. **17.1%** feel a frequent need to inform their whereabouts and **11.6%** do not inform the same to their parents and guardians. An important case study in this context is that –

"A 15-year-old girl of 5th grade is living in the CCI named S1 (name changed) for five years. Even after several counselling sessions her in-depth emotions were not tamed. She remained aggressive, destructive and caused disruptive situations. It was understood from their situation and background that she was abandoned by her father in a railway station during a journey. She was taken into rescue by a social worker who informed the police and ensured the admission in the CCI. It is understood that the ACE she underwent has severely caused the unresolved feelings of anger, revenge and hurt in her. As a result of it, she has concerns concentrating and was absent minded. Through therapy, she was aware of her behaviour and was able to resolve the same using techniques like Johari Window and SWOT Analysis. Post therapy, she learned to control her emotions and this significantly improved her studies."

This case study is a testimony on how adverse conditions in life during childhood can affect the child's mental health.

SI. No	Cause of discomfort or fear	Number of responses	Percent
1	Someone hurt me physically	39	19.4
2	Someone insulted	46	22.9
3	Someone bullied me badly	34	16.9
4	Someone touched me in a way that felt wrong	25	12.4
5	I don't want to talk about it right now	17	8.5
6	Any other	1	0.5
7	Not Applicable	39	19.4

Table 5: Circumstance that made them feel scared or uncomfortable

It is understood that the scary and fearful situations that young adults and adolescents go through include inflicting physical violence, insult causing mental pressure, bullying and unsafe touches. In table 5, about **22.9%** of the young adults stated that they felt insulted at many points in time which discomforted them and **19.4%** of them were scared because of physical violence. **12.4%** stated that sexual violation and unsafe touches were a moment of scare for them and **16.9%** felt it was bullying. **8.5%** were not willing to speak about this.

Majority of respondents i.e., **74%** experience fear or discomfort in some way. This indicates that emotional distress, anxiety, or fear is a common experience for many respondents, linking directly to their mental health. **2.1%** chose not to respond. The fact that **24%** did not report experiencing fear or discomfort can indicate better emotional resilience or emotional oppression. It is vital to explore whether this group has developed healthy coping mechanisms or if they simply do not feel the need to address their emotions in these contexts. Around **36.3%** said they never felt scared about uncomfortable situations. Around **18.5%** of them were mildly scared, **12.3%** were scared quite a bit, **11.60%** were severely scared, **13%** of them stated moderate fear in such situations and **8.2%** of the respondents were somewhat scared. Of the young adults who

faced such instances, it is positive to note that **65%** of them were able to report them and **6%** of them did not.

When a person who has experienced ACEs finds themselves in a scared or uncomfortable situation, the effects of their past trauma can be triggered in ways that may increase feelings of fear, anxiety, or helplessness. These situations could involve anything from relationship conflicts, stressful life events, or even seemingly minor triggers that remind them of the original trauma. The reaction to these situations is often influenced by the types of ACEs they've encountered, whether it's emotional or physical abuse, neglect, parental separation, or exposure to household dysfunction such as substance abuse or domestic violence.

Sl. No	**Location**	**Number of Responses**	**Percent**
1	At home	55	27.5
2	At private place	13	6.5
3	At school	32	16.0
4	At a relative's house	11	5.5
5	At a friend's house	5	2.5
6	At a park or playground	12	6.0
7	I don't remember	7	3.5
8	I don't want to talk about it	11	5.5
9	Somewhere else	10	5.0
10	Not Applicable	44	22.0

Table 6 - Young adults' experiences of fear or discomfort: Location Insights

The place of such instances can aggravate the ACEs in individuals. In this study, as per table 6 it is also evident that most of such incidents i.e., **27.5%** of them happened at home where the perpetrators are known to the young adults and adolescents. Around **16%** felt

uncomfortable and scary situations in the school; **6.5%** of the young adults faced such violations in private spaces; **5.5%** of them stated that they underwent the same at a relative's place and another **5.5%** did not want to divulge these details. About **6%** of them faced such circumstances from playgrounds. **3.5%** were unable to remember such a detail of their adverse experience and **5%** stated that it occurred in a place other than the above.

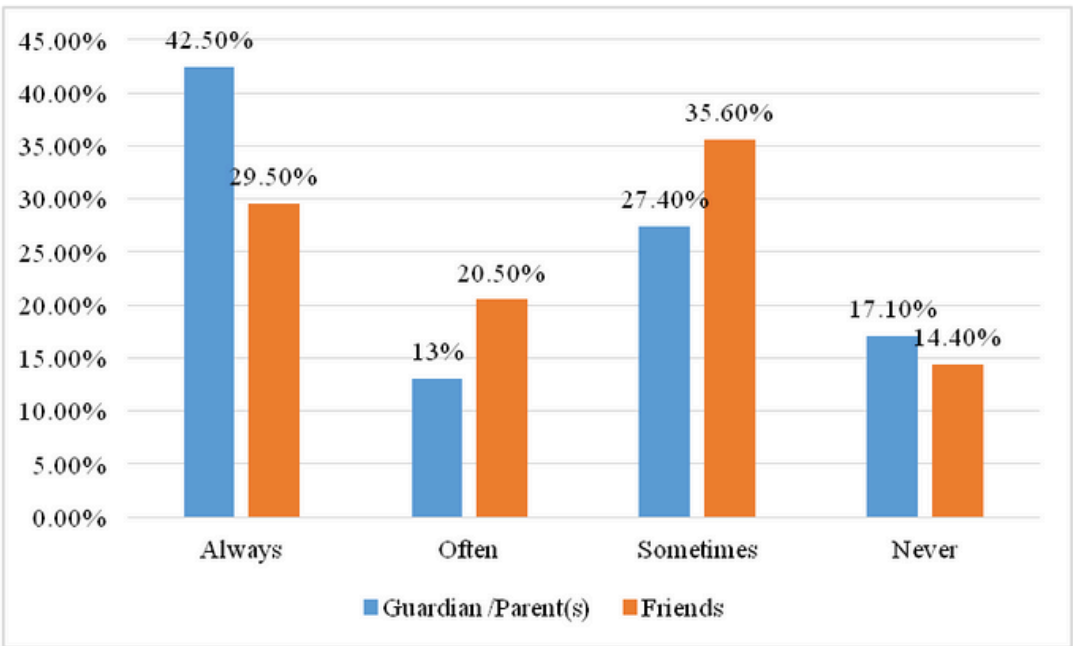

Figure 9 - Cross examination between the emotional support from guardian / parent(s) vs friends

Having a confidant to support and engage reducing their trauma is important in such circumstance. Out of 146 young adult responses, **42.50%** of them felt that they were always supported by parents/guardians and **29.5%** felt they were supported by their friends. **13%** felt constant support often from parents/guardians and **20.5%** felt that they were supported so by friends. **27.5%** felt they were sometimes supported by parents/guardians and **35.6%** of them stated that they were supported sometimes by friends. **17.1%** of the young adults stated never supported by parents/guardians and **14.4%** stated even friends never supported them.

The importance of consistent and reliable parental support is evident. When young adults feel consistently supported by their parents, they are likely to have better emotional outcomes. However, for the 17.1% who report never feeling supported by their parents, the effects of ACEs can be more pronounced, potentially leading to long-term psychological or behavioural issues. While some young adults experience strong support systems, others face significant gaps in emotional support, either from parents or peers. Addressing these disparities is essential for mitigating the damaging effects of ACEs and ensuring that young adults have the emotional tools they need to thrive, even in the face of difficult experiences.

In this context, it is important to understand the degree at which the counsellors and caretakers ideate and understand the ACEs faced by young adults as shown in table 7.

SI. No	Common unfavourable childhood events	Number of responses	Percent
1	Physical abuse	20	15.5
2	Emotional neglect	24	18.6
3	Poverty	19	14.7
4	Violence in the family/community	26	20.2
5	Rejection by community/society	21	16.3
6	Bullying	17	13.2
7	Any other [sexual assault, negative peer influence]	2	1.6

Table 7 - Most common unfavourable childhood events

They stated that most of them are affected of family-based violence i.e. **20.2%,** emotional neglect is the next concern they face i.e. **18.6%, 15.5%** faced physical abuse, **14.7%** are affected of the poverty in their families and **16.3%** of them stated neglect from community/peer group as a concern and **13.2%** stated the young adults are bullied too. A meagre number of **1.6%** of them stated sexual assault and negative peer influence as a cause of the situation of the young adults better.

Counsellor recorded a significant case of a child –

"In an awareness Programme conducted by the DB-YaR Forum Centres' A1 (name changed – CCI), a team identified a 11-year-old who was addicted to drugs. During a conversation with his mother, it was understood that the parents of the children were in the verge of divorce and the mother is now left with four children. The mother was distressed for the fact that her child uses drugs. Peer influence and exposure to corporal punishment and theft were the causes to it. Pointing at a critical intervention requirement, the child was taken to the CWC. The child was admitted in A1 CCI and he was provided with emotional assistance through counselling. This was found to be essential for behaviour change. As a result, he became regular to school, overcame his addiction and showed remarkable behavioural progress. He was deinstitutionalised eventually and united with his mother."

Sl. No	**Young adults' views on caretakers/ counsellors' understanding of their past**	**Number of respondents**	**Percent**
1	Always	78	53.4
2	Often	25	17.1
3	Sometimes	33	22.6
4	Never	10	6.8
Total		**146**	**100.0**

Table 8 -Young adults' views on caretakers/counsellors' understanding of their past

The empathetic role counsellors are important to understand at this juncture. According to table 8, **53.4%** stated that they always understood their past. **22.6%** felt that they were able to understand them empathetically at times. **17.1%** felt they often understood the same. **6.8%** of them stated that they never understood the past of these young adults.

When young adults feel that their Counsellors or caretakers truly understand their experiences, they are more likely to feel validated. This can reduce feelings of shame or guilt often associated with ACEs.For those who feel that they are only sometimes or

never understood, the trauma of ACEs may remain unaddressed or unresolved. The lack of empathetic support could exacerbate negative feelings, perpetuating cycles of neglect, shame, or anger. Empathy is an essential aspect of trauma recovery.

Looking at how the counsellors define the relationship with the respondents that they deal within DB- YaR forum centre, it was identified that **88.6%** of the responses of the counsellors has been positive like sharing a loving, cordial, listening and happy relationship. **1.8%** of the responses of them feel that they have a non - cordial relationship with the young adults. **6.4%** felt the young adults were over-attached to them and **2.8%** of them stated that they felt mutual care and trust in the process.

The nature of the relationships between counsellors, caretakers, and the respondents is directly related to the impact of ACEs.Young adults and adolescents who experience trauma often struggle with attachment, trust, and emotional regulation. The way adults respond to these needs—whether with empathy, love, and understanding—can either mitigate or exacerbate the effects of their past experiences.

Sl. No	**Counsellor's response on interventions or support systems to help young adults**	**Number of respondents**	**Percent**
1	Yes, we have comprehensive programmes	17	54.8
2	Yes, but only limited support systems	10	32.3
3	No, we haven't implemented such programmes	4	12.9
Total		31	100.0

Table 9 - Counsellor's response on Interventions or support systems to help young adults

With the level of interaction and relation that the young adults share with them, it was identified from table 9 that **54.8%** of the counsellors stated that comprehensive programmes for intervention and support systems are created and ventured into. But, **32.3%** of them stated that there is a limited support system in the resilience building process and **12.9%** of them do not have any implemented programmes.

The level of intervention and support systems for young adults within DB-YaR's Programmes varies significantly, with the majority of young adults benefiting from comprehensive Programmes that address the complexities of ACEs. However, a significant portion of young adults still faces limited or no support, highlighting the need for expansion and improvement.

A significant percentage of counsellors and caretakers is **26.9%** prioritize helping young adults understand how their early adverse experiences that help in behaviour building. The largest percentage **30.1%** of respondents highlighted the importance of creating a safe and supportive space for young adults to talk about their past experiences. This approach is foundational in addressing ACEs.

Sl. No	Assist individuals with unfavourable childhood experiences	Number of responses	Percent
1	Helping to understand and address how early bad experience affect his/her behaviour now	25	26.9
2	Making a safe and supportive place to talk about the past	28	30.1
3	Remembering that a child's early experiences matter, not just current Behaviour	15	16.1
4	Listening to and talking about forgotten childhood memories	14	15.1
5	My personal prejudice becomes a hindrance to addressing child's issues	4	4.3
6	Not feeling confident/capable to handle the above-mentioned issues of young adults	4	4.3
7	Any other [For serious cases, medication is used to help resolve addictions, not to give more importance to that instead focus on their dream and create a good atmosphere. More credibility and attentive listening, engaging them inDrawing and play therapy. Group and individual sessions moving forward forgetting past]	3	3.2

Table 10 - Supporting young adults with Adverse Childhood Experiences

ACEs can significantly impact a child's development, and focusing only on current behaviour without considering the root causes can lead to misdiagnosis or inappropriate interventions. As per table 10, **16.1%** of Counsellors and caretakers emphasized this approach, showing that many are aware of the importance of a trauma-informed perspective that looks at the child's whole history, not just present actions. A slightly smaller group **15.1%** believes in the importance of talking about forgotten or repressed childhood memories. **4.3%** of them stated that their biased personal opinion is a major challenge in addressing ACEs. **3.2%** of them stated that medication for serious mental health concerns, focus on young adults' aspirations, art/play therapy and group or individual sessions helps in ensuring better safety for young adults.

Maintaining records and documentation for each child is an important way of following up children with ACEs inside the CCI or in the community programmes. **9.7%** of them maintain only hardcopies of the records, **3.2%** as soft copy, **83.9%** as both hard and soft copies as well as **3.2%** in a combination of both. It is vital to note that this increases the chances of a decreasing the gaps in intervention even if a counsellor or a care taker is replaced by another. There can be sense of similar documentation mechanism with in the DB – YaR Forum Centre that can be easily practiced.

In the above data it is clear that parental and emotional support are critical for mitigating the long-term effects of ACEs. There is a need for improved engagement from parents, peers, and counsellors. Trauma-informed care should be universally implemented across all Programmes to ensure that young adults' histories are understood and addressed in interventions. Mental health support and counselling services should be expanded and tailored to meet the emotional needs of young adults, particularly those struggling with grief, loneliness, or fear. Comprehensive intervention Programmes must be prioritized, especially for young adults in households with high levels of violence, emotional neglect, and abuse. Documenting and sharing records is a positive step for creating continuity and ensuring that young adults receive consistent care.

4.2.1. ACEs and Substance Abuse

The ACEs can be a cause for substance abuse in individuals at a young age. This section will deal with the causes, sources and consequences of substance abuse among young adults with ACEs. It is noted that most of the young adults who willingly participated in the study were not users of substances. A total of 106 young adults do not belong to the substance user's category in the study. The section will ideally examine **40 young adults** who used substance living in CCI or under the aegis of community level intervention Programme.

