Identifying Abuse and Maltreatment in Child Care Institutions

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1. Background & Rationale for Monitoring Child Care Institutions on Abuse and Maltreatment Issues

Following the alleged sexual abuse and assault of children in a shelter home in Muzzafarpur, Bihar, the Dept. of Women & Child Development, Government of Karnataka proposed to take tighter measures and formulate systemic methods to ensure the safety of children within the state Juvenile Justice system. Upon request of DWCD, the NIMHANS team has developed this document to enable relevant authorities, including DWCD personnel, child welfare committees, juvenile justice boards and indeed all other stakeholders engaged in care and protection of vulnerable children, particularly those housed in child care institutions, to better understand and monitor children's safety from abuse and exploitation. This document lays out standards and methods that are for use to identify abuse and maltreatment in CCIs; it is meant to complement (not substitute) other monitoring tools and formats that individual states may have already developed, in order to monitor the general functioning of CCIs. While abuse may be physical, sexual or emotional in nature, this guideline focuses primarily on identification and response to on physical and sexual abuse in child care institutions.

1.1. Current Issues & the Context of Juvenile Justice

In recent years, there have been increasing reports of child sexual abuse (in all likelihood, always prevelant but under-reported) across the country. In the context of children in care and protection, or children in institutions, most incidents of child sexual abuse are known to have occurred before the child is placed under state care i.e. when the child was living with family/ in the larger community and/or in the street. Thus, the child is then afforded protection through child welfare committee services and state care, in institutions run by government and non-government agencies.

When a child is placed in a child care institution (CCI)[1] registered under the Juvenile Justice Act or the Dept. of Women and Child Development / Dept. of Social Justice and

[1] CCIs include children home, observation home, special home, place of safety, specialized adoption agency and open shelter, which also house children in need of care and protection, and those in conflict with law.

Empowerment or other relevant state departments, the child is automatically assumed to be safe and protected. While this assumption is not an incorrect one, there unfortunately continue to be instances where such vulnerable children are abused and exploited, even in child care institutions designated for their care and protection. For instance, in 2007, a PIL was filed at the Supreme Court based on a media report drawing attention to alleged sexual exploitation of children in orphanages in Mahabalipuram, Tamil Nadu; most recently, there have been cases of alleged sexual abuse of girls at shelter homes in Muzzafarpur, Bihar and Deoria, Uttar Pradesh. In fact, the Supreme Court has taken *suo moto* cognizance of the Bihar incident, and has since, directed the Ministry of Women and Child Development to place before it the data of social audit and survey conducted in shelter homes across the country

While it is the incidents of sexual abuse in CCIs that have often made news headlines, the fact is that other forms of abuse are also rampant in these institutions. The Tata Institute of Social Sciences report on shelter homes in Bihar (through which the Muzzafarpur home incidents came to light) also describe other forms of abuse that are perpetrated against the children, from serious physical violence to being forced to work in the houses of the institution staff, and emotional and verbal violence. According to this report, such maltreatment of children has also led to them resorting to self-harm and suicide behaviours.

Alas, what we know of the above-mentioned child care institutions is perhaps only the tip of the iceberg. Some of the main reasons for the enactment of the Juvenile Justice Act were to *'impose on the State a primary responsibility of ensuring that all the needs of children are met and that their basic human rights are fully protected'* and that *'children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and that childhood and youth are protected against exploitation and against moral and material abandonment'*. It therefore becomes doubly ironic and against the mandate of the JJ Act when children within the care and protection systems are abused and maltreated. If the very agencies and systems that are responsible for providing protection to some of the most vulnerable children in the country i.e. children who are orphaned/abandoned/(previously) abused/ HIV infected or affected and disabled, are abusive and exploitative instead, it is a serious concern—in fact, the POCSO Act 2012 terms (sexual) abuse by a caregiver of a child as 'aggravated abuse'. In the light of the above, it is critical to devise monitoring systems that will ensure the continued safety, care and protection of vulnerable children, especially those in institutions.

