Standard Operating Procedures

for

Incorporating Child Psychosocial & Mental Health Care Aspects

Developed by

Community Child & Adolescent Mental Health Service Project

Dept. of Child & Adolescent Psychiatry

NIMHANS, Bangalore

Supported by Dept. of Women & Child Development, Government of Karnataka

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2018

The SOP is developed with the objective of having a uniform protocol to be followed for Child Psychosocial and Mental Health Care Aspects in Karnataka, for those handling cases of Child Sexual abuse under the POCSO Act (2012). This document is a joint effort by Karnataka State Commission for Protection of Child Rights (KSCPCR) and Dept. of Child & Adolescent Psychiatry, NIMHANS, Bangalore.

Contents

This document is written for agencies providing psychosocial and mental health care to children and adolescents presenting with an alleged history of sexual abuse. However, it is also for agencies that may be working with sexually abused children on legal and other care issues (even if not directly in psychosocial care) so that they understand what the processes are in psychosocial care in CSA, thus knowing what to expect and ensure that the child receives appropriate psychosocial and mental health care and assistance.

1. Psychosocial and Mental Health Assessment

It is important to obtain a detailed history and assessment of the child, including information on family and school context, developmental level and functionality, emotional and behavioural issues (pre and post sexual abuse), circumstances of the alleged abuse, the child's experience and understanding of the abuse and other related problems. Treatment and interventions for abuse must be developed based on the complete assessment of the child's context and issues; this is because every child is unique and has his/her own unique ways, based on age, developmental stage, personality and temperament, family and social circumstances, and the nature of abuse, of processing the abuse experience. Information requires to be obtained through assessment of the child and family/caregivers.

1.1. Demographic Details:

Name, Gender, Age, Date of Birth, Gender, Place of Residence/Address, Who the Informant is and how he/she is related to the child

1.2. Referral

- Agency Referral (CWC/KSCPCR, other medical specialists such as GP/Paediatrician/Gynaecologist): A letter from referral service/agency should be requested/filed, including the date and time of referral and the time lag between this and the initial consultation with the mental health/ other medical services; The Letter from the referral agency should state circumstances of referral, whether a case has been filed, and the current status of the case. If a case has been filed a copy of the First Information Report (FIR), Sexual Offence Report is required for our case file.
- Self-referral—by child's parents: whether parent or primary caregiver is present at the time of initial and subsequent consultations should be noted; in case only one parent is available, information about the other parent and his/her absence, possible parental martial conflict/ separation/ divorce issues, or the fact that the alleged perpetrator of CSA could be one of the parents, need to be documented; relevant identification and contact numbers of persons accompanying the child/adolescent should be noted. [Again, if parents/ caregivers have filed an FIR, a copy of this must be placed in the file].

1.3. Initial Account of Abuse Incident(s)

Documentation should include information (obtained from persons accompanying the child and/or child if child is willing to provide the information) regarding:

- **Circumstances of the alleged abuse**
  - Who was the alleged perpetrator?
  - What happened?

- Where it happened?
- When it started, the number of times abuse occurred?
- How disclosure came about and circumstances following disclosure?
- Where and with whom is the child living now? Is he/she safe there?

- Agencies that the child and family have been in contact with prior to the referral to NIMHANS/ pathway to referral to NIMHANS (e.g.: Police, CWC, Child Protection Services, Other hospitals, NGO)
- Collateral information from other sources (e.g.: Police, CWC)

Note: This is not the time for asking the child to provide the abuse narrative in great detail as this is likely to distress and traumatize the child further; the objective at this point is to establish that abuse has occurred and to know the nature of abuse i.e. contact versus non-contact, penetrative versus non-penetrative abuse with a view to making decisions regarding medical interventions.

1.4. Medical Evaluation

In case a child is referred immediately after abuse i.e. within a few hours or days), it is necessary to first proceed with a medical evaluation and requisite medical interventions as a priority. Treatment history and response to treatment (in case the child has already undergone or is undergoing treatment) should be recorded.