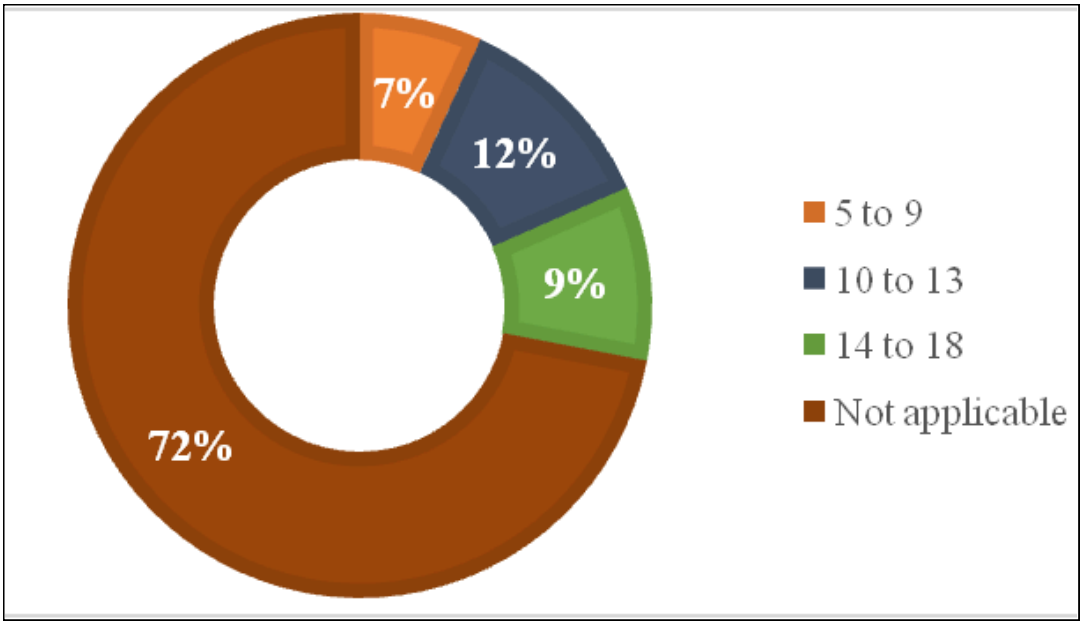

Figure 10 - Age at the first-time intake of substance

As per figure 10, **7%** of them initiated their first intake of substance between the age of 5 - 9 years. Around **12%** of them quoted 10 - 13 years as their first age of intake and the rest **9%** took did it first between the age group of 14 - 18 years.

SI. No	Type of substance	Number of responses	Percent
1	Dendrite	1	0.5
2	Fuel (Kerosene/Petrol)	13	6.8
3	Ganja	14	7.4
4	Gutkha	6	3.2
5	LSD	1	0.5
6	Marijuana	3	1.6
7	Paint	9	4.7
8	Pan Parag	5	2.6
9	Solvent/Whitener	5	2.6
10	Tobacco/Vaping	26	13.7
11	None	107	56.3

Table 11 - Type of substance

Dentrite, Fuel (like Kerosene and Petrol), Ganja, Gutkha, LSD, Marijuana, Paint, Pan Parag, Solvent/Whitener and Tobacco/Vaping were the forms of substances used by the respondents generally. A per table 11, more than **50%** of the respondents were not part of any such intake which is positively noted. The following table shows the degree of respondents who used such substances. **11.20%** of them stated oral usage, **16%** used cigarettes for intake, **16.2%** of them sniffed such products and **1.2%** stated other means like pencil biting, alcohol and beeda 420 (a type of paan).

The source of acquiring substances is varied among the young users. Out of the total respondents, **9.4%** buy such products directly from vendors, **13.8%** stated that they were offered by someone, **5%** stated that they borrowed money from others to buy these products, **1.9%** of them stated that they indulged in stealing as a practice to buy these products and **1.3%** of them stated they utilised pocket money as a means to access them.

SI. No	Triggers for Substance Use	Number of responses	Percent
1	After Exams	2	1.1
2	Friends party	21	11.9
3	When angry	11	6.2
4	When someone blames me	6	3.4
5	When someone scolds me	2	1.1
6	When there is a disturbance in the family	2	1.1
7	When there is a quarrel with friend	3	1.7
8	When I feel lonely	9	5.1
9	When I am stressed	5	2.8
10	When I feel hungry	1	0.6
11	Any other [with friends, when feel like it]	5	2.8
12	Not applicable	110	62.1

Table 12 - Triggers for substance use

There are varied reasons for which substance usage was practices by them. Peer pressure is a major cause of substance abuse. **11.9%** of them stated that they consume it while partying with friends; **6.2%** of them stated that they use substance to settle down their anger; **3.4%** of them stated that they consume when someone blames for no cause; post exam stress, when someone scolds and adverse experience in the family is another cause of use of substance among **1.1%** of the young adults. They also stated that hunger, stress, quarrels and whenever they feel like are the reasons leading to substance use.

Sl. No	Instances or circumstances that comforted after intake of substances	Number of responses	Percent
1	Being alone and able to relax	20	12.1
2	Lessening of anxiety, stress or negative emotions	6	3.6
3	Numbing painful thoughts or memories	6	3.6
4	Feeling more confident and outgoing	9	5.5
5	Excitement, sensation and pleasurable high	2	1.2
6	Diminished worries about day-to-day problems	3	1.8
7	No particular circumstances, just the effects of the substance	2	1.2
8	Not applicable	114	69.1
9	Any other [peer group pressure, friends, felt that it should not be taken]	3	1.8

Table 13 - Instances or circumstances that comforted after intake of substances

As per table 13, it was identified that **12.1%** of the young adults feel relaxed, and **3.6%** of them have mental health concerns like anxiety, stress and negative emotions. **3.6%** of them stated tingling and numbness in the body, whereas another **3.6%** of the responses showed numbing thoughts. **5.5%** of the young adults feel confident after the intake, while **1.2%** of them stated excitement after the consumption. **1.8%** of them stated low worries, and **1.2%** of them stated no such impacts. **1.8%** stated no such pressure.

In this context, the following case story is important -

"A 9-year-old boy ran away from his home in Nepal due to abusive circumstances where his alcoholic father beat him up, his mother, and elder brother. He was rescued by Childline

in India and handed over to the police and there-by to CWC, later being placed in a government children's home and eventually transferred to Don Bosco YaR Centre CCI - A1. At 14, he started to smoke and use other substances with friends at school, which declined his academic performance. After multiple counselling sessions, he stopped smoking and started managing his anger, rebellious behaviour, and disobedience. Although he regained focus on his studies for a while, his addiction led to his academic discontinuation. He pursued on-the-job training after class 9 and is now working in a restaurant at the age of 18."

Sl. No	**Period**	**Frequency**	**Percent**
1	0 to 1 month	11	7.5
2	2 to 6 months	8	5.5
3	6 months to 1 year	5	3.4
4	More than 1 year	1	0.7
5	More than 2 years	3	2.1
6	3 years and above	4	2.7
7	Unknown / Can't remember	5	3.4
8	Not applicable	109	74.7
Total		**146**	**100.0**

Table 14 - Period of the substance intake

As per Table 14, it was found that **2.7%** of respondents had been using the substance for over 3 years, **2.1%** for more than 2 years, and **0.7%** for over a year. Also, **3.4%** reported using it for 6 months to a year, **5.5%** for 2 to 6 months, and **7.5%** had been using it for less than a month. Though duration is important, it is equally important to understand the frequency at which the intake takes place. This will help in the analysis of addiction.

SI. No	Frequency of intake	Frequency	Percent
1	Multiple times a day	8	5.5
2	Twice a day	5	3.4
3	Once a day	6	4.1
4	Multiple times a week	5	3.4
5	Twice a week	3	2.1
6	Once a week	2	1.4
7	Sometimes/Rarely	11	7.5
8	Not applicable	106	72.6
Total		**146**	**100.0**

Table 15 - Frequency of substance intake

As per table 15, it was found that a majority of respondents, **7.2%**, reported rarely using the substance. **5.5%** stated they consumed it multiple times a day, while **3.4%** used it twice a day or several times a week. **4.1%** reported using it once a day, **2.1%** used it twice a day, and **1.4%** mentioned they used to consume it once a day.

Critically looking at the impact of substance abuse on young adults with adverse childhood experiences, the following were identified -

- **18.5%** of the young adults believed that substance can never avoid problems; **8.9%** of them stated that it never damaged their self-esteem; **11%** of the young adults this never damage their self-identity; **15.8%** of the young adults stated that it does not contribute to sleeping troubles; and **14.4%** of them stated it never made them hostile.
- **8.2%** of the young adults stated that it damages their self-identity and makes them hostile at times. **7.5%** of the young adults felt that substances damaged their self-esteem at times; **6.8%** of them said that it damaged their self-esteem at times; and **4.1%** of them stated it helps in avoiding problems sometimes.

- **3.4%** of the young adults feels that it can often help them avoid problems, but damages their self-esteem, self-identity and hostile behaviour.
- **3.4%** of the young adults stated that it helps them avoid problems and it always damages their self-esteem. **6.8%** of the young adults stated that it damages their self-esteem and **1.4%** of them stated that their constant insomnia and hostile or aggressive behaviour.

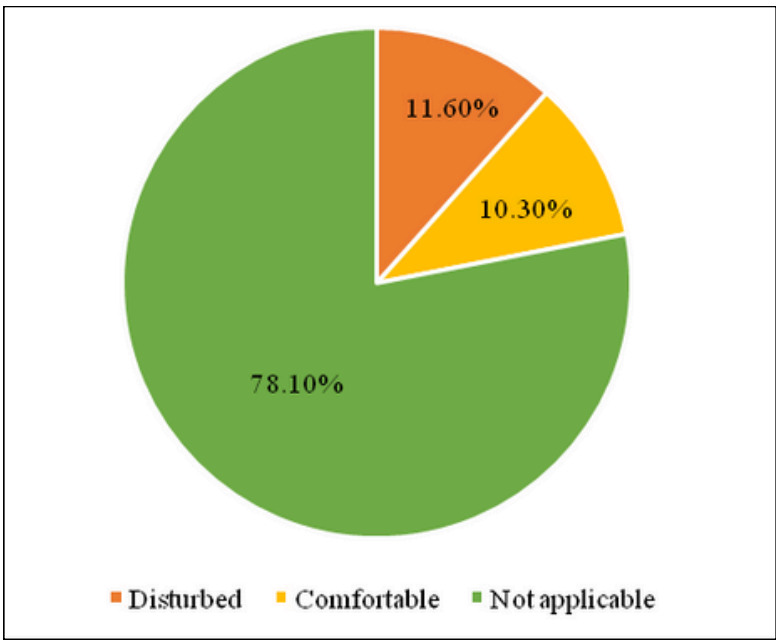

Figure 11 - Felt disturbed or comfortable while using the substance

The figure 11 shows that about **11.6%** of the young adults felt disturbed after the intake of substance and **10.3%** of them felt comfortable after intake.

SI. No	Level	Level of disturbance during substance use		Level of comfort during substance use	
		Number of respondents	Percent	Number of respondents	Percent
1	Mild	5	3.4	3	2.1
2	Somewhat	12	8.2	7	4.8
3	Moderate	5	3.4	9	6.2
4	Quite a bit	3	2.1	7	4.8
5	Severe	3	2.1	3	2.1
6	Not applicable	118	80.8	117	80.1
Total		**146**	**100**	**146**	**100**

Table 16 - Cross-tabulation between level of disturbance vs comfort while using substance

Table 16 shows that **8.2%** of the young adults somewhat disturbed of the intake; **3.4%** of them stated that they are moderately disturbed; **3.4%** of them were mildly disturbed; **2.1%** of them stated quite a bit or severely disturbed and **2.1%** stated that they were disturbed quite a bit. **6.2%** of them stated that they are moderately comfortable after substance intake; **4.8%** of them stated that they are somewhat comfortable; **2.1%** of the young adults have mild and severe comfort after intake.

SI. No	Effort to get away from Substances	No of respondents	Percent
1	Made efforts	31	21
2	Did not make any effort	10	7
3	Not applicable	105	72
Total		**146**	**100.0**

Table 17 – Made effort to get away from Substances

It was observed from the above table that Counselling parents to understand the psycho-social factors affecting their young adults was also a key focus for **23%** of respondents abuse and **7%** of them have not made any such efforts. Table 18 illustrates the efforts made to overcome the substance abuse.

Sl. No	**Efforts made to overcome**	**Number of responses**	**Percent**
1	Aggression/Violence	5	2.9
2	Binge eating	2	1.1
3	Creating expression	5	2.9
4	Did not make any significant efforts	4	2.3
5	Leaned on family/friend support system	8	4.6
6	Made lifestyle changes (avoided triggers, changed friend groups, etc.,)	10	5.7
7	Passive silence	3	1.7
8	Self-care (exercise, meditation, hobbies, etc.,)	3	1.7
9	Self-destruction/harming	1	0.6
10	Sought counselling/ therapy	3	1.7
11	Struggles but kept trying different approaches	1	0.6
12	Taking family responsibilities	5	2.9
13	Used medication-assisted treatment	7	4.0
14	used self-help resources (books, apps,)	2	1.1
15	Any other [Not even think about the issue, due to personal relationship, had a strong will power	3	1.7
16	Not applicable	113	64.6

Table 18 - Efforts made to overcome

Table 18 highlights various efforts young adults have made to address a specific challenge, with varying levels of engagement. As a major mechanism of bringing them back to life, **5.7%** made life style changes, **4.6%** sorted help from family and friends and **4%** were medicated. **1.7%** stated self -care practices like medication and exercise as their effort to overcome. **1.7%** were into therapy and **2.9%** found expression as their coping mechanism. **1.7%** resorted to passive silence and some formed destructive behaviour as a sense of coping. **This data reflects both guided and unguided coping strategies of the respondents. Counsellors can ensure that they give better attention to the same.**

Sl. No	**Withdrawal symptoms**	**Number of responses**	**Percent**
1	Allergy	7	3.2
2	Anxiety	9	4.2
3	Behavioural changes	7	3.2
4	Body pain	11	5.1
5	Depression	4	1.9
6	Fatigue/Tiredness	4	1.9
7	Fever	6	2.8
8	Headache	6	2.8
9	Sadness	5	2.3
10	Irritability	5	2.3
11	Nausea	4	1.9
12	Seizure	1	0.5
13	Shivering	4	1.9
14	Sleep Disturbance / Insomnia	7	3.2
15	Stomach Pain/ Problems	5	2.3
16	Hyperactivity	3	1.4
17	Irregular Heartbeat	2	0.9
18	Sweating	2	0.9
19	Not applicable	120	55.6
20	Any other [loss of appetite]	4	1.9

Table 19 - Withdrawal symptoms

Table 19 outlines various withdrawal symptoms reported by respondents; among those who did experience symptoms, body pain was the most commonly reported **5.1%**, followed by anxiety at **4.2%** and allergy at **3.2%**. Other notable symptoms included sleep disturbances/insomnia **3.2%**, irritability **2.3%**, sadness **2.3%,** and stomach problems **2.3%**. Less frequently reported symptoms included seizures **0.5%,** irregular heartbeat **0.9%,** and sweating **0.9%.** Some young adults also mentioned symptoms like fatigue, nausea, and shivering **each 1.9%**, while others reported additional symptoms like loss of appetite. **These withdrawal symptoms reflect the diverse experiences respondents have, though the majority reported no withdrawal effects.**

SI. No	Reasons lead you to start using substance	Number of Responses	Percent
1	Abusive situation	1	0.5
2	Access to substance	6	3.1
3	Crowded family	2	1.0
4	Curiosity	18	9.4
5	Death of loved ones	3	1.6
6	Eliminate shyness	1	0.5
7	Family disputes	4	2.1
8	Family violence	7	3.7
9	Having free time	8	4.2
10	Joy seeking	6	3.1
11	Lack of access to counselling	1	0.5
12	Lack of knowledge about complications of substance abuse	3	1.6
13	Low self-confidence	3	1.6
14	Love failure	3	1.6
15	Over strictness of parents	1	0.5
16	Nuclear family situation	1	0.5

Table 20 - Reasons lead to start using substance

SI. No	Reasons lead you to start using substance	Number of Responses	Percent
17	Parents' Divorce/Separation	2	1.0
18	Peer Groups	1	0.5
19	Presence of an addicted person in residential/educational place	11	5.8
20	Any Other [no response]	1	0.5
21	Not Applicable	108	56.5

Table 20 - Reasons lead to start using substance

There are several causes for substance use, in table 20, those who provided reasons, curiosity was the most common factor **9.4%,** followed by presence of an addicted person in the household or educational setting **5.8%** and having free time **4.2%.** Other factors included family violence **3.7%,** access to substances **3.1%,** and joy seeking **3.1%.** Emotional and personal issues, such as death of loved ones, family disputes, and love failure, each accounted for a small but notable proportion **around 1.6%**. Lack of knowledge on the cons of substance usage, low confidence level and peer pressure can also be causes of substance initiation and relapse in them. As mentioned before, strict parenting, nuclear families leading to neglect can also be the reasons for substance usage.