1.2. Definitions of Child Abuse and Maltreatment

Childhood abuse and maltreatment refers to any interaction or lack of interaction by adults, whether families, caregivers or others, that results in harm to physical, mental and developmental states of children. Child abuse can be broadly categorized as follows:

a) Acts of omission:

- Consist of things caregivers *should do* to children but do not do—which amounts to neglect.
- Comprise of psychological neglect, sustained parental non-responsiveness and psychological or physical unavailability.
- For instance, parents/ caregivers who do not respond to children with love, affection and caring; or do not take care of the physical/medical/ nutritional needs of children.

- It also entails depriving children of educational, play and recreational and other opportunities they require for optimum growth and development.

b) Acts of commission:

- Things caregivers *should not* do to children but do them, and so hurt children.
- Involves actual trauma directed toward the child in the form of acts of abuse, whether physical, sexual, or emotional/psychological.

More specifically, child abuse may be of the following types:

Neglect & Physical Abuse

- Entails inadequate parenting or caregiving where there is potential for injury resulting from omissions of caregivers.
- Involves poor hygiene, lack of compliance with medical therapy, malnutrition that occurs due to lack of proper feeding practices by caregivers.
- Any non-accidental physical injury to the child and can include striking, kicking, burning, or biting the child, or any action that results in a physical impairment of the child.
- Includes corporal punishment—which refers to use of physical punishment, force or threat to decrease the frequency of child misbehavior, but that results in (risk of) injury to the child.

Sexual Abuse:

- Is an interaction between a child and an adult where the child is used for sexual stimulation.
- Entails exploration of sexuality between a minor, traditionally understood as below 18 years of age, could be exploitative if the age difference between them is more than 5 years.
- Includes but is not restricted to rape/penetrative genital contact (whether by using the body or any other external object).
- May involve digital handling of the child's genitalia, non-genital forms of sexual touching as well as non-contact forms of abuse for the pleasure of the perpetrator such as exposing the child to pornography or taking nude pictures of the child.

Emotional Abuse:

- Behaviors, speech, and actions of parents, caregivers, or other significant figures in a child's life that have a negative mental impact on the child or seriously damage the emotional health and development of a child.
- Examples of emotional abuse include:
  - name calling
  - insulting or humiliating
  - discriminating against a child based on caste, gender, (lack of) abilities/talents or any other issue
  - threatening violence (even without carrying out threats)
  - allowing children to witness the physical or emotional abuse of another
  - withholding love, support, or guidance
- Children who are neglected, or physically or sexually abused also suffer emotional abuse.

1.3. Consequences of Child Abuse and Maltreatment

Depending upon the age of the child, immediate impacts of child abuse can range from post-traumatic stress disorder, anxiety and depression, to confusions and mistrust about interpersonal relationships; children's developmental trajectories (i.e. their achievement of

milestones) can be adversely impacted with disruptions in their day-to-day functioning resulting from the psychological trauma.

- **Adverse Impact on Developmental Trajectories**

- Direct injuries resulting from abuse could adversely affect children's physical and loco-motor development.
- Trauma impairs children's daily functioning in terms of feeding and sleep patterns, thereby impacting their nutritional and health status, which in turn, affect growth and development.
- Severe trauma interferes with the usual acquisition of self-capacities and developmentally appropriate skills in children.
- Both due to pre-occupation with the trauma event and related anxieties, as well as developmental impairment, it becomes difficult for children to acquire and process new information, develop family, social and peer relationships.
- Due to the impact on socio-emotional development, there is likely to be impairment of functions relating to self-identity, social and cognitive skills.

- **Negative Assumptions about Self**

- Negative assumptions refer to how the child makes inferences based on how she is treated.
- Example: "I must be basically unacceptable/ bad"; "something must be basically wrong with me to deserve such punishment".
- Consequently, the child perceives herself as weak and inadequate.
- Child also views others as dangerous or rejecting or hurtful.
- Negative assumptions about self can lead to poor self-esteem and difficulty in forming or maintaining healthy inter-personal relationships.