- **Physical Examination:**
  - Physical examination of child to be conducted including 2 ID marks
  - The child's family or caregiver should be present in the room during the examination.
  - Permission of the child and consent of the parent to be taken before examination
  - What physical symptoms does the child have at present/ (e.g.: burning sensation during micturition, White Discharge per Vagina, itching in the perineal area, bleeding, any injury, pain in any area etc.)
- **Post-exposure Prophylaxis (PEP)**

If child is within the 36 hour window period (especially in case of penetrative abuse):

- Has the child received Post-exposure prophylaxis (within 36 hours) in case of penetrative abuse?
- If not, refer to Paediatric ART Centre[1] for Post-exposure Prophylaxis (PEP);
- Even if child is not in the window period and the penetrative abuse has occurred within a month, refer to the Paediatric ART Centre so that a decision can be taken regarding initiation of PEP.
- Ensure that the child/adolescent has received oral contraceptive pills to prevent pregnancy.
- Ensure that child has been medically evaluated by a Registered Medical Practitioner, namely a paediatrician or gynaecologist from a government hospital, for sexually

[1] In Bangalore city, Pediatric ART centres are located in Indira Gandhi Institute of Child Health, Bowring & Lady Curzon Hospital, and Vani Vilas Hospital. Similarly, pediatric ART centres will need to be identified and contacted in case of penetrative sexual abuse.

transmitted diseases (STDs), urinary tract infection and/or injuries[2]. The STD investigation must be repeated at the end of 4 weeks, 3 months and 6 months

- **Forensic Examination**

Check whether an additional specific forensic evaluation has been done (examination requested by police documenting abuse, if swabs have been taken in case of penetrative abuse), and if so, whether the report available. Obtain the report from the relevant source.

- **Pregnancy Tests**
  - Ensure that a urine pregnancy test has been done.
  - In case the results are false negative, it would be best to obtain an additional gynaecological opinion.
  - In case the child/adolescent is under 20 weeks pregnant, discussions about abortion may need to be done with the child/adolescent and her caregivers. It is also advisable to liaise with an obstetrician at this time.
- **Preparing the Child/ Adolescent for Medical Tests and Treatment**

Always prepare children and adolescents for medical evaluations and procedures as these can be frightening and invasive for them; in fact, they can be almost as frightening and feel as invasive as the abuse experience. It is necessary therefore to reassure them on their safety, ensure their comfort during medical evaluations by having known/familiar/trusted people or caregivers with them; and it is important to give children information on the medical tests and procedures in simple, comprehensible ways so that they feel that they have some predictability and control over an otherwise difficult and frightening situation.

Preparing Children & Adolescents for Medical Evaluations and Procedures: What to Tell Them

We want to ensure that your health is alright. When children have been in unsafe circumstances and have been hurt/ abused, they may acquire some infections. Testing for this will help us identify if the infection is indeed present and start the appropriate treatment fast.

Unprotected sex with known/unknown (or more than one person) can result in injury and disease—especially as we do not know what infections those people have. So, we need to do some tests to check for any possible infection so we can treat it.

Since you have been hurt and abused by someone in ways that are physical and sexual, there are chances of your being pregnant. It would be important to do a test and find out if you are pregnant, for a few different reasons: i) doing a test early enough may help you terminate the pregnancy in case you do not want to continue with the pregnancy/ keep the baby i.e. if we delay finding out, it may be hard to implement the medical processes necessary to terminate the pregnancy; ii) in case you wish to keep the baby, then it will be critical for you to maintain your health and your baby's health in certain ways—so finding out early will help us guide you on how to do this. So, finding out sooner about whether or not you are pregnant will help you make some decisions comfortably... and offer you more options in this regard. (For children/ adolescents at risk of pregnancy).

[2] In Bangalore city, the child may be referred to Indira Gandhi Institute of Child Health or Vani Vilas Hospital.

1.5. Emotional and Behavioural Symptoms

Ask the parents/caregivers about emotional and behavioural responses and changes in the child following the abuse incidents; older children and adolescents may be interviewed directly to understand emotional and behavioural changes.

Emotional & Behavioural Signs & Symptoms in Child Sexual Abuse	
Younger Children	Older Children & Adolescents
• Sexualized behaviour • Avoidance of specific adults • Nightmares/ Sleep disturbance • Clingy behaviour/ separation anxiety • Fearfulness and anxiety • Bedwetting • School refusal • Decreased scholastic performance • Medically unexplained body aches and pains	• Self-harm • Depression/ isolation • Anger • Fearfulness and anxiety • Sleep disturbance/ nightmares/ flashbacks • Avoidance of specific adults • School refusal • Decreased scholastic performance • Medically unexplained body aches and pains/ fainting attacks • High risk behaviours—sexual behaviour/ substance abuse/ runaway

It is important to understand any emotional and behavioural issues the child had prior to the abuse and compare these to those that may have occurred post-abuse. This is because i) we need to understand exactly which emotional and behavioural problems that are attributable to abuse; ii) we need to understand how pre-abuse emotional and behavioural issues may have determined the ways in which the child has processed the abuse experience and been impacted by it. In either case, the child would need to receive treatment and assistance for all emotional and behavioural issues, both pre-existing ones as well as those that developed as a result of the abuse.