SI. No	**First source of introduction to the substance**	**Number of respondents**	**Percent**
1	Classmate	6	4.1
2	Friend	23	15.8
3	Neighbour	2	1.4
4	Relative	6	4.1
5	Any other [by self]	3	2.1
6	Not applicable	106	72.6
Total		**146**	**100.0**

Table 21 - First offered or introduced the substance

In Table 21, there are several sources of substances for these users. Friends were the most common source of introduction **15.8%,** followed by classmates and relatives, both at **4.1%.** A small number of young adults reported introducing the substance to themselves **2.1%** or having a neighbour introduce it **1.4%**. This suggests that peer influence, particularly from friends and classmates, plays a significant role in the initiation of substance use, while a large portion of respondents did not identify any specific young adults responsible for offering the substance.

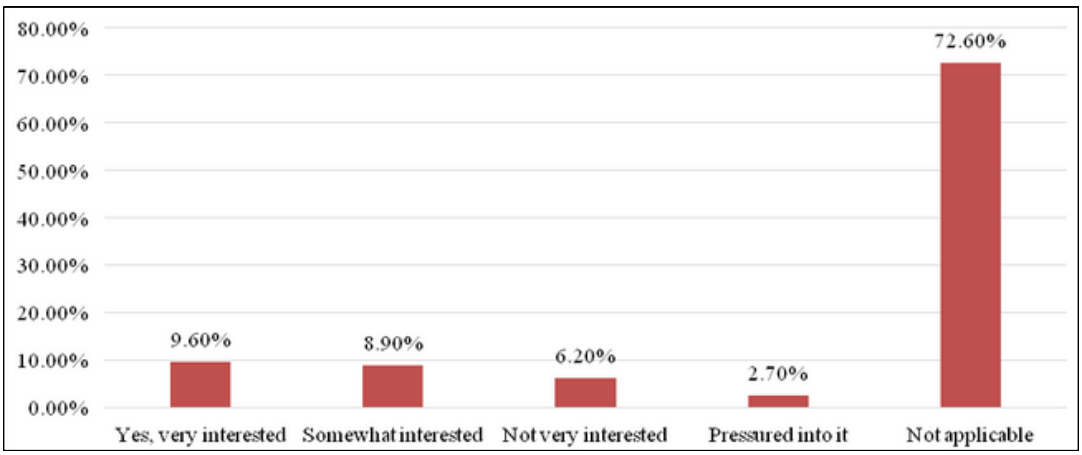

Figure 12 - Willingness to experiment: accepting the substance when first offered

In figure 12 it is an explicit that about **9.6%** of the young adults are very interested in using substances, **8.9%** of them stated they were somewhat interested; **6.2%** are not interested, and **2.7%** of them are pressured into it.

Sl. No	Source	Number of responses	Percent
1	Borrowing from Family	11	6.70
2	Borrowing from Friends	23	13.90
3	Borrowing from Others	1	0.60
4	Given by adults	3	1.80
5	Illegal activities	2	1.20

Table 22 - Source of money

Sl. No	Source	Number of responses	Percent
6	Legal earnings	2	1.20
7	Pocket money	11	6.70
8	Stealing	1	0.60
9	Other means	2	1.20
10	Not Applicable	109	66.10

Table 22 - Source of money

In Table 22, the sources of money as per the counsellors included friends **13.9%** and borrowing from family **6.7%**. The usage of pocket money was reported by **6.7%** of respondents. Other sources included provision of substances by adults **1.8%**, engaging in illegal activities **1.2%,** or obtaining substances through legal earnings **1.2%** or other means **1.2%.** A small proportion also reported indulging in stealing **0.6%** or borrowing from others **0.6%**. **This suggests that substances were often accessed through social relationships (family and friends), while a significant number of young adults did not identify a specific source.**

The influence of social media and family dynamics on substance use among young adults. **15.1%** of young adults reported being positively influenced by social media images, while **11%** stated they experienced a negative influence from social media. A significant portion, **23.3%,** stated that social media had no influence on them regarding substance use.

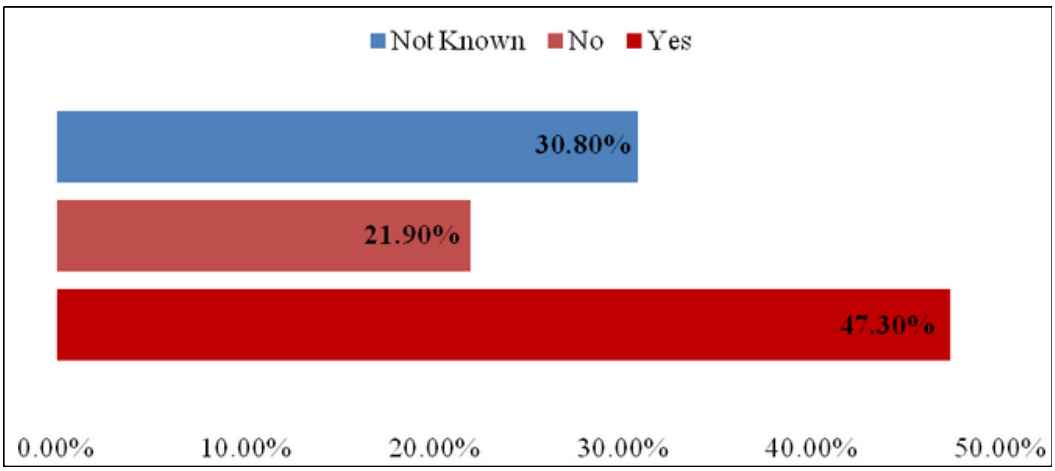

Figure 13 - Family members/relatives engaged in substance abuse

In figure 13, family usage of substances is presented. **47.3%** reported that family members were involved in substance use, which could potentially contribute to their exposure to or normalization of such behaviour. On the other hand, **21.9%** of them stated that their families were not involved in substance usage. **30.8%** were unsure whether their family members used substances, indicating a lack of awareness or openness on the topic within some families. **This data underscores the role of both social media and family environments in shaping attitudes toward substance use, with a particularly high percentage being influenced by family members who are involved in substance use themselves.**

Sl. No	Ever engaged in illegal activities to obtain the substance	Ever been to policestation/observation home in context of substance abuse			Total
		Yes	No	Not applicable	
1	Engaged	4	0	0	4
2	Not engaged	5	37	2	44
3	Not applicable	1	2	95	98
Total		**10**	**39**	**97**	**146**

Table 23 - Cross tabulation between illegal activities for substance acquisition vs legal encounters in the context of substance abuse among young adults

The cross-tabulation data in table 23, highlights the relationship between engaging in illegal activities to obtain substances and involvement with law enforcement or observation homes. Among those who engaged in illegal activities **6.8%**, 4 of them **2.7%** had also been to a police station or observation home, indicating a direct link of facing the consequences of their act. Majority i.e., **30.1%** of the respondents were not engaged in illegal activities. About 37 i.e., **25.3%** reported no illegal engagement. The overall involvement with law enforcement is relatively low.

SI. No	Family's awareness of substance Abuse	Number of respondents	Percent
1	Aware	26	17.8
2	Not aware	12	8.2
3	Not applicable	108	74.0
Total		**146**	**100.0**

Table 24 - Family's awareness of Substance Abuse

Table 24 states family members were aware of the young adults' substance abuse, table 21 shows that **17.8%** of respondents reported that their family did know about their substance use. In contrast, **8.2%** stated that their family did not know. Out of the 108 respondents stated 'not applicable' as the response.

SI. No	Action taken	Number of responses	Percent
1	Beating	13	7.7
2	Blaming	4	2.4
3	Counselled by family	10	5.9
4	House arrest	4	2.4
5	No action	1	0.6
6	Referred to counselling centre	4	2.4
7	Referred to a religious centre	1	0.6
8	Referred to de-addiction centre	3	1.8
9	Relocated to relative's place	1	0.6
10	Scolding	7	4.1
11	Not Applicable	120	71.0
12	Any Other [told to keep away]	1	0.6

Table 25 - Action taken by the family

Table 25 outlines the actions taken by family members upon discovering an individual's substance abuse. The most common response was beating, **7.7%,** followed by counselling by family members, **5.9%.** Other actions included scolding **4.1%,** blaming **2.4%**, and house arrest **2.4%.** A small number of young adults were referred to counselling centres, religious centres, or de-addiction centres (each around **2.4%** or lower). Some young adults were relocated to a relative's place **0.6%,** or told to keep away **0.6%**. A significant proportion, **71%,** reported that it is not applicable with a probable indication of not facing any positive or negative family intervention. It is to be noted that **108** respondents of the **71%** of the responses were due to no substance usage. The rest were possibly indicating that they did not face any family intervention for this issue. It is positive to note that families of around **30%** have taken steps and interventions to end the substance usage in the respondents, but the steps were negative.

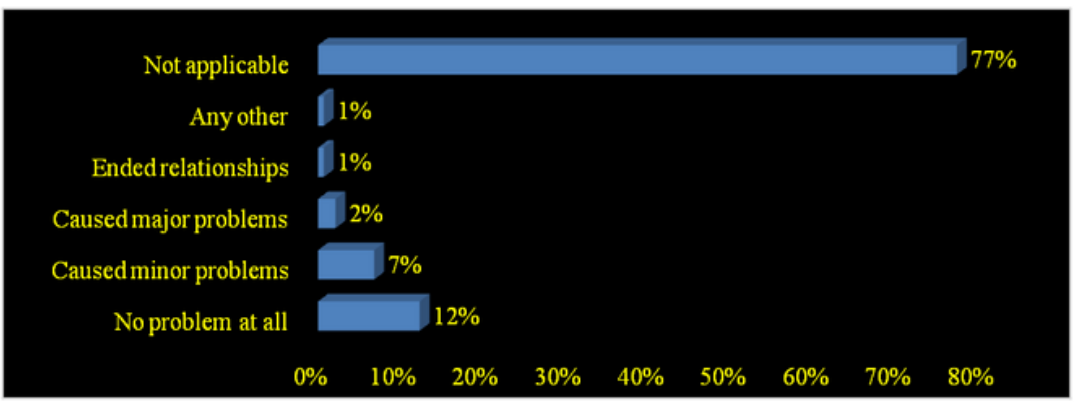

Figure 14 - Problems in relationship with friends or family due to intake of substance

In figure 14, the family/friends of the young adults engaged with stated that **12%** of them did not show any problem; **7%** of them had caused minor problems with the usage; **2%** of them had major concerns; **1%** of them ended relationships with the young adults and another **1%** showed disinterest.

About **16%** of the young adults did not get any treatment and **9%** of them got treatment for the same. **6.7%** were taken to de-addiction centre, **4%** were in a counselling centre and **2%** of them were taken to a clinic.

Further to this, it was also observed that **12%** of them stopped using substance knowing its consequences; **8%** of them reduced the frequency of intake; **2%** of them continued the consumption and another **2%** of them was under was unaware of petrol smell as an addiction and also got into counselling at the CCI.

SI. No	Knowledge Level	Number of respondents	Percent
1	Poor	1	3
2	Average	4	13
3	Good	17	55
4	Excellent	9	29
Total		**31**	**100**

Table 26 - Counsellor's response on knowledge about understanding of substance abuse

In table 26, counsellors who handle the mental health of the young adults under adverse conditions and take substance, need a knowledge base about substance abuse. **55%** of them have a good understanding about substance usage and its influences. **13%** of them have an average knowhow and **3%** of them have a poor understanding.

Based on figure 15, **45%** of them occasionally worked for the recovery of young adults from adverse experience; **23%** of them have not worked with them; **22%** of them have frequently handled such cases and **10%** of them stated that they do not have any idea on how to handle such cases. It was also observed on the various approaches taken to support young adults in overcoming challenges and building resilience.

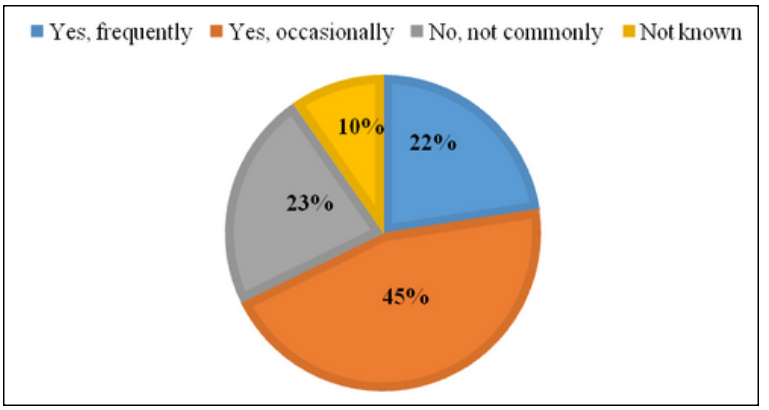

Figure 15 - Counsellor's response on patterns of childhood adversity in substance abuse recovery

Sl. No	Particulars	No of responses	Percent
1	Providing a secure and nurturing environment to children	30	31
2	Encouraging children to engage in activities for building resilience	23	24
3	Motivation parents to have positive attitude towards children	20	21
4	Counselling the parents to understand their psycho-social situation affecting their children	22	23
5	Any other [In my practice, I've mostly focused on helping those children identify, understand and accept and acknowledge their current situation. The second step is to help children envision a future where they, along with their future children no longer experience the same things of the past. Then we empower them to take charge of their lives and rewrite their stories, making them realise that they have the power to change the narrative and give their stories a happy ending, regardless of whatever their past has been. Conduct school mental health programmes / provide psychoeducation in schools / promote individualized counselling and therapy in schools to find out the problems if any]	2	2

Table 27 - Breaking the Cycle: Preventing the Intergenerational Transmission of Childhood Trauma and Its Impact on Mental Health and Substance Abuse

Counselling parents to understand the psycho-social factors affecting their young adults was also a key focus for **23%** of respondents. The most commonly reported approach was providing a secure and nurturing environment for young adults **31%,** followed by encouraging young adults to engage in activities to build resilience **24%.** Another significant action was motivating parents to have a positive attitude toward their young adults **21%. About 2% of respondents highlighted helping young adults understand and change their living styles, conducting school mental health programmes, and providing**

individualized counselling and therapies to identify and address underlying problems. These findings suggest that emotional support, parental involvement, and proactive interventions in schools can support the mental and emotional well-being.