- **Trauma Flashbacks**

- Trauma flashbacks refer to re-experiencing trauma at a later time (weeks, months or even years after)—as flash backs.
- Thoughts can be triggered or 'switched on' by exposure to some environmental stimuli or experience that is similar to the trauma.
- Children remember the details of event, especially sights, sounds, touch and other sensations—and these often cause distress and anxiety that impair functioning.

- **Interference in development of emotional regulation skills**

- Emotional regulation refers to the ability to manage and control emotions, particularly difficult emotions such as anger and anxiety, in the wake of provocative situations.
- Children who have been abused are at risk of being more easily overwhelmed by emotional distress
- They tend to use maladaptive ways to cope with stress, such as dissociation (fainting/ black-outs) and other methods of avoidance.
- They have difficulty in responding in a 'balanced' way, within a moderate range of emotions: the slightest provocation, even if unrelated to the event may produce extreme reactions of extreme fear or anger—which create difficulties for them in social and inter-personal situations.
- Preclinical and clinical studies have shown that repeated early-life stress and trauma experiences lead to alterations in central neurobiological systems leading to increased (mal) responsiveness to stress; this in turn increases the risk of psychopathology in both children and adults.

There is also considerable evidence on how adult survivors of child sexual abuse are at high risk of developing various types of mental health morbidities: anxiety, depression, self-harm, and substance abuse, which may have their roots in childhood and adolescence, following abuse trauma, are known to continue into adulthood, affecting individuals' sense of self-

efficacy and identity, long-standing interpersonal difficulties, as well as distorted thinking patterns, emotional disturbance, and continued posttraumatic stress.

2. Objectives of Monitoring Abuse and Maltreatment Issues in Child Care Institutions

- To ensure that child care institutions are places of care and protection, in accordance with the provisions of the Juvenile Justice Act 2015.
- To monitor protection concerns in child care institutions through (early) identification of abuse and maltreatment issues.
- To provide speedy and timely assistance to affected children found to be in situations of abuse and harm while residing in child care institutions.
- To enable relevant authorities and child services to undertake timely and appropriate actions against caregivers and other functionaries and stakeholders in the care and protection system for protection violations committed by them.

3. Role of Child Welfare Committees & Juvenile Justice Boards

The Juvenile Justice Act 2015 has adequate provisions for addressing child protection issues both within and outside the state child care and protection system. It is therefore suggested that as the child welfare committees (CWCs) and juvenile justice boards (JJBs) are already vested with the powers/ functions to monitor child protection issues and visit child care institutions to do so, it would be most suitable for these bodies to undertake the abuse monitoring function in child care institutions. In fact, some of the specific roles and responsibilities ascribed to CWCs and JJBs make clear their functions relating to child protection of institutionalized children.

Amongst others, there are three CWC functions outlined in Chapter V of the JJ Act that have particular reference to monitoring (and responding to) abuse issues in child care institutions:

- *Conducting inquiry on all issues relating to and affecting the safety and well-being of children under this act'.*
- *Ensuring care, protection, appropriate rehabilitation or restoration of children in need of care and protection, based on children's individual care plan, and passing necessary directions to parents or guardians or fit persons or children's homes or fit facility in this regard.*
- *Taking suo moto cognizance of cases and reaching out to children in need of care and protection, and who are not produced before the committee, provided that such decision is taken by at least three members.*
- *Taking action for rehabilitation of sexually abused children who are reported as children in need of care and protection to the committee, by Special Juvenile Police Unit or the local police, as the case may be, under the Protection of Children from Sexual Offences Act 2012.*

The JJ Act also states that *'a visit to an existing child care institution by the Committee, to check its functioning and well-being of children shall be considered as a sitting of the committee'.*