1.6. Academic and School History

This includes the child's educational and school status, the child's academic performance (both current and past) and any learning issues/ disabilities the child may have.

1.7. Family History

This includes basic demographic information on the child's parents/ caregivers (in terms of their educational qualification, occupation and income level) as well as the child's living arrangements, parental relationships, child's emotional relationship & attachment to parents, illness & alcoholism in parents, parental marital conflict, single-parenting, any loss experience suffered by child of primary caregiver.

1.8. Institutional History

This includes information on places the child has lived in other than the family home--which institutions child has lived in or is living in currently, for what periods of time, reasons for institutionalization.

1.9. Mental Status Examination

Upon first contact or during the first meeting with the child, he/she should be assessed for:

- General appearance
- Assess speech, mood, thought, suicidal ideation, perceptual disturbances, orientation

Specific observations should look for signs of subjective distress, clinging, crying, reactions to touch, intrusive images, thoughts, "flashbacks", other felt disturbances, and somatic symptoms (physical pain and fatigue).

1.10. Child's Version of Events

This includes interviewing the child so as to obtain information on the sequence of abuse events and how they occurred according to the child, and how the child perceived and understood the abuse. The interview may have to be carried out in well-planned sessions, over a period of time, especially in case of younger children or children with post-traumatic disorder. Creative play methods, such as stories, art and toys/dolls may have to be used to elicit children's narratives. Such indirect methods are gentle and non-threatening and also allow younger children with less developed verbal abilities to communicate their experiences of abuse. During these sessions, while eliciting children's abuse narratives, open-ended questions that encourage children to express themselves freely, should be used. A detailed verbatim recording of the interview should be done—through written documentation as well as video recordings in case of play sessions with young children, so that these can also be used for legal proceedings.

[See Annexe for a detailed document on CSA inquiry procedure].

2. Psychosocial and Mental Health Interventions

Based on the detailed assessment and history of the child, a plan of management must be developed. This includes: child counselling / therapy, family counselling, pharmacotherapy (if required for any specific psychiatric disorders), consultation / liaison with other agencies and personnel such as CWC, police, NGOs.

2.1. Counselling and Therapy for the Child

a) First Level Responses are initial responses provided to the child in the immediate aftermath of the abuse and trauma experiences. They are a means of temporarily suppressing bothersome feelings and memories to shield the child from the immediate impact of abuse. They are used when the child may be too overwhelmed to address the issues and feelings at hand, so as keep the child from extreme levels of anxiety as increasing anxiety that might lead her to be dysfunctional or to developing more severe mental health issues. First level responses therefore focus on the following:

- Reassuring child about safety and help.
- Getting the child to practice containment techniques such as relaxation and recreation (deep breathing, yoga, art, play…activities the child likes to do and finds relaxing).
- Enabling the family/ caregivers to be supportive and to spend quality time playing with and reassuring the child.

- Ensuring that the child's developmental needs are met so that the child has some sense of predictability and control once again i.e. gradually enabling child to resume normal routine activities such as going to school, playing with other children and other activities he child used to perform before the abuse events.

Asking questions about the abuse and attempting to establish depth interventions when the child is facing a crisis is not a useful beginning. This is not the time to for detailed inquiry. If there are serious and disruptive manifestations --like self-harm behaviours, incapacitating anxiety, post-traumatic stress disorder (PTSD) symptoms with severe panic, appropriate psychiatric referral is important.

b) Interventions for Long Term Healing and Recovery

Longer term therapy entails regular sessions with a trained therapist or mental health professional (psychiatrist/ psychologist/ social worker) who has the skills to engage the child in reflection and dialogue to process and resolve the abuse experiences. The purpose of therapy with a sexually abused children or adolescents is NOT to help them 'forget' the experience and 'get past it'. The objectives of depth therapeutic interventions for sexually abused children and adolescents are:

- Inquiry: Helping child to detail/provide a narrative on sexual abuse experience in a gentle non-threatening manner.
- Healing & Recovery: Enabling child to overcome abuse trauma and move from confusion to clarity; empowering child to develop coping & survivor skills.
- Personal Safety & Abuse Prevention: Identifying ways to cope/respond in case abuse is imminent or after abuse has occurred (for children); acquire life skills such as decision-making, assertiveness, negotiation (for adolescents).