SI. No	Type of Substance	Number of Responses	Percent
1	Dendrite	2	2
2	Fuel (Kerosene/Petrol)	7	7
3	Ganja	18	19
4	Gutkha	10	10
5	Magic Mushroom	1	1
6	Marijuana	5	5
7	Paint	7	7
8	Pan Parag	12	13
9	Solvent/Whitener	7	7
10	Tobacco/Vaping	17	18
11	Tar	2	2
12	Varnish	1	1
13	None	4	4
14	Any other [Alcohol, Cigarette, Cool lip]	3	3

Table 28 - Types of substances young adults used majorly (from the counsellors)

In table 28, to enable an approach of betterment, counsellors are supposed to understand the types of substances used by the young adults. Ganja was the most recognized substance, with **19%** of responses identifying it. Other commonly known substances include tobacco/vaping **18%** and pan parag **13%.** Gutkha was noted by **10%** of respondents, while fuel (kerosene/petrol) and paint each accounted for **7%.** Other substances such as solvent/whitener and fuel, were recognized by **7%,** and dendrite and tar had a relatively lower recognition at **2%** each. A few substances such as alcohol, cigarettes and coolip were used by **3%** of them. Notably, **4%** of young adults indicated

they did not know of any of these substances. **This highlights that counsellors are most familiar with commonly abused substances, which can make interventions more comprehensive and contextual.**

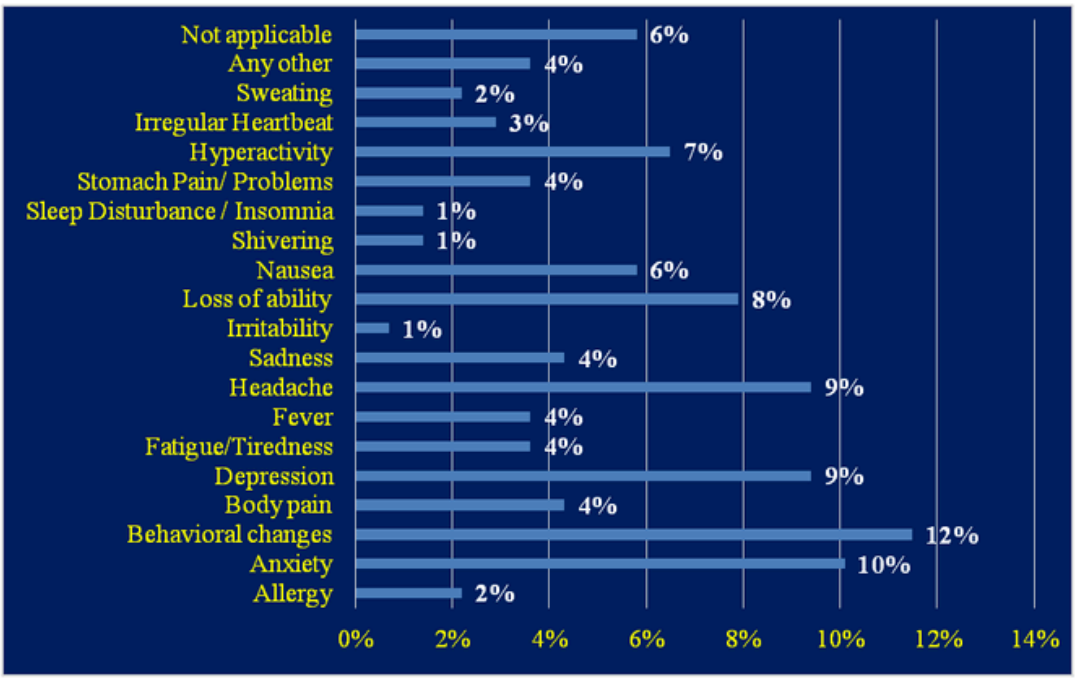

Figure – 16, withdrawal symptoms of the young adults as observed by counsellors

The above figure 16 shows the withdrawal symptoms of the young adults and highlight the prevalence of various withdrawal symptoms observed by counsellors, with a total of 139 responses. The most commonly reported symptoms include Behavioural changes **12%**, anxiety **10%**, and depression **9%,** while other symptoms such as headache, loss of ability, and hyperactivity were also notable. Less frequent symptoms included irritability, shivering, and sleep disturbance, each affecting just **1%** of young adults. Additionally, **6%** of counsellors reported no withdrawal symptoms at all, while **4%** mentioned experiencing other unspecified symptoms. These findings suggest that withdrawal can lead to a range of physical and emotional challenges, with variability in intensity and frequency.

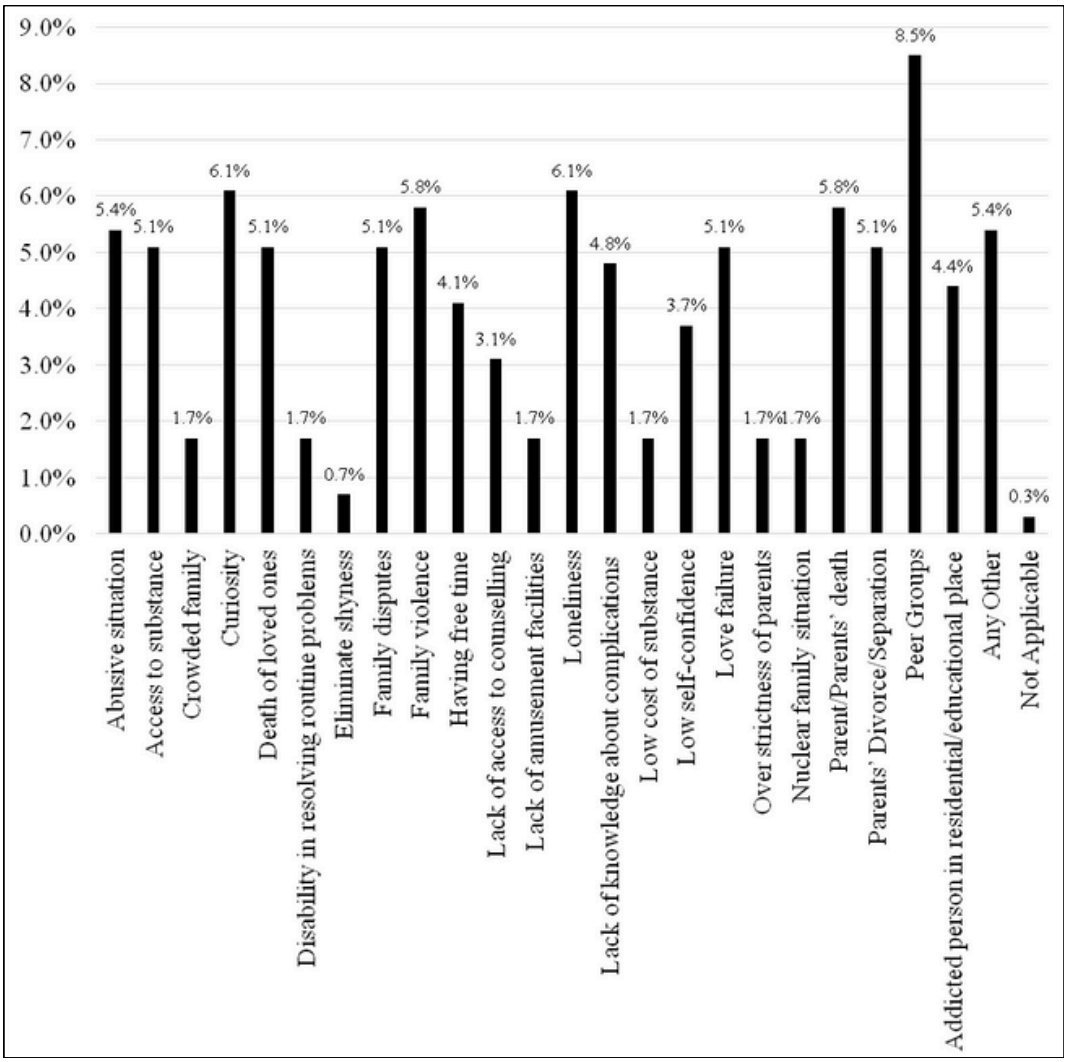

Figure 17 - Counsellor's purview about the various reasons that led children to start using substances

Figure 17 shows the purview of counsellors about the various reasons that led children to start using substances, based on 294 responses. Peer groups emerged as the most significant factor, with **8.5%** of counsellors stating this. They further stated that curiosity and loneliness **6.1% each** were among the respondents, and another **5.4%** of counsellors cited abusive situations, family violence, parental death **5.8%** and death of loved ones **5.1%** as the causes of indulging in substances. **Family-related issues, such as disputes, divorce, or the presence of an addicted person in their families, also aggravate**

the situation. Another **5.1%** of them were affected by parental divorce or separation and love failure. The young adults indicated a lack of knowledge about the consequences of substance abuse **4.8%** and low self-confidence **3.7%. Peer influence, family dynamics, and emotional challenges play a significant role in children's decision to engage in substance use.**

SI. No	Source of money	Number of responses	Percent
1	Borrowing from Family	12	9.7
2	Borrowing from Friends	28	22.6
3	Borrowing from Others	12	9.7
4	Given by adults	10	8.1
5	Illegal activities	17	13.7
6	Legal earnings	5	4.0
7	Mutual benefit for buyer and consumer	4	3.2
8	Pocket money	17	13.7
9	Stealing	17	13.7
10	Not Applicable	2	1.6

Table 29 - Counsellor’s purview about the source of money for young adults to get the substance

Table 29 shows that assessing the know-how of the counsellors on the sources of money for substances, it was identified that they borrow from friends **22.6%**, indulge in stealing, illegal activities, and pocket money **13.7%**. Borrowing from family and others accounted for **9.7%**, while borrowing from adults was noted at **8.1%**. Smaller percentages indicated substances were obtained through legal earnings **4.0%** or mutual benefit between the buyer and consumer **3.2%.** A very small proportion **1.6%** indicated that the source did not apply to their knowledge. **These findings suggest that Counsellors are most aware of substances being obtained through relatives, illegal activities, or financial resources like pocket money.**

SI. No	Socio-cultural elements	Number of responses	Percent
1	Peer pressure	26	21.1
2	Accessibility of substance	12	9.8
3	Unstable living conditions	16	13.0
4	Curiosity or experimentation	16	13.0
5	Socio-economic status	14	11.4
6	Mental health issues or emotional distress	18	14.6
7	Culture approval of certain substances	11	8.9
8	Perception of substance abuse as a coping mechanism	6	4.9
9	Any other	4	3.3

Table 30 - Socio-cultural factors influencing substance abuse

Table 30 reflects the socio-cultural factors influencing substance abuse, as identified by young adults. The most common socio-cultural element was peer pressure, which was mentioned by **21.1%** of young adults, indicating that social influence plays a significant role. Other prominent factors included mental health issues or emotional distress **14.6%**, unstable living conditions **13.0%,** and curiosity or experimentation **13.0%**. Socio-economic status also emerged as a notable factor, with **11.4%** of young adults acknowledging its influence. Additionally, accessibility of the substance **9.8%** and cultural approval of certain substances **8.9%** were reported as contributing factors. A smaller proportion of young adults **4.9%** identified the perception of substance abuse as a coping mechanism, and **3.3%** reported other factors. **These findings suggest that social pressures, mental health challenges, and environmental conditions significantly shape attitudes and behaviours related to substance use.**

To identify and understand if ACEs have a link to mental health among young adults in DB-YaR Forum centres, the counsellors were the major respondents in the context of understanding mental health on a scale of 1 to 5.

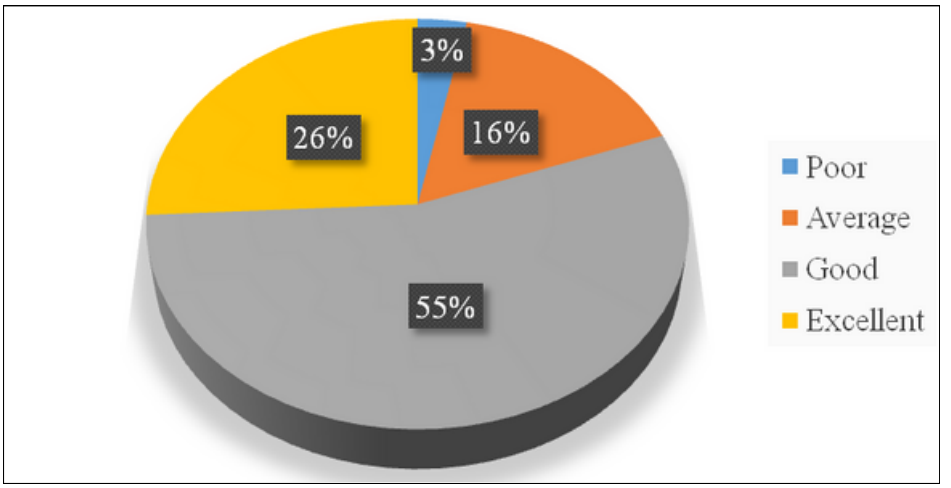

Figure 18 - Counsellor's understanding of the mental health concerns caused among young adults with ACEs

In Figure 18 about understanding of mental health concerns among young adults with ACEs, by the counsellors it is identified that **55%** feel they have a good awareness about the same; **26%** had an excellent understanding of the same. **16%** of them have only average knowhow and **3%** have poor understanding.

Sl. No	**Description**	**Frequency**	**Percent**
1	Yes, frequently	3	10
2	Yes, occasionally	7	23
3	No, not commonly	15	48
4	Not known	6	19
Total		**31**	**100.0**

Table 31- Co-occurring mental health issues seen among young adults handled by the Counsellors who recovered from substance abuse

In table 31, on examining the cases of recurrence of mental health issues like sadness, trauma and anxiety among young adults handled by the Counsellors who recovered from substance abuse, it was observed that **48 %** reported no such cases. **10%** shared frequent occurrence, and **23%** of them shared occasional incidence. **19%** of them were unaware of any such instances.

Sl. No	**Methods**	**Number of responses**	**Percent**
1	Reading books/articles	23	17.2
2	Field experience	24	17.9
3	Educational courses	21	15.7
4	Online resources	13	9.7
5	Training or certification Programmes	12	9.0
6	Personal experiences	19	14.2
7	Conversations with professionals	22	16.4

Table 32 - Counsellors' approaches to understanding mental health and substance abuse

Table 32 highlights the counsellors' academic understanding on the field of mental health. A total of **134 responses** were received. Only **17.9%** stated that field work leads to more understanding and skill sets in counsellors. **17.2%** stated reading of books and articles, and **16.4%** stated conversations with professionals as a cause of their understanding. For **14.2%**, personal experiences played a significant role. **15.7%** stated educational courses, **9.7%** indicated training and **9%** stated certifications. Practice, professional expertise and academic knowhow back their level of knowledge.