Therapeutic methods need to be innovative and age-appropriate. Thus, multiple creative methods that allow for children & adolescents to understand and reflect on situations and experiences require to be used (versus mere information and instruction giving).

**The Community Child and Adolescent Service Project, Dept. of Child & Adolescent Psychiatry, NIMHANS has developed 3 activity workbooks on CSA and personal safety use with children/ adolescents: i) Child Sexual Abuse Prevention and Personal Safety (for Children aged 4 to 7 years); ii) Child Sexual Abuse Prevention and Personal Safety (for Children aged 7 to 12 years); iii) Life Skills for Adolescents Series: Sexuality & Relationships. The activity books use age-appropriate methods such as movement games, body mapping, art, board games, adaptation of children's games (hopscotch/ kunte billay), story-telling and narratives and film clips. (These materials are available, upon request, to child care service providers].*

c) Pharmacotherapy for the Child

As mentioned already, if a child develops post-traumatic stress disorder (PTSD) symptoms, including severe anxiety and/or self-harm behaviours, and thus becomes dysfunctional (i.e. is unable to resume routine/ daily activities), psychiatric medication may need to be considered for a certain period of time, until the child is able to return to normal levels of functioning. When the child is in this state, psychotherapy and counselling methods alone will not suffice as the child is

unlikely to be receptive to such methods. Thus, medication may need to be started, along with some containment techniques, followed by other psychotherapeutic interventions.

2.2. Family Counselling

a) Initial Response and Guidance

In the immediate aftermath of abuse, parents and caregivers of sexually abused children may also be confused and anxious about how to respond to the child and the situation in general. The following guidance may be provided to families and caregivers of sexually abused children:

- Do not ignore or undermine a child's statements and innocuous remarks.
- Believe what your child tells you.
- Do not to blame the child.
- Contact Childline (1098) for assistance on how to report to police, Child Welfare Committee and medical/ psychological help systems.
- File an FIR or police report.
- Ensure that the child is provided with emergency medical services (EMS) (within 24 hours of filing the FIR) provided by state Registered Medical Practitioners (RMP) in government hospitals.
- Seek counselling from child mental health experts in government institutions to ensure that psychosocial assistance and healing interventions are provided to the child; and that evidence gathering and other legal processes are embedded within the healing context.
- Tell the child that the abuse was not the child's fault. Explain to the child about the measures that are being taken to make the child feel safe at home and at school.
- Show openness to the child sharing his/her experiences by saying," When you want to tell me about what happened, how you feel about it, I am ready to listen."
- Get the child back to maintaining regular home (mealtime, bedtime, playtime) and school routines, for, normalizing processes are essential to recovery.

b) Guidance on Mandatory Reporting

The purpose of mandatory reporting, under POCSO, is to ensure that sexual offence comes to light and gets punished, to ensure that the child (especially when abuse takes place within the family) is safe and does not continue to suffer abuse, to provide justice to the child concerned and prevent abuse of other children. As justified as it is in its intent, the stipulation of mandatory reporting is ridden with dilemmas and is often difficult to implement. Parents and caregivers are often reluctant to report child sexual abuse for reasons ranging from stigma and discrimination associated with sexual abuse to fear of legal procedures and systems.

It is recommended therefore that mandatory reporting is not a one-off procedure but that it follows a process which entails the following:

- Written documentation of the child's (or family's) report/ account of sexual abuse in an official manner i.e. there should be nothing loose or informal about documentation, which must also be done in a clear and meticulous way.
- Explaining to the child and family that there are laws about child sexual abuse (POCSO) and that it is recommended that they report the abuse—with reasons for how and why it

could be advantageous to them i.e. how it would ensure safety of the child/ other children, get the perpetrator to be punished etc.