Sl. No	Mental health concerns	Number of response	Percent
1	Anxiety	14	14.6
2	Depression	20	20.8
3	Change in sleep patterns	15	15.6
4	Mood Swings	22	22.9
5	Attention deficit	10	10.4
6	Self-harm thoughts/Behaviour	12	12.5
7	Any other [None and Centre has no substance abuse young adults]	3	3.1

Table 33 - Prevalent mental health concerns as per counsellors

Table 33 presents the mental health concerns among respondents recovering from substance abuse as per the counsellors. A total of 96 responses were recorded. Mood swings were the most commonly reported issue, affecting **22.9%** of adolescents and young adults, followed by depression **20.8%** and anxiety **14.6%**. Other include sleep patterns **15.6%** and self-harm thoughts/behaviour **12.5%**. Attention deficit was stated by **10.4%** of the counsellors, while **3.1%** indicated no mental health concerns. **This indicates psychological concerns such as depression and mood swings as prominent concerns.**

Sl. No	Symptoms in identifying potential mental health difficulties	Number of responses	Percent
1	Reduced sleep but enhanced focus	11	13.3
2	Reduced self-care	16	19.3
3	Enhanced energy and mood	18	21.7
4	Feeling scared even in the absence of potential threats	11	13.3
5	Withdrawal from social activities and maintaining privacy	19	22.9
6	Increased hunger and weight gain	4	4.8
7	Not applicable	4	4.7

Table 34 - Symptoms to look for in identifying potential mental health difficulties in young adults battling substance abuse reported by counsellors

Table 34 outlines symptoms to look for in identifying potential mental health difficulties in young adults and adolescents who are enduring substance abuse, based on 83 responses. The most reported symptoms included withdrawal from social activities and maintaining privacy **22.9%,** enhanced energy and mood **21.7%,** and reduced self-care **19.3%.** They also stated reduced sleep, but enhanced focus and feeling scared even in the absence of potential threats were both noted in **13.3%** of responses. Increased hunger and weight gain were stated by **4.8%. This data suggests that emotional and behavioural changes, such as withdrawal symptoms and mood swings.**

Sl. No	Particulars	Number of responses	Percent
1	Referral to professional	15	21.1
2	Empower young adults to overcome the stigma	26	36.6
3	Open discussion on substance abuse and mental health	22	31.0
4	Educate young adults and guardians about the link between mental health issues and substance usage	6	8.5
5	Any other [by various play activities, I will not allow my girls to do that]	2	2.8

Table 35 - Counsellors' strategies for addressing stigma in substance abuse and mental health

Table 35 presents various approaches to reducing stigma stated by counsellors related to substance abuse and mental health issues, based on 71 responses. The important strategy was empowering the adolescents or young adults to overcome stigma, accounting for **36.6%** of the responses. Open discussions on substance abuse and mental health were stated by **31.0%**, while **21.1%** responses emphasized referral to professionals for further support. Educating the adolescents or young adults and their guardians on mental health issues and substance use reflected on by **8.5%. 2.8%** proposed using playing activities or personal actions, like preventing certain behaviours in their families as an intervention to tackle stigma. It is hereby suggested that open communication, empowerment, and education can help in addressing and reducing stigma around sensitive issues.

SI. No	Types of establishments or centres	Number of responses	Percent
1	Clinic	6	6.5
2	Counselling Centre	23	24.7
3	De-addiction Centre	20	21.5
4	Govt. Hospital	5	5.4
5	Local/Spiritual Medicine Man	2	2.2
6	Religious centre (Church, Temple, Mosque)	6	6.5
7	Private Consultation/hospital	4	4.3%
8	Psychiatric Hospital	12	12.9%
9	Retreat/Rehabilitation centre	11	11.8%
10	Not applicable	4	4.3%

Table 36 - Support centres accessed by young adults as reported by counsellors

Table 36 provides information on the types of establishments or centres where the respondents sought help, based on 93 responses. The establishments included counselling centres **24.7%,** followed by de-addiction centres **21.5%** and psychiatric hospitals **12.9%.** Other responses stated retreat/rehabilitation centres **11.8%** and clinics or religious centres **6.5% each.** Government hospitals and private consultations accounted for **5.4%** and **4.3%**, respectively, while local/spiritual medicine men represented **2.2%**. This data suggests that counselling and specialized treatment centres play a central role in addressing mental health and substance abuse challenges.

Sl. No	Role that Social Support contribute	No of responses	Percent
1	Provide emotional support	29	25.4
2	Encourage healthy lifestyle	28	24.6
3	Promote healthy recreation	24	21.1
4	Facilitate access to social network	19	16.7
5	Facilitate access to professionals	14	12.3

Table 37 - Role of social support on recovery from substance abuse and mental health challenges

Table 37 illustrates the various roles that social support networks, such as family, friends, and community groups, play in the recovery and management of co-occurring substance abuse and mental health issues, based on **114 responses**. The most significant role was providing emotional support, **25.4%** of respondents, followed by encouraging a healthy lifestyle **24.6%** and promoting healthy recreation **21.1%**. About **16.7%** noted that the networks help in accessing social relations, while **12.3%** stated that they connect adolescents or young adults to professionals. This portrays the role of social support networks in recovery, with emotional support, and helping to manage both substance abuse and mental health challenges. **Annexure 4 (Case Story 1)** depicts the case story to understand the primary intervention of the counsellors in such cases.

Sl. No	Procedures	Number of responses	Percent
1	Dialogue with the person/child	27	31.8
2	Refer to counsellor	22	25.9
3	Refer for professional treatment	17	20.0
4	Referral to Director / Authority	16	18.8
5	Any other [None / Psychotherapy]	3	3.5

Table 38 - Procedures followed by counsellors to address the mental health needs of young adults

Table 38 identifies the mental health needs of young adults collating 85 responses. **31.8%** of the responses stated that they are having a dialogue with a person or child. **25.9%** of them stated that they refer to counsellors, and **20%** of them used professional treatment referrals. **18.8%** of them were referred to a director or authority for action. **3.5%** stated psychotherapy or no such treatments at all. So, open communication and professional referrals directly refer to curing the mental health requirement of the adolescents and young adult respondents.

Sl. No	**Ways to support**	**Number of responses**	**Percent**
1	Provide a caring and non-judgmental environment	29	34.1
2	Encourage privacy to avoid negative influences	16	18.8
3	Access to professional help for control	27	31.8
4	Avoid discussing mental health to prevent discomfort	12	14.1
5	Any other [Involve the community, psychoeducate the community do that stigma is removed and empower the community to come up with certain interventions to keep a check on substance abuse in the community, come up with stringent rules and regulations for the community as a whole and offering support to a person who is a victim of substance abuse and his/her family.]	1	1.2

Table 39 - Ways to support young adults with substance abuse

Table 39 shows the ways to support adolescents/young adults with substance abuse. There are around 85 responses were collated. **34.1%** took a caring and non-judgemental approach to them; **18.8%** of them encourage privacy for avoiding negative influences, and **31.8%** emphasized accessing professional help for control. **14.1%** avoid discussions about mental health to prevent discomfort, and **1.2%** stated equipping the community and providing them with psychoeducation as the means to deal with it.

SI. No	Recommended Resources	Number of responses	Percent
1	Community support groups	26	21.8
2	Substance abuse forums online	10	8.4
3	Counselling sessions	31	26.1
4	Medical Treatment	24	20.2
5	Therapy sessions	26	21.8
6	Any other [Other Support groups / Accompanying and listening to them]	2	1.7

Table 40 - Recommended resources by counsellors to support young adults with substance abuse

Table 40 presents the recommended resources by counsellors to support young adults with substance abuse, based on **119 responses.** The most commonly recommended resource was counselling sessions, cited by **26.1%** of respondents, followed by community support groups and therapy sessions **21.8% each**. Medical treatment was sought by **20.2%**, while substance abuse forums online were suggested by **8.4%**. Around **1.7%** mentioned other resources, such as support groups or accompanying and listening to young adults. **Counsellors emphasize the importance of professional counselling, therapy, and community support in the recovery process for those dealing with substance abuse. Annexure 5 – Story 1 highlights a success story of these interventions.**

"A 15-year-old child was referred to DB YaR Centre due to aggravating behavioural concerns, low academic performance and substance abuse. After an assessment, it was diagnosed that he has PTSD, anxiety and substance abuse disorder. A comprehensive treatment plan was developed with a focus on trauma-informed care and cognitive behavioural therapy, motivational interviewing and family therapy. The counsellor in his school was involved in the process for better academic performance. His relationships with the family and peers strengthened and remained sober with continued support."

SI. No	Address societal factors	Number of responses	Percent
1	Advocate for policy changes	10	14.9
2	Community-based interventions	23	34.3
3	Collaborate with other professionals	13	19.4
4	Network with other organisations	17	25.4
5	Not applicable	4	6.0

Table 41 - Ways to address societal factors related to substance abuse and mental health

Table 41 outlines various ways to address societal factors related to substance abuse and mental health, based on 67 responses. Community-based interventions were mentioned in **34.3%** of responses, **25.4%** stated networking with other organizations and **19.4%** collaborating with professionals.**14.9%** of responses indicates to advocating for policy changes, while **6%** indicate that any such approach was not applicable. **This highlights the importance of collaboration, community engagement, and policy advocacy in addressing societal factors that impact substance abuse and mental health.**

SI. No	Spiritual/religious practices	Number of responses	Percent
1	Yoga/Meditation	28	28.6
2	Moral Education	27	27.6
3	Prayers/Devotions	19	19.4
4	Good Morning/Night Talks	23	23.5
5	Not Applicable	1	1.0

Table 42 - Spiritual and religious practices reported by counsellors

Table 42 presents the spiritual and religious practices reported, based on 98 responses. The most common practice was yoga/meditation, cited by **28.6%** of respondents, followed closely by moral education **27.6%** and good morning/night talks **23.5%**. Prayers/devotions were mentioned by **19.4%** of respondents, while **1.0%** indicated that spiritual or religious practices were not applicable. **This data suggests that practices such as yoga, meditation, and moral education play significant roles in supporting young adults, potentially aiding in mental health and overall well-being.**

4.3 Key FGD Highlights:

All of them conducted Focused Group Discussions, but instead of confidentiality, the direct statements of the children were not provided. The following are purely the understanding of the counsellors in the process –

- In the discussion, they shared how they began using drugs, with peer group influence being one of the reasons for the same. They think that using drugs makes them appear cool with social media influence. Although some expressed a desire to improve their lives, they recognized that their dependence on drugs was a major obstacle preventing them from making positive changes.
- Feeling ashamed, feeling judged and hiding addiction are the other highlights from the FGD conducted. These phrases highlight the shame and feeling of judgment the individuals feel in the process. This is caused due to addiction as a result of emotional concerns, hiding the habit, social stigma, and unwillingness to seek help.
- Many respondents repeatedly mentioned Mental health and substance abuse stigma significantly hinders help-seeking, with fear of judgment from peers and family being a primary barrier. Unsupportive family structures and lack of communication lead to isolation. Peer influence plays a crucial role, as many initially experiment with substances due to social pressure from friends.
- ·A recurring theme was the difficulty in accessing mental health and substance abuse services, especially youth-specific Programmes. Participants expressed frustration with the lack of resource accessibility. Many participants connected their substance use to past traumatic experiences. They used substances as a way to cope with the pain and emotional distress caused by their trauma.

CHAPTER 5

Results and Conclusion

The study was conducted among young adults and counsellors who are associated with DB-YaR Forum Child Care Institutions and Community Programmes. All of the respondents included were based on their self-interest. It was identified that most of the young adults who participated in the research process were not addicted to substances. A large portion of them who were addicted did not show any indication of how the interventions of the counsellors are quite effective, which is shown in the case stories and success stories defined in the chapters before. Some of the major highlights of the findings are provided in this chapter.

5.1 Adverse Childhood Experiences in Young Adults

Family structure and relationships play a crucial role in the emotional and psychological outcomes for the subjected respondents. While many of them have supportive family relationships, others face neglect or strained connections, leading to aggravated ACEs. The findings emphasize the importance of improving family support systems, especially for young adults from households with high levels of dysfunction or conflict.

Emotional distress, grief, and feelings of insecurity are prevalent among the respondents affected by ACEs. Mental health support and counseling services are critical for helping young adults cope with emotional pain, including grief, loneliness, and suicidal tendencies. Comprehensive mental health programmes focused on trauma-informed care are necessary to address the underlying emotional challenges faced by these individuals. The study highlights the importance of trauma-informed care in interventions, ensuring that caregivers and Counsellors are equipped to understand and address the root causes of behaviour rather than just the symptoms. Counseling programmes must be empathetic to the respondents, keeping their past experiences in mind, as this understanding is crucial for effective healing and behaviour modification.

While many receive support from parents and peers, a significant portion still feels unsupported. **Expanding support systems, particularly for those who lack parental support, is crucial for promoting resilience and emotional healing.** Caregivers and counsellors must be trained to provide consistent, empathetic support, helping to navigate the emotional effects of their ACEs. Recording and documenting practices emphasise the way the entire process allows for better long-term tracking of their emotional and psychological development, ensuring that necessary interventions are provided consistently.

5.2 Adverse Childhood Experiences and Substances

Early exposure to substances is a key concern. The substances reported include dendrite, fuel (kerosene/petrol), ganja, tobacco/vaping, gutkha, and more. Despite this variety, more than 50% of respondents reported not engaging in substance use, which is a positive indicator. Substances were most commonly consumed orally, via smoking (cigarettes), and sniffing. A small portion also reported using alternative methods like pencil biting or alcohol consumption.

Peer influence was a major source of access (friends offering substances), and **9.4%** of respondents reported buying substances directly from vendors. Other sources include borrowing money, stealing, or using pocket money. Common psychological effects include feelings of relaxation, confidence, and excitement, but there are also negative impacts like anxiety, stress, and sleep disturbances. **The primary reasons for starting substance use were curiosity, the presence of addicted individuals in the household or social circles, peer pressure, and family violence.**

It is also reported that family members were involved in substance use, suggesting that familial environment plays a key role in the initiation and normalization of substance use. Common withdrawal symptoms include sadness, irritability, and sleep disturbances. Anxiety and depression were also prevalent, highlighting the emotional and psychological toll of quitting substances. Out of the total 146 respondents, **6.8%** of respondents engaged in illegal activities to obtain substances, and a small subset **2.7%** faced legal consequences (e.g., involvement with police or observation homes).

Of the 31 counsellors, the majority **55%** reported having a good understanding of substance abuse, but only a small proportion had experience with cases involving adverse childhood experiences (ACEs), indicating a gap in expertise in this area. **Peer pressure** was the most significant socio-cultural influence **21.1%,** followed by **mental health issues and unstable living conditions 13% each**, showing that environmental and social factors contribute strongly to substance abuse.

5.3 Adverse Childhood Experiences and Mental Health

Mood swings, depression, and anxiety were the most common mental health issues reported among young adults. **Self-harm thoughts/Behaviour** were also prevalent. Common symptoms associated with substance abuse include **withdrawal from social activities, enhanced energy and mood, and reduced self-care.** These behavioural changes indicate potential mental health difficulties.

Counsellors focus on **empowering young adults, open discussions,** and **professional referrals** to reduce the stigma surrounding mental health and substance abuse. Social support plays a critical role in recovery, with **emotional support and encouragement for healthy lifestyles** being the most mentioned contributions from family, friends, or community groups.

The most commonly recommended resources for recovery include counseling sessions, followed by community support groups and therapy sessions. This underscores the critical role of both professional and community-based resources in the recovery process. In terms of interventions for mental health needs, common approaches involve engaging in dialogue with the individual, referring them to Counsellors, and directing them to professional treatment. Spiritual and religious practices, such as yoga/meditation and moral education, are frequently utilized to support mental well-being, highlighting the significant cultural or spiritual component in the recovery journey.

Efforts to address societal factors focus largely on community-based interventions and networking with various organizations. These strategies emphasize the importance of collaboration and community involvement in tackling the broader societal issues that contribute to substance abuse.

It is ideated that ACEs affect multiple aspects of adolescent and young adult life, which include behaviour, emotional regulation and even reflects in relationships. The holistic approach of family support, trauma-informed care, emotional support and education can help them grow positively from their circumstances. This report tried to engage in understanding the prevalence, causes and consequences of substance use. It also trickles down to the gap in intervention, support, training of counsellors, mental health support and access to referral services. There is a need to address this through the programme and interventions that help in their comprehensive recovery.

To conclude, the identified gaps in addressing substance abuse and mental health issues among young adults include an inconsistent understanding of ACEs among counsellors, limited focus on specialized mental health support, insufficient stigma-reduction strategies, and challenges in accessing mental health resources such as de-addiction centres and psychiatric hospitals. Additionally, there is a lack of integration of spiritual and cultural practices into recovery Programmes, inadequate training on co-occurring disorders, and a limited emphasis on community-based interventions and policy advocacy. Recommendations to address these gaps, recommendations include expanding counsellor training on ACEs, strengthening referral systems to mental health professionals, promoting policy reforms, incorporating spiritual practices into recovery strategies, integrating treatment for co-occurring disorders, and improving access to specialized treatment centres, ultimately enhancing the support and outcomes for young adults in recovery.

CHAPTER 6

Recommendation and Way Forward

This chapter will include the recommendations that are proposed to enhance the support and recovery processes for young adults at DB-YaR Forum Centres and intervened communities, with a particular focus on addressing substance abuse and mental health challenges. These interventions are based on the recognition of the complex, intertwined nature of mental health issues and substance use and the need for comprehensive, multifaceted approaches. Peer education, trauma-informed counselling, integrated recovery Programmes, and community engagement are central to these recommendations, as they aim to reduce stigma, empower individuals, and promote long-term well-being.

Peer Education Programmes: Establish structured peer education programmes where trained young adults who have experienced recovery or mental health challenges guide their peers on substance abuse prevention, coping strategies, and mental health awareness. This helps normalize conversations around these issues and fosters a sense of community support.

Trauma-Informed Counselling and Support: Offer specialized counselling sessions using trauma-informed approaches that address both the emotional and psychological needs of young adults, especially those affected by ACEs. Counsellors should be trained to understand the complexity of trauma and its links to substance abuse.

Integrated Mental Health and Substance Abuse Recovery Programmes: Develop and integrate recovery Programmes that simultaneously address both substance abuse and co-occurring mental health disorders such as anxiety, PTSD, and depression. This holistic approach improves recovery outcomes by treating both issues together.

Community-Based Awareness Campaigns: Launch awareness campaigns within local communities to reduce the stigma surrounding substance abuse and mental health issues. Involve young adults in these campaigns to build community awareness and encourage open discussions.

Spiritual and Cultural Wellness Programmes: Incorporate yoga, meditation, and moral education into recovery Programmes. These practices can provide emotional and mental stability, and spiritual wellness can offer additional support for individuals recovering from substance abuse.

Strengthening Referral Systems: Improve the referral system to connect individuals to specialized mental health professionals, psychiatric hospitals, or de-addiction centres. Make it easier for Counsellors to refer young adults for advanced treatment when necessary.

Life Skills and Coping Mechanisms Workshops: Organize workshops that teach life skills, resilience, and coping mechanisms to young adults. These skills can help individuals manage stress, build healthy relationships, and resist the temptation of substance abuse.

Family and Peer Support Groups: Establish family support groups that provide a safe space for individuals to discuss their challenges and progress in recovery. Peer-led groups, where individuals share their experiences and strategies for overcoming difficulties, can be especially effective.

Enhanced Training for Counsellors on Co-occurring Disorders: Conduct regular training and workshops for Counsellors on best practices for dealing with co-occurring mental health and substance abuse disorders. This will ensure that Counsellors have the skills and knowledge to support young adults who face complex challenges.

Future Research Prospects:

1. Counsellors' capacity and knowledge positioning
2. A larger study on understanding the individual and dependent coping strategies and support programmes (evaluation of existing)

References:

Achenbach, T. M., & Cicchetti, D. (1974). *The development of psychopathology: The developmental psychopathology model. Developmental Psychology,* 10(4), 609-615.

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C. L., Perry, B. D., Dube, S. R., & Giles, W. H. (2006). *The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology.* European Archives of Psychiatry and Clinical Neuroscience, 256(3), 174-186.

Arnett, J. J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist, 55(5),* 469-480.

Barth, R. P. (2009). Preventing child abuse and neglect with parent training: Evidence and opportunities. The Future of children, 95-118.

Bronfenbrenner, U. (1979). *The ecology of human development: Experiments by nature and design.* Harvard University Press.

Caruth, C. (1995). *Trauma: Explorations in memory.* Johns Hopkins University Press.

De Young, A. C., Smith, P. B., & Johnson, D. R. (2011). *Title of the article. Title of the Journal, Volume(Issue),* pages.

Dube, S. R., Felitti, V. J., Dong, M., Chapman, D. P., Giles, W. H., & Anda, R. F. (2003). *Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span: Findings from the Adverse Childhood Experiences Study. JAMA, 286(24), 3089-3096.*

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. American Journal of Preventive Medicine, 14(4), 245-258.

Fuller-Thomson, E., Brennenstuhl, S., & Irwin, J. D. (2016). *Childhood adversity and health outcomes in adulthood: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions. Child Abuse & Neglect, 53, 75-85.* https://doi.org/10.1016/j.chiabu.2015.10.014

Gardner, M., & Steinberg, L. (2023). *Peer influence on risk-taking, risk preference, and risky decision making in adolescence and adulthood: An experimental study. Developmental Psychology.*

Herrenkohl, T. I., Sousa, C., Tajima, E. A., Herrenkohl, R. C., & Moylan, C. A. (2016). *Childhood abuse and exposure to domestic violence and risk of adolescent alcohol and drug use: A longitudinal study. Journal of Interpersonal Violence, 31(5), 1-22*. https://doi.org/10.1177/0886260515604103

Herman, J. L. (1997). *Trauma and Recovery: The Aftermath of Violence--From Domestic Abuse to Political Terror. Basic Books.*

Hughes, K., Bellis, M. A., Hardcastle, K. A., Sethi, D., Butchart, A., Mikton, C., Jones, L., & Dunne, M. P. (2017). The effect of multiple adverse childhood experiences on health: A systematic review and meta-analysis. The Lancet Public Health.

Kessler, R. C., Davis, C. G., & Kendler, K. S. (1997). *Childhood adversity and adult psychiatric disorder in the US National Comorbidity Survey.* Psychological Medicine, 27(5), 1101-1119.

National Institute on Drug Abuse (NIDA). (2021). Substance Use and Mental Health Issues. Retrieved from https://www.nida.nih.gov

Newbury-Birch, D., Walker, J., Leah, A., Beyer, F., Brown, N., Jackson, K., Gill, C., Gilvarry, E., & Kaner, E. (2017). Impact of alcohol consumption on young people: A systematic review of published reviews. Department for Children, Schools and Families.

Poole, N., Greaves, L., & Mathieson, S. (2018). *Addressing the intersection of childhood trauma and substance use: A review of the literature. Substance Use & Misuse, 53(7), 1069-1083.* https://doi.org/10.1080/10826084.2018.1425865

Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Behavioural Health Barometer: National and Regional Trends in Behavioural Health.*

Teicher, M. H., Samson, J. A., Polcari, A., & McGreenery, C. E. (2006). *Sticks and stones and broken bones: The impact of childhood trauma on the structure of the brain.* Current Directions in Psychological Science, 15(6), 225-229.

Trivedi, G. Y., Pillai, N., & Trivedi, R. G. (2021). Adverse Childhood Experiences & mental health–the urgent need for public health intervention in India. Journal of preventive medicine and hygiene, 62(3), E728.

United Nations. (1989). *Convention on the Rights of the Child.* https://www.ohchr.org/en/professionalinterest/pages/crc.aspx

World Health Organization (WHO). (2020). Adolescent Health. Retrieved from https://www.who.int

Centers for Disease Control and Prevention. (n.d.). *Adverse childhood experiences (ACEs).* Centers for Disease Control and Prevention. https://www.cdc.gov/aces/about/index.html

Centers for Disease Control and Prevention. (n.d.). *About the CDC-Kaiser ACE study.* Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/acestudy/about.html

Harvard Catalyst. (n.d.). MMR (Massachusetts Medical Research). Harvard Catalyst. https://catalyst.harvard.edu/community-engagement/mmr/

University of New Mexico, Institute for Social Research. (n.d.). Adverse childhood experiences: Summarized literature review. https://isr.unm.edu/centers/center-for-applied-research-and-analysis/behavioral-health-initiative-reports/summarized-literature-reviews/adverse-childhood-experiences.pdf

Appendices

Appendix 1

Consent Form

I,_____

from centre _____

have understood the information shared by the caretakers and I am volunteering to participate in the Research 'Examining the Interconnections Between Adverse Childhood Experiences, Substance Abuse and Mental Health' conducted by DB YaR National Forum.

Signature of the Child: _____

Signature of the Guardian/Director: _____

Date: _____

Appendix 2

FOCUS GROUP DISCUSSION

Kindly note that the information shared will be strictly used for this study.

Objectives of the Study

1. Explore the role of adverse childhood experiences in predisposing individuals to both Substances abuse and mental health concerns.
2. Analyze the potential factors contributing to the co-relation of mental health concerns and substance abuse.
3. Investigate the influence of societal factors on the relationship between Substance abuse and mental health.

No. of children in the group: _____

Section A - Adverse Childhood Experiences

1. What are your good and bad childhood memories?
2. What makes you happy?
3. What makes you sad?
4. What makes you anxious?
5. What makes you angry?
6. What makes you worried?
7. What makes you upset?
8. What do you know about Mental Health? (few people to share)

Section B -Mental health concerns and substance abuse

9. What do you know about Substance/ Drug Abuse? (few people to share)
10. Is there such a thing as good or bad Substance? What might they be?
11. What are the mental health concerns (lack concentration in studies, day dreaming, lack of motivation, etc.) faced by young people using Substance?

Section C- Societal Factors

12. What problems or difficulties do young people face by using Substance?
13. Do young people think it is fashionable to use Substance?
14. What are the efforts you or others tried/ made to overcome the Substance Abuse?
15. How would you help other young people who are struggling with big problems related to Substance abuse and mental health?

Appendix 3

Questionnaire for Children

Kindly note that the information shared will be strictly used for this study.

Objectives of the Study

1. Explore the role of adverse childhood experiences in predisposing individuals to both Substances abuse and mental health concerns.
2. Analyze the potential factors contributing to the co-relation of mental health concerns and substance abuse.
3. Investigate the influence of societal factors on the relationship between Substance abuse and mental health.

Demographic/Basic Details

1. Age:

- 11 to 14
- 15 to 18
- Above 18

2. Gender:

- Female
- Male
- Other

3. Education:

- 6 to 8
- 11 to 12
- 9 to 10
- Higher Education
- Any other: _____

4. Do you stay in CCI?

- Yes
- No

5. How long have you stayed in the CCI/known this organization?

- 6 months - 1 year
- 1 year – 5 years
- 1 year – 5 years
- More than 10 years

Section A - Adverse Childhood Experiences

Objectives of the Study

1. What is the highest level of schooling your father has completed?
   - Illiterate
   - Up to class VIII
   - Up to class X
   - Not Known
   - Up to Class XII
   - Up to Graduation
   - Post Graduation and above
   - Any other: _____

2. What is the highest level of schooling your mother has completed?
   - Illiterate
   - Up to class VIII
   - Up to class X
   - Not Known
   - Up to Class XII
   - Up to Graduation
   - Post Graduation and above
   - Any other: _____

3. Occupation of Father:
   - Construction worker
   - Contract
   - Cook
   - Daily Wage (Skilled)
   - Daily Wage (Unskilled)
   - Driver
   - Farmer
   - Fruit Seller
   - Government Service
   - Home maker
   - Hospital Worker
   - House Maid
   - Street Vendor
   - Tailor
   - Self Employed
   - Own Business
   - No fixed income
   - Jobless/No occupation
   - Not known
   - Any other:_____

4. Occupation of Mother:
   - Construction worker
   - Contract
   - Cook
   - Daily Wage (Skilled)
   - Daily Wage (Unskilled)
   - Driver
   - Farmer
   - Fruit Seller
   - Government Service
   - Home maker
   - Hospital Worker
   - House Maid
   - Street Vendor
   - Tailor
   - Self Employed
   - Own Business
   - No fixed income
   - Jobless/No occupation
   - Not known
   - Any other:_____

5. What is the total earning of family (father and mother) per month?

- Less than Rs 6000
- Rs 6000-10000 per month
- Rs 11000-15000 per month
- Rs 16000-20000 per month
- Rs 20000 and above
- Not known

6. How many members are there in your family?

- 1-3
- 4-6
- 7-9
- More than 9

7. What type of family structure best describes yours?

- Nuclear Family
- Single Parent family
- Joint family
- Extended Family
- Any other: _____
- Foster Family
- Adoptive Family
- Stepfamily
- Not Known

8. Parental Marriage Status:

- Parents are living together
- Parents live separately
- Mother left the family
- Father left the family
- Parents are divorced
- Parents Divorced- Father remarried
- Parents Divorced – Mother remarried
- Father-Widower
- Mother-Widow
- Mother died- Father remarried
- Father died-Mother remarried
- Both parents remarried
- Not known
- Any other:_____

9. Father/Male Guardian & Child Relationship (multiple option can be ticked):

- Listening
- Cordial
- Loving
- Happy
- Not Applicable
- Non-Cordial
- Rejection
- Over Protection
- Abusive
- Violent

10. Mother/Female Guardian & Child Relationship (multiple options can be ticked)

- Listening
- Cordial
- Loving
- Happy
- Not Applicable
- Non-Cordial
- Rejection
- Over Protection
- Abusive
- Violent

11. Did your guardian/parent(s) set definite rules about your behaviour both at home and outside the home?

- Always
- Often
- Sometimes
- Never

12. Did your guardian/parent(s) know who were you with or where you were?

- Always
- Often
- Sometimes
- Never

13. Did you lose you guardian/parent(s)?

- Yes
- No

13.a What was your feeling after the loss of parents / loved ones? (multiple options can be ticked)

- Difficulty accepting the loss
- Grief
- Emotional distress
- Guilt/Regret
- Helplessness
- Loneliness
- Insecurity of Future
- Suicidal Tendency
- Any other: _____

14. Has anyone ever done something to you that made you feel scared or uncomfortable?

- Yes
- No
- Won't Say

14.a How scared or uncomfortable did you feel?

- 1- Mild 2 - Somewhat 3 - Moderate 4 - Quite a bit 5 - Severe

14.b What made you feel scared or uncomfortable? (multiple options can be ticked)

- Someone hurt me physically
- Someone insulted
- Someone bullied me badly
- Someone touched me in a way that felt wrong
- I don't want to talk about it right now.
- Any other: _____

14.c How often did this happen to you?

- Once
- Twice
- More than twice
- I don't want to say

14.d Where were you when it happened? (Multiple options can be ticked)

- At home
- At private place
- At school
- At a relative's house
- At a friend's house
- At a park or playground
- I don't remember
- I don't want to talk about it
- Somewhere else (Explain): _____

14.e Did you tell anyone about what happened?

- Yes
- No
- Not Applicable

14.f To whom did you tell about what happened? (multiple options can be ticked)

- A parent/family member
- A friend
- A teacher or someone at school
- Counseller/Psychologist
- Trustworthy person
- Any other: _____

15. Did you get emotional support from your guardian/parents?

- Always
- Often
- Sometimes
- Never

16. Did you get emotional support from your friends?

- Always
- Often
- Sometimes
- Never

17. Do you agree that your caretakers/counsellors understand your past ?

- Always
- Often
- Sometimes
- Never

Section B: Mental Health Concerns and Substance Abuse

1.a What was the substance which you used to take? (Multiple options can be ticked)

- Dendrite
- Paint
- Fuel (Kerosene/Petrol)
- Ganja
- Gutkha
- LSD
- Magic Mushroom
- Marijuana
- Pan Parag
- Solvent/Whitener
- Tobacco/Vaping
- Tar
- Varnish
- None

1.b Do you know any other kind of substance besides the given? If yes, name them

_____

1.c What is the mode of intake of the substance or the activity in question? (multiple options can be ticked)

- Injection
- Oral
- Smoke (like cigarette)
- Sniff
- Not Applicable
- others: _____

1.d What was your age for the first time of substance intake?