- Reassuring the child and family that there would be no pressure or coercion—that ultimately no report would be made without their consent and that were they to choose, in due course/ after due consideration, to report, we will assist them to do so.
- Understanding the child and family's hesitancy to report i.e. to elicit the reasons and fears they have not to want to report, and then to try and address these fears and concerns one-by-one. (Should their concerns be addressed, they might be more willing to go ahead with the reporting process).
- Assuring the child and family that confidentiality would be maintained through the processes of reporting i.e. the press/media/ school/general public would not be aware of the identity of the child.
- Explaining all processes involved in reporting, to child and family i.e. to guide and assist them through the gamut of agencies involved, from the police to child welfare committee and the magistrate; preparing the family and child about the sequence and type of reporting that would be necessary at each stage gives them greater clarity and reassurance and increases the likelihood of their reporting abuse.
- To start with healing interventions and tell the child that we can re-visit the reporting issue at a later point, when he/she feels ready to do so.

Thus, it is recommend that reporting be embedded in the process of psychosocial interventions for the child and family rather than a disconnected, stand-alone process that needs to be done immediately—and which then only serves to exacerbate the confusion and trauma that the child and family is already experiencing soon after the abuse incident/ disclosure or discovery. The POCSO Act would be more realistic if it acknowledged and took into consideration the dilemmas of mandatory reporting in practice and allowed for it to be a process of gentle persuasion, a discussion rather than an instruction, that could occur over time, within larger healing and recovery processes, instead of insisting on a more immediate reporting method and expecting it to be followed by all.

2.3. Consultation and Liaison with Other Agencies

The mental health services must coordinate with other agencies such as medical services, child care institutions, schools, and child welfare committees with a view to assisting the children with health, placements, return to school and other advocacy issues respectively. The main aim of coordinating with such agencies is to facilitate (psychosocial rehabilitation of children and enable them to heal in predictable and sensitive ways that address their basic needs of health, shelter, education, and protection. All such coordination initiatives must be documented by the mental health agency. Further, children and families must be consulted and informed about all coordination initiatives and decisions i.e. children's concerns and decisions may not be over-rules without adequate discussion with them/ their families.

3. Systems Issues and Reporting

A critical aspect of child protection, CSA warrants systemic approaches that are uncompromisingly child-centric. When an event occurs, it is addressed by systems of criminal justice, police, schools, families, and healthcare. However, in attempting to conduct inquiry, interrogation and detailing of the event to verify it and then bring the perpetrator to book, the child's best interests cannot be compromised. The balance between the need for justice and empowered recovery of the child becomes precarious. There is thus an urgent need to develop a protocol-based systemic response ensuring that the child's agenda i.e. healing and recovery, is at the core of it. Processes involving medico-legal systems for the child and the family must be devised in a manner as to avoid further traumatization of the child. In fact, inquiry with the child should be conducted once instead of multiple times, and only by mental health professionals and/or police personnel/SJPU trained in CSA work and forensic interviewing with children (to avoid re-traumatization)—again, as part of the psychosocial and healing processes.

3.1. Protocol for Place & Sequence of Reporting Abuse

A clear protocol to be developed as to where and in what sequence the child and family can seek assistance. Ideally, this should be as follows:

- First, the child should obtain medical assistance and treatment of injuries/PEP kit administration for pregnancy/STD/ HIV prevention (even if they report to the police first, they need to be sent for medical aid immediately).
- This should be followed by referral to mental health services—to address post-traumatic stress issues (through supportive work/therapy with child & family).

3.2. Police Inquiry

Police and legal inquiry should be **embedded within the psychosocial assistance processes** (the idea is not to obtain legal evidence first and 'let counselling carry on' as police personnel have often understood).

Child interviews can be conducted in child's home/ place of residence or a neutral space such as Police Commissioner's Office if a child-friendly space is created there, or at the mental health services/ facility wherein the child is being assisted. Children should not be interviewed in police station, nor, at any point during the initial or later stages of inquiry processes, should they ever be taken to the police station.

Police interviewing must avoid:

- Having the perpetrator and the child come face to face.
- Repeated questioning.
- Taking the child to the scene of crime and/or re-enacting event.
- Persuading child to provide information through insistence/ use of sweets, toys, chocolate.
- Touching the child unnecessarily.

3.3. Recording of Magistrate's Statement

As per Section 164, children and adolescents are required to give a statement to the magistrate, regarding the abuse. As already stated, repeated inquiry regarding the abuse may result in further traumatization of the child. However, given that the law mandates the magistrate's

statement, it is important that the magistrates be trained in sensitive and child-friendly ways to elicit the child's narrative and record the statement.

a) Child's Developmental Ability to Provide a Statement

It must be recognized that narration or giving of a statement is a function of child development. The child's ability to give a statement therefore depends on his/her age and developmental level i.e. abilities and skills in the five domains of child development --loco-motor, speech and language, cognitive, social and emotional development. Narration is a function of speech & language abilities, which immediately exempts very young children from providing statements. But narration is also a function of social and cognitive skills i.e. a child may have no physical problems but due to poor cognitive development, be unable to give a full statement; or a child may have physical and cognitive abilities but due to poor social skills, be unable to engage with other people, thereby affecting his/her ability to give a statement. In the light of this, the following are recommendations for recording the magistrate's statement:

- Very young children, (ages 0 to 3.5 years) will be unable to provide a statement.
- At a minimum, a child has to be about 3.5 years of age, to even attempt taking a statement. (Even then, some children will have language delays and be unable to report).
- A systematic developmental assessment of the child needs to be conducted (by a mental health professional) to establish the ability of the child to be able to provide a statement.
- Children with intellectual disability will need to be assessed to understand what their abilities and deficits are, and if they can report. Those with moderate to severe intellectual disability may find it especially hard to provide a statement.
- Children with severe trauma/ post-traumatic stress disorder and associated dysfunctionality, no matter what the age and developmental ability, may be unable to provide the statement, or at least not within the stipulated time or until psychosocial assistance is well underway.
- In the above instances, it is recommended that the magistrates make the exception and attempt to obtain the statement by:
    - Allowing child development/ mental health professional to assist with statement recording in spaces comfortable to children (i.e. outside the court), using play and other creative methods to elicit narratives (especially from young children with limited verbal abilities and/or children with intellectual disability or trauma).
    - Permitting of use of audio-visual recording of child's statement, especially when it is recorded by mental health professionals in spaces other than the court (such as in hospital playrooms and therapeutic spaces).
    - Ask for additional/specialised assistance by way of interpreters, translators, sign language experts and special educators for children with disability.
    - Allowing family and caregivers to accompany the child and remain with the child during the magistrate's statement recording; this especially applies to institutionalized children, who often have no family to accompany them and wherein the child's caregiver and/or therapist/counsellor should be allowed to be with the child during the statement recording.

- Accepting statements from the child's family and caregivers (especially in case of very young or disabled children).

b) Use of Child-Friendly Methods for Recording of Statement

Given children's age, developmental stage and their fears and bewilderments with regard to legal and systemic processes, a direct approach to elicit a report on the abuse would invariably fail. In fact, such an approach may lead the child to retract his/her statement and thus nullify the entire effort at justice. It is therefore important to train magistrates in the basics of child interviewing skills so that they can follow a systematic, structured method of statement recording that allows the child to be relaxed and comfortable and that then enables the child to provide the statement on abuse. Broadly, the steps in statement recording would include:

- Rapport Building with a Young Child (greeting the child, use of toys and play activities and neutral conversations with child)
- Introduction of the magistrate and the space (explaining in very simple terms what the function of the court and magistrate are and why the child had been asked to come there).
- Assuaging the child's fears & anxieties
- Taking the Statement (inquiring about the abuse through use of neutral, open-ended questions and gentle probes and use of pictures)

Additionally, the magistrate's statement must avoid:

- Hurrying the child to talk.
- Persuading the child to provide information through insistence/ use of sweets, toys, chocolate.
- Asking children to enact what happened.
- Probing for details of how the child felt at time of abuse (unnecessary details that might re-traumatize child).
- Touching the child unnecessarily.

4. Capacity Building of Service Providers

As described in various sections above, different types of service providers, from mental health service providers to police and legal service providers and child protection staff, are involved is assisting sexually abused children and adolescents. Below is a table suggesting the various types and cadres of staff who require to be trained in child sexual abuse work, including the training objectives and content, and the required training time.

Training content should centre around understanding children, childhood and child development in a broad sense, and then to locate child sexual abuse within larger contexts of children's issues i.e. training should not be narrowed to sexual abuse alone as it will not be useful to service providers who then will be unable to position themselves within a broader child protection context. Also, training should help service providers to develop skills, predicated on strong conceptual frameworks. Disjointed sessions by varied and diverse professionals, focussing purely on issues and theories on children and sexual abuse, using lecture and discussion methods should be avoided. Instead, training programs should be participatory in

nature, using creative methodologies, to enable service providers to develop the skills and methods required to work in contexts of abuse and trauma.