- 5 to 9
- 10 to 13
- 14 to 18
- Above 18
- Not Applicable

1.e What was the time period of your substance intake?

- 0 to 1 month
- 2 to 6 months
- 6 months to 1 year
- More than 1 year
- More than 2 years
- 3 years and above
- Unknown/Can't remember
- Not Applicable

1.f What was the frequence of intake?

- Multiple times a day
- Twice a day
- Once a day
- Multiple Times a week
- Twice a week
- Once a week
- Sometimes/Rarely
- Not Applicable

1.g How soon after first trying the substance did you start using it regularly?

- Within hours
- Within days
- Within a week
- Any other: _____
- Within two weeks
- Within months
- Not Applicable

2. What was the means of access to the substance? (multiple options can be ticked)

- Buying
- Borrowing/Lending
- Offered
- Any other: _____
- Peddling
- Stealing
- Not Applicable

3. When did you feel like taking the substance? (multiple options can be ticked)

- After exams
- Before exams
- Family Get-together
- Friends' Party
- When angry
- When someone blames me
- When someone scolds me
- When there is a disturbance in the family
- When there is a quarrel with friend
- When I feel lonely
- When I am stressed
- When I feel hungry
- Any other: _____

4. Did you use substance to avoid problems?

- Never
- Sometimes
- Often
- All the time
- Not Applicable

5. Did you feel that substance abuse has damaged your self-esteem?

- Never
- Sometimes
- Often
- All the time
- Not Applicable

6. Did you feel that the substance abuse has damaged your self-identity?

- Never
- Sometimes
- Often
- All the time
- Not Applicable

7. Did you have trouble sleeping or concentrating because of substance abuse?

- Never
- Sometimes
- Often
- All the time
- Not Applicable

8. Has substance abuse made you hostile, aggressive or violent?

- Never
- Sometimes
- Often
- All the time
- Not Applicable

9. a How disturbed were you when taking substance on a scale of 1 to 5?

1- Mild 2 - Somewhat 3 - Moderate 4 - Quite a bit 5 - Severe

9.b How comfortable were you when taking substance on a scale of 1 to 5?

1- Mild 2 - Somewhat 3 - Moderate 4 - Quite a bit 5 - Severe

10. Which were the instances or circumstances that comforted you after intake of substances? (multiple options can be ticked)

- Being alone and able to relax
- Involvement in Sexual Activities
- Lessening of anxiety, stress or negative emotions
- Numbing painful thoughts or memories
- Feeling more confident and outgoing
- Excitement sensation and pleasurable high
- Diminished worries about day-to-day problems
- No particular circumstances, just the effects of the substance
- Not Applicable
- Any other:_____

11. Did you make efforts to get away from substances?

- Yes
- No
- Not Applicable

11.a What kind of efforts did you make to overcome substance addiction? (multiple options can be ticked)

- Aggression/ Violence
- Binge Eating
- Creative expression
- Did not make any significant efforts
- Leaned on family/friend support system
- Made lifestyle changes (avoided triggers, changed friend groups, etc.)
- Passive silence
- Practiced self-care (exercise, meditation, hobbies, etc.)
- Self-destruction/ Harming
- Sought counseling/therapy
- Struggled but kept trying different approaches
- Taking Family responsibilities
- Used medication-assisted treatment
- Used self-help resources (books, apps, etc.)
- Not Applicable
- Any other: _____

12. Did you ever experience withdrawal symptoms?

- Yes
- No
- Not Applicable

13. What were the withdrawal symptoms visible while quitting substance? (multiple options can be ticked)

- Allergy
- Anxiety
- Behavioral Changes
- Body Pain
- Depression
- Fatigue/Tiredness
- Fever
- Headache
- Hyperactivity
- Sweating
- Irregular Heartbeat
- Sadness
- Irritability
- Loss of Ability
- Nausea
- Seizure
- Shivering
- Sleep Disturbance/ Insomnia
- Stomach Pain/ Problems
- Not Applicable
- Any other;_____

Section C: Societal Factors

1. What are the reasons that lead you to start using the substance? (multiple options can be ticked)

- Abusive situation
- Loneliness
- Access to substance
- Crowded family
- Curiosity
- Death of loved ones
- Disability in resolving routine problems
- Eliminate shyness
- Family disputes
- Family violence
- Having free time
- Joy seeking
- Lack of access to counselling
- Lack of amusement facilities
- Not Applicable
- Lack of knowledge about complications of substance abuse
- Low cost of substance
- Low self-confidence
- Love failure
- Over strictness of parents
- Nuclear family situation
- Parent/Parents' death
- Parents' Divorce/Separation
- Peer Groups
- Presence of an addicted person in residential/educational place
- Any other: _____

2. Who first offered or introduced the substance?

- Classmate
- Coworker
- Friend
- Local loiters
- Neighbor
- Parent
- Relative
- Shopkeepers/ Vendors
- Sibling
- Stranger
- Not Applicable

3. Did you willingly accept and wanted to try the substance when first offered?

- Yes, very interested
- Somewhat interested
- Not very interested
- Pressured into it
- Not Applicable

4. What was the source of money for buying the substance?

- Borrowing from Family
- Borrowing from Friends
- Borrowing from Others
- Given by adults
- Legal earnings
- Pocket money
- Stealing
- Mutual benefit from buyer and consumer
- Illegal activities
- Not Applicable
- Other means: _____

5. Do images in media/social media influence perceptions about substance?

- Yes, positively
- Yes, negatively
- No influence
- Not known

6. Are any of the family members/relatives engaged in substance abuse?

- Yes
- No
- Not Applicable

7. Have you ever engaged in illegal activities to obtain the substance abuse?

- Yes
- No
- Not Applicable

8. Have you ever been to police station/observation home in context of substance abuse?

- Yes
- No
- Not Applicable

9. Did the family know about your substance abuse?

- Yes
- No
- Not Applicable

9.a If yes, what action did they take? (multiple options can be ticked)

- Beating
- Blaming
- Counselled by Family
- House arrest
- No action
- Referred to boarding school
- Referred to counseling center
- Relocated to relative's place Scolding

10. Has your intake of substance caused problems in relationship with friends or family?

- No problems at all
- Not Applicable
- Caused minor problems
- Caused major problems
- Ended relationships
- Not Applicable _____

11.a If yes, what type of establishment or center where you brought to for addressing the issue?

- Clinic
- Counseling Center
- De-addiction Center
- Govt. Hospital
- Local/Spiritual Medicine Man
- Religious center (Church, Temple, Mosque…)
- Private Consultation
- Private Hospital
- Psychiatric Hospital
- Retreat/Rehabilitation center
- Not Applicable
- Any other: _____

12. Have you continued to use the substance even though it was causing problems in life?

- Stopped using
- Overusing
- Reduced frequency
- Kept using/Consuming
- Not Applicable
- Any other: _____

13. Please share anything else which is important to this study?

Appendix 4

Questionnaire for Counsellor/ Caregiver

Kindly note that the information shared will be strictly used for this study.

Objectives of the Study

1. Explore the role of adverse childhood experiences in predisposing individuals to both Substances abuse and mental health concerns.
2. Analyze the potential factors contributing to the co-relation of mental health concerns and substance abuse.
3. Investigate the influence of societal factors on the relationship between Substance abuse and mental health.

Demographic/Basic Details

1. Name of the Center/ Institution: _____

2. Name of the City/Town: _____

3. Name of the Province:

- Bangalore
- Chennai
- Dimpaur
- Guwahati
- Hyderabad
- Kolkata
- Mumbai
- New Delhi
- Panjim
- Shillong
- Tiruchy
- Kolkata

4. Gender:

- Male
- Female
- Any other

5. Education:

- Technical Education
- Graduate
- Specialized Subjects:_____
- Post Graduate
- Doctorate

6. Do you work in CCI or Outreach (Community based) Program?

- CCI
- Outreach Program
- Both

7. How long have you been working in a CCI/ Outreach Program of this organization?

- 6 months to 1 year
- 1 year to 2 years
- Any other:_____
- 2 years to 3 years
- 3 years to 5 years

8. What is your role/ designation within the organization? (multiple options can be ticked)

- Counselor
- Psychotherapist
- Psychologist
- Caregiver/ Warden
- Social Worker
- Home/ CCI In charge
- Career Counselor
- Marriage and Family Therapist
- Educator
- Any other: _____

9. What are the records/ reports of children maintained? (multiple options can be ticked)

- Social Investigation Report (SIR)
- Individual Case Study (ICS)
- Counselling Report
- Success Story
- Individual Care Plan (ICP)
- Any other:_____

10. How is your organization maintaining the above-mentioned documents?

- Hard copy
- Soft copy
- Both
- Any other: _____

11. How regularly does the organization utilize Homelink CHILD MISS online web portal?

- Always
- Often
- Sometimes
- Never
- Any other: _____

12. How regularly the data of children is updated (hard copy) by the organization?

- Always
- Often
- Sometimes
- Never
- Any other: _____

13. How long have you been working with Children with various organizations?

- 6 months to 1 year
- 1 year to 2 years
- 2 years to 3 years
- 3 years to 5 years
- Any other: _____

14. How will you rate yourself on the understanding of substance abuse on a scale of 1 to 5?

1 - Very Poor 2 - Poor 3 - Average 4 – Good 5 – Excellent

15. How will you rate yourself on the understanding of mental health on a scale of 1 to 5?

1 - Very Poor 2 - Poor 3 - Average 4 – Good 5 – Excellent

16. How have you developed your understanding of mental health and substance abuse? (multiple options can be ticked)

- Reading books/articles
- Training or Ceritication Program
- Field Experience
- Personal Experience
- Educational Courses
- Conversation with Professionals
- Online Courses
- Any other: _____

Section A - Adverse Childhood Experiences

1. What are the most common unfavorable childhood events among children with substance addiction and mental health issues? (multiple options can be ticked)

- Physical abuse
- Emotional neglect
- Poverty
- Violence in the family/community
- Rejection by community/society
- Bullying
- Any other: _____

2. In your experience of working with children who have faced adverse childhood experiences, which of the following behavioral patterns have you observed or noticed as potential themes of repetition? (multiple options can be ticked)

- Abusive language
- Social withdrawal and isolation
- Aggression or Reaction
- Difficulty with emotional expression
- Intense fear or anxiety in specific situations
- Attachment issues or trust problems
- Difficulty with concentration or attention
- Difficulty forming healthy relationships
- Lack of sensitivity towards others
- Any other: _____

3. How would you describe the children's relationship with you? (multiple options can be ticked)

- Listening
- Cordial
- Loving
- Happy
- Non-Cordial
- Rejection
- Over Attachment
- Violent
- Any other: _____

4. How do you assist individuals with unfavorable childhood experiences in resolving substance addiction and mental health issues? (multiple options can be ticked)

- Helping to understand and address how early bad experience affect his/her behavior now
- Not feeling confident/capable to handle the above-mentioned issues of children
- Making a safe and supportive place to talk about the past
- Remembering that a child's early experiences matter, not just current behavior
- Listening to and talking about forgotten childhood memories
- My personal prejudice becomes a hindrance to addressing child's issues.
- Any other: _____

5. How do you help prevent the intergenerational transmission of negative childhood experiences that can lead to substance abuse and mental health issues? (multiple options can be ticked)

- Providing a secure and nurturing environment to children
- Encouraging children to engage in activities for building resilience
- Motivating parents to have positive attitude towards children.
- Counselling the parents to understand their psycho-social situations affecting their children
- Any other: _____

6. How do you assist people who have had adverse childhood experiences in developing resilience and coping mechanisms? (multiple options can be ticked)

- Allowing the person (child) to have his/ her own way
- Promoting avoidance of discussing prior traumas
- Promoting healthy emotional expressions
- Referring the child to another professional
- Access to social support networks
- Any other:_____

7. Have you noticed any patterns of undesirable childhood events (e.g., abuse, neglect, trauma) in children you have worked with in recovery from substance abuse?

- Yes, frequently
- Yes, occasionally
- No, not commonly
- Not known

8. Have you established any interventions or support systems to help children recover from adverse childhood experiences and improve their general well-being?

- Yes, we have comprehensive programs
- Yes, but only limited support systems
- No, we haven't implemented such programs
- Not known

Section B - Substance Abuse and Mental Health

1. What substances, if any, do you believe the children have used majorly? (Multiple options can be ticked)

- Dendrite
- Fuel (Kerosene/Petrol)
- Ganja
- Gutkha
- LSD
- Magic Mushroom
- Marijuana
- Paint
- Pan Parag
- Solvent/Whitener
- Tobacco/Vaping
- Tar
- Varnish
- None
- Any other: _____

2. What withdrawal symptoms did you observe majorly in the children when they stopped using substances? (Multiple options can be ticked)

- Allergy
- Anxiety
- Behavioral Changes
- Body Pain
- Depression
- Fatigue/Tiredness
- Fever
- Headache
- Hyperactivity
- Irregular Heartbeat
- Not Applicable
- Sadness
- Irritability
- Loss of Appetite
- Nausea
- Seizure
- Shivering
- Sleep Disturbance/ Insomnia
- Stomach Pain/ Problems
- Sweating
- Any other:_____

3. Have you seen any co-occurring mental health issues (such as sadness, anxiety, or trauma) in children you've worked with who have recovered from substance abuse?

- Yes, frequently
- Yes, occasionally
- No, not commonly
- Not Known

4. What are the most prevalent mental health concerns among young people recovering from substance abuse? (multiple options can be ticked)

- Anxiety
- Depression
- Change in sleep patterns
- Mood Swings
- Attention deficit
- Self-harm thoughts/behavior
- Any other: _____

5. How do you address the mental health needs of children in your care who have recovered from substance abuse? (multiple options can be ticked)

- Refer them to mental health professionals
- Refer to Authority/Director of the Centre
- Provide in-house counseling and support
- Develop individualized treatment plans
- Any other: _____

6. What symptoms can you look for to identify potential mental health difficulties in individuals battling with substance abuse? (multiple options can be ticked)

- Reduced sleep but enhanced focus
- Reduced self-care
- Enhanced energy and mood
- Feeling scared even in absence of potential threats
- Withdrawal from social activities and maintain privacy
- Increased hunger and weight gain
- Any other: _____

7. What are procedures that you carry out when a child shows symptoms of mental health / substance abuse problems?

- Dialogue with the person/child
- Refer to counselor
- Refer for professional treatment
- Any other:_____
- Punishment
- Referral to Director / Authority
- Dismissal

8. How do you tackle the stigma on the above issues while working with children? (multiple options can be ticked)

- Referral to professional
- Empower children to overcome the stigma
- Open discussion on substance abuse and mental health
- Educate children and guardians about the link between mental health issues and substance usage
- Any other: _____

9. Your personal observation on interconnection between Mental Health and Substance Abuse:

Section C - Societal Factors

1. What do you believe were the reasons that led children to start using substances? multiple options can be ticked)

- Abusive situation
- Access to substance
- Crowded family
- Curiosity
- Death of loved ones
- Disability in resolving routine problems
- Eliminate shyness
- Family disputes
- Family violence
- Having free time
- Joy seeking
- Lack of access to counselling
- Lack of amusement facilities
- Not Applicable
- Loneliness
- Lack of knowledge about complications of substance abuse
- Low cost of substance
- Low self-confidence
- Love failure
- Over strictness of parents
- Nuclear family situation
- Parent/Parents' death
- Parents' divorce/separation
- Peer group pressure
- Presence of an addicted person in residential/educational place
- Any other: _____

2. What do you believe was the source of money for the majority of the children to buy substances?

- Borrowing from Family
- Borrowing from Friends
- Borrowing from Others
- Given by adults
- Illegal activities
- Not Applicable