**The Community Child & Adolescent Service Project, Dept. of Child & Adolescent Psychiatry, NIMHANS has already developed training methods, materials and manuals for use with children's service providers. These have been adapted for use with various types of service providers and can be shared upon request, with trainers and/or training could be undertaken by the NIMHANS team.*

Suggested Capacity Building Initiatives for CSA Service Providers

Target group	**Objectives & Content**	**No. of days**
Police officers / SJPU	To enhance the quality of child protection services by: ● Sensitizing them to children who have undergone sexual abuse and trauma. ● Enabling them to develop basic communication and interviewing skills to facilitate supportive child relationships with children. ● Helping them to assist children in legal processes such as 164 statement and court proceedings in accordance with POCSO, in child-friendly ways.	2 days (1 day classroom conceptual training + 1 day practical skill training)
Magistrates/ Special court Judges/ Child Welfare Committee Members	To enhance the quality of child protection and psychosocial care services, ● Sensitizing them to children who have undergone sexual abuse and trauma. ● Enabling them to develop basic interviewing skills to be able to record children's statement.	1 day
Counsellors/ Social workers/ Child Care Institution Staff	To enhance the quality of child protection and psychosocial care services available to sexually abused children by enabling them to: ● Develop basic communication skills to facilitate supportive care worker-child relationships. ● Identify/interview/ assess children who have undergone sexual abuse. ● Provide first level responses to abused children in a state of trauma. ● Facilitate longer term healing and recovery processes for abused children. ● Provide special interventions to children living in difficult contexts. ● Provide systemic recommendations to CWC and other child protection/education/legal personnel.	3 days (classroom training) + 14 days supervised practical field training.

Annex

Guidelines for Conducting Child Sexual Abuse Inquiry by Mental Health Services

A. Process of Inquiry

A. 1. Introduction

Introduce yourself, explain need for video cam/ microphone. *[As you can see, we have a video-camera and microphones here. They will record our conversation so I can remember everything you tell me. Sometimes I forget things and the recorder allows me to listen to you without having to write everything down.]*

A. 2. Ensuring Accurate Reporting

Establish the need for telling the truth, capacity to differentiate between what's true or not and to say 'I don't understand' or to tell examiner when he makes a wrong statement. *[1.'Part of my job is to talk to children[teenagers]about things that have happened to them. I meet with lots of children [teenagers] so that they can tell me the truth about things that have happened to them. So, before we begin, I want to make sure that you understand how important it is to tell the truth.'2. [For younger children, explain: 'What is true and what is not true']. 'If I say that my shoes are red (or green) is that true or not true?' [Wait for an answer, then say:] 'That would not be true, because my shoes are really [black/ blue/etc.].And if I say that I am sitting down now, would that be true or not true [right or not right]?' [Wait for an answer.] 3. 'It would be [true/right], because you can see I am really sitting down.' 'I see that you understand what telling the truth means. It is very important that you only tell me the truth today. You should only tell me about things that really happened to you.' [Pause.] 4. 'If I ask a question that you don't understand, just say, "I don't understand." Okay?' [Pause] 'If I don't understand what you say, I'll ask you to explain. 'What would you say if I made a mistake and called you a 2-year-old girl [when interviewing a 5-year-old boy, etc.]?' [Wait for an answer.] 'That's right. Now you know you should tell me if I make a mistake or say something that is not right.*

Capacity to differentiated 'truth' established	Yes	No
Capacity to say 'I don't understand' established	Yes	No
Capacity to tell interviewer that she/ he 'is not right' established	Yes	No

A.3. Rapport Building with Child

Build rapport with the child. *[1. 'I really want to know you better. I need you to tell me about the things you like to do.' [Wait for an answer.] 2. 'Tell me more about [activity the child has mentioned in his/her account. AVOID FOCUSING ON TV, VIDEOS, AND FANTASY].' [Wait for an answer.]*

A. 4. Training in episodic memory (Narrative event practice)

'It is very important that you tell me everything you remember about things that have happened to you. You can tell me both good things and bad things.'[*Identify a recent event the child experienced- first day of school, birthday party, holiday) and build up upon that using qualifiers like 'tell me, what happened next, 'Think hard about [activity or event] and tell me what happened on that day from the time you got up that morning until [some portion of the event mentioned by the child in response to the previous question]. 'Tell me more about [activity mentioned by the child].' [Wait for an answer.] [Note: Use this question as often as needed throughout this section.] 'Earlier you mentioned [activity mentioned by the child]. Tell me everything about that.']*

A.5. Transition to substantive issues (Abuse enquiry)

['Now that I know you a little better, I want to talk about why [you are here] today.' Use open ended questions. use a series of general prompts, or prompts based on background information, that are as non-suggestive as possible, but become gradually more focused, for example, "I heard you talked to 'X' about something that happened – tell me what happened," "I see you have [a bruise, a broken arm, etc.] – tell me what happened." "I heard you saw [the doctor, a policeman, etc.] last week – tell me how come/what you talked about," "Is [your mom, another person] worried about something that happened to you? Tell me what she's worried about," "I understand someone might have bothered you – tell me what happened," "I understand someone may have done something that wasn't right – tell me what happened." "I understand something may have happened at [location] – tell me what happened."]

A.6. Probe for Disclosure

[*'You've told me why you came to talk to me today. You've given me lots of information and that really helps me to understand what happened.' [If child has mentioned telling someone about the incident(s), ask details, if not then probe about possible immediate disclosure by saying: 'Does anybody else know what happened?' How did they come to know?]*

A.7. Closing the Interview

Provide opportunity for further disclosure and contact information. [Say:] 'You have told me lots of things today, and I want to thank you for helping me.' 1. 'Is there anything else you think I should know?' [Wait for an answer.] 2. 'Is there anything you want to tell me?' [Wait for an answer. 'Are there any questions you want to ask me?' [Wait for an answer.] 4. 'If you want to talk to me again, you can call me at this phone number.'[Hand the child a card with your name and phone number.]

B. Additional Guidelines for Inquiry

B.1. Children have capacity to remember which can be established earlier in the interview process by the interviewer to describe specific events, thus determining whether the child can retrieve information from episodic memory or does not understand the task.

B.2. Developmentally immature children too have memories but have difficulty in retrieving them. Thus a technique of scaffolding is used in which a series of detail-oriented questions are asked e.g. −"Did you do anything when you were at that house?" "What did you do?" "Was someone there when you did [what the child reported]?" The interviewer thus offers "cues" or "cognitive supports" that allow the child to access his or her memory. As previously mentioned, this process is perceived to be developmentally appropriate because even very young children are believed to possess the capacity for recognition memory through the use of scaffolding.

B.3. Attention and accuracy of recall: Quality of information provided by young children begins to decrease with increased attempts to refocus. In other words, once a three-year old has lost interest and has been refocused to the interview process several times, she or he may begin to answer questions randomly, without thought or consideration of the questions posed. Thus, the following guidelines could be used to keep the time limit while interviewing children:

General Reference: Duration of Engagement
3 year olds = 15 minutes
4 – 5 year olds = 20 to 25 minutes
6 – 10 year olds = 30 to 45 minutes
10 – 12 year olds = Up to an hour

B.4. Accuracy of information and competency of child: In order to give an accurate response, children need to both understand and remember the question in its entirety. Compound questions (e.g., "Where were you and what were you doing?"); embedded questions (e.g., "Do you remember what you were doing?"); questions that include prepositions ("Was that before or after your birthday?"); indexical words ("Did you know that?"); or any sophisticated linguistic structures are all examples of inquiries too complex for children under age five and thus should be avoided. In addition ambiguous questions too are problematic for pre-schoolers (e.g., "How were your clothes?"). A follow-up question might be, "Were your clothes on, or off, or something else?

B.5. Concrete Versus abstract: Preschool children have specific and literal thought processes of and thus use of questions that are simple and concrete, not abstract or complex are advocated. Pre-schoolers have difficulty in grasping abstract and relational concepts e.g. familial connections or relationships; time or sequence; and various forms of measurement, such as speed, distance, dimension, or quantity. Higher order words (e.g., "move" or "touch") are also too abstract, because they encompass a wide range of meanings. Children who think in terms of the more specific lower order words may deny that they were "touched," but acknowledge that they were "tickled" or "licked.

Age of Child	Who	What	Where	When	Structured Report	Contextual Details
3						
4-6						
7-8						
9-10						
11-12						

B.6. Providing context: Even when lower order words and simple sentence structures are used in the interviewer's questioning, younger children may become confused by questions without context. Thus, it is important that interviewers provide a context for each question asked, using the child's identification of that context ("When you were at the park . . ."). Similarly, it is important for interviewers to inform children any time the interviewer intends to change topics, allowing the child to transition into a new context along with the interviewer.