- Legal earnings
- Stealing
- Any other:_____
- Pocket money
- Mutual benefit from buyer and consumer

3. What type of establishment or center did majority of the addicted children referred to?

- Clinic
- Counseling Center
- De-addiction Center
- Govt. Hospital
- Local/Spiritual Medicine Man
- Religious Center (Church, Temple, Mosque…)
- Private Consultation/Hospital
- Psychiatric Hospital
- Retreat/Rehabilitation Center
- None
- Not known
- Not Applicable
- Any other: _____

4. What role do you believe social support networks, such as family, friends, or community groups, contribute to recovery and management of co-occurring substance abuse and mental health issues? (multiple options can be ticked)

- Provide emotional support
- Facilitate access to social network
- Encourage healthy lifestyle
- Facilitate access to professionals
- Promote healthy recreation
- Any Other: _____

5. What socio-cultural elements, do you believe have influenced the substance usage habits of the children you have worked with? (multiple options can be ticked)

- Peer pressure
- Accessibility of substance
- Unstable living conditions
- Curiosity or experimentation
- Perception of substance abuse as a coping mechanism
- Socio-economic status
- Mental health issues or emotional distress
- Culture approval of certain substance
- Any other: _____

6. What socio-economic standards, do you believe have influenced the substance usage habits of the children you have worked with? (multiple options can be ticked)

- Low family income
- Lack of parental education
- Living on streets
- Unhealthy neighborhood environment
- Dropping out from schools Involved in Menial Jobs
- Any other: _____

7. How can you support individuals with substance abuse and mental health difficulties in their community? (multiple options can be ticked)

- Provide a caring and non-judgmental environment
- Encourage privacy to avoid negative influences
- Access to professional help for control
- Avoid discussing mental health to prevent discomfort
- Any other: _____

8. As a caregiver/counselor, what resources do you recommend for those dealing with substance abuse and mental health issues to address societal factors? (multiple options can be ticked)

- Community support groups
- Substance abuse forums online
- Counselling sessions
- Medical Treatment
- Therapy sessions
- Any other: _____

9. How have you addressed societal factors that may contribute to substance abuse and mental health concerns among children in your care?(Multiple options can be ticked)

- Advocate for policy changes
- Community-based interventions
- Any other: _____
- Network with other organisations
- Collaborate with other professionals

10. What spiritual/ religious practices do you use to address the substance abuse and mental health concerns?

- Yoga/Meditation
- Moral Education
- Any other: _____
- Prayers/Devotions
- Good Morning/Night Talks

General Questions:

1. What specific challenges have you faced when supporting the recovery and well-being of youngsters struggling with substance abuse and mental health?

2. What are the most successful techniques for treating these children's complex needs, including substance abuse and mental health?

3. How do you collaborate with other professionals (e.g., social workers, mental health professionals) to ensure a comprehensive approach to the care and support of these children?

4. Please provide a **case study** (without revealing personal identities) of a child dealing with adverse childhood experience/substance abuse/mental health issue. Describe the situation, actions taken, and outcomes. (Minimum 200 words)

5. Please provide a **success story** (without revealing personal identities) of a child dealing with adverse childhood experience/substance abuse/mental health issue. Describe the situation, actions taken, and outcomes. (Minimum 200 words)

6. Can you share the intricate highlights from the **Focus Group Discussions (FGD)**, such as repetitive themes, key phrases, notable quotes, etc.? (Minimum10 points)

7. Please share anything else which is important to this study

Appendix 5

Case Stories

STORY 1

Case Story on the Cause of Substance Abuse: Child A, 17-Year-Old Boy

Child A, a 17-year-old boy, has been living in a Don Bosco CCI for most of his life after his parents passed away when he was very young. Despite the care and support provided at the orphanage, he always felt the emptiness of losing his family. As he grew older, Child A attended school, where he managed to make some friends, but his life was marked by a sense of isolation and lack of a true familial bond.

One day, a teacher in his school asked the students about their fathers. When it was Child A's turn, the question triggered an overwhelming sense of embarrassment. Having no father to speak of, he was forced to remain silent in front of his classmates, who likely noticed his discomfort. For the first time, Child A felt exposed, different, and ashamed of his background. This moment stayed with him, haunting him deeply.

To cope with the emotional pain and to avoid facing similar situations in the future, Child A began using substances. His decision to use drugs was not merely about the desire for temporary relief but more of an attempt to create a shield against the world's judgment and to numb the feelings of inadequacy and loneliness. **The substances offered him a way to disconnect from the reality he struggled to accept—a reality where he lacked a father figure and struggled with the stigma of being an orphan.**

Over time, his behavior began to change. He became more withdrawn and increasingly detached from his friends and the supportive environment of the orphanage. His initial use of substances progressed, and Child A found himself increasingly reliant on them as a coping mechanism for not only the painful memory of that classroom moment but also for the overall absence of family and support in his life.

Eventually, Child A made the decision to run away from the orphanage. His sense of hopelessness and the need to escape from his painful memories led him to seek solace in the streets, where he turned to using various substances to cope with the emotional turmoil. The addiction further isolated him, as it became his way of surviving the emotional emptiness he carried.

The cause of Child A's substance abuse lies in the accumulation of emotional and psychological distress stemming from his orphaned status, a traumatic experience during a seemingly innocuous school interaction, and the lack of adequate emotional support. His struggle to belong, his desire to hide his painful reality, and the inability to process his grief led him down the path of substance abuse, which he used as a cover-up for his vulnerability and emotional scars.

Case Story 2

Child B is a young individual in a child care institution who has developed a recurrent habit of running away, engaging in stealing, and using substances, particularly Ganja. His behavior has been concerning for the staff and caregivers at the institution, who have noticed a pattern of rebellion, defiance, and withdrawal. Although he has not shared much about his past experiences, his actions suggest that there may be unresolved trauma and emotional needs that he has not yet processed.

Despite being provided with care and shelter, Child B consistently displayed a longing for something deeper, something that he couldn't articulate but seemed to center around his need for real love, care, and connection. His actions, such as running away and using substances, appeared to be ways of seeking out emotional fulfillment or escape from emotional pain. It was clear that he was struggling with significant emotional distress, possibly related to his past and the lack of a consistent, loving family structure.

Recently, Child B was found using Ganja again, and this time, he began to experience noticeable symptoms of substance abuse, including disorientation, agitation, and physical symptoms. His condition worsened, leading to his hospitalization for detoxification. The immediate medical intervention helped to stabilize him physically, but it was clear that the underlying emotional and psychological issues still needed to be addressed.

Following detoxification, Child B was transferred to a rehabilitation center for de-addiction counseling. The rehabilitation center offered both medical and therapeutic care designed to address not only his physical addiction but also the psychological and emotional root causes of his behavior. During his time at the rehabilitation center, Child B participated in individual therapy sessions, group counseling, and various rehabilitative activities. These sessions helped him explore his feelings of abandonment, the trauma of his past, and the unmet need for genuine love and care.

Though Child B was reluctant to open up initially, over time, he began to engage more in counseling. He slowly started to uncover some of the deeper wounds that drove his substance abuse and delinquent behavior. He realized that his pattern of running away was not just an attempt to escape the institution but also a desperate search for love and validation outside of the structured care environment. His stealing, he revealed, was often a way to exert control over his life or to gain attention in a way that felt more immediate and rewarding.

After completing his rehabilitation, Child B returned to the child care institution, but the journey to healing is far from over. It is evident that while the detoxification process helped him break the cycle of physical dependency, his emotional and psychological recovery will require continuous support. The institution has committed to closely monitoring his progress and providing ongoing counseling as part of an aftercare plan.

Regular counseling sessions are now part of Child B's routine at the institution. He continues to work with a therapist, focusing on building healthier coping mechanisms, addressing his feelings of abandonment, and learning how to form meaningful, trusting relationships. Additionally, his caregivers are now more aware of his emotional needs and are actively involved in reinforcing positive behaviors and providing a supportive environment.

Although he still struggles with his emotions and sometimes exhibits signs of frustration or restlessness, Child B has shown progress. He is learning to open up more about his experiences, though it remains a slow process. His caregivers have been trained to be more attuned to his emotional cues, providing a safer and more nurturing environment that reduces the likelihood of him running away or resorting to harmful behaviors.

Case Story 3

Child C arrived at the Child Care Institution (CCI) with a history of substance abuse, particularly Ganja, which he had been using for some time. His addiction had resulted in significant behavioral changes, including an aggressive and rebellious demeanor. His aggressive tendencies made it difficult for staff to manage his behavior, and there were frequent outbursts and incidents of defiance. This combination of substance abuse and aggression indicated a deep-seated emotional and psychological struggle, which needed to be addressed comprehensively to help the child recover.

Though Child B was reluctant to open up initially, over time, he began to engage more in counseling. He slowly started to uncover some of the deeper wounds that drove his substance abuse and delinquent behavior. He realized that his pattern of running away was not just an attempt to escape the institution but also a desperate search for love and validation outside of the structured care environment. His stealing, he revealed, was often a way to exert control over his life or to gain attention in a way that felt more immediate and rewarding.

Actions Taken:

The first step in addressing Child C's challenges was providing individual counseling. The counselor began by building a rapport with the child, creating a safe and non-judgmental space where he could express his feelings. The counselor used a client-centered approach, encouraging the child to talk about his life, experiences, and the reasons behind his substance use. It became evident that the child was using substances as a way to cope with feelings of anger, frustration, and possibly trauma from his past.

Cognitive Behavioral Therapy (CBT) was introduced as a therapeutic approach to help Child C identify the negative thought patterns that fueled his aggression and substance abuse. The therapist worked with the child to recognize the triggers that led him to use Ganja and how his thinking patterns contributed to his emotional outbursts. Over time, Child C learned to replace these negative thoughts with healthier, more adaptive ones. CBT also helped him understand the impact of his actions on others and himself, fostering a sense of responsibility.

In addition to CBT, REBT was used to challenge Child C's irrational beliefs and help him reframe his perceptions of himself and his situation. The child had developed a belief that he was unable to change and that substance use was his only way of coping. REBT helped him recognize and challenge these beliefs, replacing them with more rational and empowering thoughts. The child gradually began to understand that his past circumstances did not define him, and he had the ability to change his behavior and thought patterns.

Awareness sessions were also conducted, where the child learned about the harmful effects of substance abuse on his physical and mental health. These sessions included discussions on how Ganja use affects brain function, decision-making, and emotional regulation. Psychoeducation helped Child C understand the long-term consequences of his addiction, reinforcing the importance of living a healthy, substance-free life.

Conclusion:

Child C's case demonstrates the effectiveness of a comprehensive, multi-faceted approach to substance abuse and behavioral issues. Through individual counseling, CBT, REBT, and psychoeducation, he was able to address both the root causes of his addiction and the aggressive behaviors that accompanied it. With ongoing support and monitoring, Child C has made significant progress in overcoming his addiction and living a healthier, more fulfilling life. His recovery is a testament to the power of therapeutic interventions and the importance of a supportive, structured environment in helping children break free from substance abuse.

Appendix 6

Success story

STORY 1

Overcoming Tobacco Addiction and Building a Healthier Future

Background: Child X is a 14-year-old girl living in a slum area with her low-income family. Her parents, although hardworking, were unable to provide much beyond basic needs. Like many children in similar situations, Child X had access to tobacco, which she started using as a way of coping with her environment or perhaps due to peer influence. Initially, Child X consumed tobacco 6-7 times a day, often asking her parents for money under the pretense of needing it for snacks.

Over time, Child X developed a dependency on tobacco. Her addiction began to negatively affect her physical and emotional well-being. She became irritable and withdrawn, losing interest in studying or interacting with her peers. Her teeth began to stain, and she felt self-conscious about her appearance, leading to a significant decline in her self-esteem. Her relationship with her family suffered as well, as her behavior became increasingly secretive and erratic.

Intervention and Action Taken:

Daily Counseling Sessions: The first step was to establish a rapport with Child X through daily counseling sessions. The primary focus was to understand the reasons behind her tobacco use and the extent of her dependency. Child X revealed that her initial exposure to tobacco came from her environment, and over time, it became a way for her to feel a sense of control or escape from the pressures of her surroundings. Her dependency grew, and she had difficulty stopping on her own.

Education on Consequences: Once a foundation of trust was established, the next focus was on educating Child X about the harmful effects of tobacco. We discussed in detail how tobacco affects the body, damages organs, and can lead to long-term health problems, such as respiratory issues, cancer, and gum disease. Emphasis was placed on how the addiction could severely impact her physical growth and future well-being. Additionally, Child X was informed about the social and emotional consequences, including how her addiction had already affected her self-esteem and relationships with her family and friends.

Motivating Change and Family Support: One of the key strategies was motivating Child X to quit tobacco by helping her see a better, healthier future. We encouraged her to set small, realistic goals for quitting tobacco rather than expecting an immediate change. These goals helped her focus on manageable steps. Additionally, family counseling sessions were held to get her parents involved and ensure they were supportive of her recovery. Family members were encouraged to create an understanding, open environment where Child X could feel safe discussing her struggles and progress.

Goal Setting and Tracking Progress: Child X and the counselor worked together to set small, achievable goals. These included reducing the number of times she consumed tobacco each day and gradually cutting it out completely. Progress was tracked regularly to celebrate successes and make adjustments when necessary. Child X responded positively to the structure and felt empowered by her ability to make progress, however small it seemed.

Outcome:

After several months of consistent effort, Child X successfully quit using tobacco. Her health began to improve significantly—her teeth became less stained, her irritability decreased, and she regained interest in school and social interactions. The withdrawal symptoms gradually faded, and her self-esteem began to improve as she saw the positive changes in her life.

Her relationship with her family also strengthened. With the support of her parents, Child X found a renewed sense of connection and trust within her home. The family counseling sessions helped bridge gaps in understanding, and her parents became more actively involved in her well-being and progress. They recognized the importance of maintaining an open, supportive environment for Child X to thrive.

Child X's experience demonstrates the importance of a holistic, supportive approach in addressing substance abuse in children. By understanding her underlying reasons for tobacco use, educating her on its harmful effects, involving her family, and setting realistic goals, Child X was able to break free from her addiction. Her success is a testament to the power of early intervention, continuous support, and the involvement of family in the recovery process.

Don Bosco National Forum for the Young at Risk

Vision: *Inspired by Don Bosco, our vision is of a world where every child and every young person lives and grows towards "fullness of life" in secure, enabling environments.*

Mission: *To inspire and lead Don Bosco personnel and their collaborators to respond with courage, creativity and commitment to the needs of the Young at Risk and to advocate and collaborate with individuals, civil society organizations and governments to ensure for the Young at Risk caring, enabling environments and opportunities for growth, and development.*

DB YaR Forum is a nationwide network of 80+ Don Bosco institutions across 20 states and union territories, committed to the safety, growth, and rights of at-risk children and young adults.

We support vulnerable youth through street outreach, rescue operations, child care facilities, counselling, education, and skill development. Our dedicated teams empower young people to become self-reliant and active in society. We promote community engagement through peer leader units, youth groups, and child rights clubs, fostering supportive environments for marginalized children.

We aim to strengthen the Young at Risk ministry by encouraging community involvement, advocating for legal and social protections for children, and providing care, protection, and spaces where young people can live with dignity and thrive.

DON BOSCO NATIONAL FORUM FOR THE YOUNG AT RISK

Bangalore- Chennai- Dimapur- Guwahati- Hyderabad- Kolkata- Mumbai- New Delhi- Panjim- Shillong- Tiruchy

C-991 Don Bosco House SPCI, Sector 7 Dwarka, New Delhi -110077

91 8851653538 Info@dbyarforum.org https://dbyarforum.org/