Likewise, according to the JJ Act, the functions of the JJB includes *'Conducting at least one inspection visit every month of residential facilities for children in conflict with law and recommend action for improvement in quality of services to the District Child Protection Unit and the State Government'.*

Thus, drawing from the Juvenile Justice Act and its provisions relating to children in institutions, whether they are children in need of care and protection or those in conflict with the law, it would be essential for CWCs and JJBs, as part of their child protection function, to undertake monitoring of child care institutions, including identification and reporting of abuse. However, other child protection staff, such as the District Child Protection Officer (DCPO) and officers of the District Child Protection Units (DCPUs) who frequently visit and monitor child care institutions and their functioning, must also be equally alert to identify and report abuse issues.

4. Indicative Guidelines for Identification of Abuse & Maltreatment in Child Care Institutions

A. Basic Information:
Agency Name & Registration:
No. of Children:
Age/ Gender of Children:
Staff Details (No. and Designations):

B. Establishing Abuse
In order to detect and monitor incidence of child abuse in institutions, a conceptual framework comprising of various strategies, at several levels, has been developed as follows:
Level 1: Observation of Signs & Symptoms of Abuse
Level 2: Discussions with Children
Level 3: Medical & Psychiatric-Mental Health Records
Level 4: Individual Interviews with Institution Staff

The levels are based on an index of certainty, with levels 1 and 2 representing the highest index of certainty of abuse i.e. where it may be presumed that abuse has occurred; and levels 3 and 4 are used to corroborate information from levels 1 and 2.
The framework and questions below can be used in the following situations:

- For routine monitoring purposes, during child protection staff visits to an institution, to detect abuse in case it is incident;
- In the aftermath of any reports regarding child abuse within an institution, to facilitate inquiry and investigation on abuse-related issues.

Level 1: Observation of Signs & Symptoms
When child protection staff visit an institution, they need to be alert to certain observable signs of physical and sexual abuse. This forms the basis of suspicion of abuse and consequent investigations into child care services and facilities within that institution. While the physical signs and symptoms of child abuse, both physical and sexual, and neglect may differ somewhat, the emotional and behavioural consequences are largely similar or over-lapping.

Identifying physical signs of abuse and neglect through observation is particularly important in the context of institutions providing care to children between 0 to 6 years and to children with intellectual and other disabilities. This is because many of these children are non-verbal and/or because of their developmental stage (or developmental disability) will be unable to articulate their experiences or express their discomforts. Thus, young

children and those with disability are particularly vulnerable to various forms of abuse and neglect, and other child rights violations—and particular alertness and care in required when monitoring institutions housing such children.

Level 1: Observation of Signs & Symptoms

Physical Signs	**For Physical Abuse** • Bruises, welts, black eyes or other injuries that can't be explained or don't match with the child's story. • Burns that cannot be explained. • Injury marks that have a pattern, like from a hand, belt, or other objects. • Injuries that are at different stages of healing (bruises change colour over time) • Fractures and dislocations. • Wear clothing that doesn't match the weather -- such as long sleeves on hot days -- to cover up bruises.
	For Sexual Abuse • Pregnancy • Sexually transmitted infections • Genital injuries • Physical injuries
	For Neglect • Skin infections and sores • Appears dirty and has severe body odour • Has poor dental hygiene • Lacks sufficient clothing for the weather • Signs of Malnutrition: - Respiratory and other infections/ illness - Skin is thin, dry, inelastic, pale, and cold - Cheeks appear hollow and the eyes sunken, as fat disappears from the face - Hair is dry and sparse
Emotional & Behavioural Signs	• Sudden unexplained change in behaviour: School refusal, people avoidance • Sudden onset of bed wetting, aches, pains, general ill health • Symptoms of depression and Post-Traumatic Stress Disorder • Appear dull, listless and inactive. • Avoidance of any kind of touch or physical contact. • Fearful appearance always seeming to be on high alert. • Withdrawal from friends and activities. • Marks of self-harm/ self-injury (especially on arms/ wrists). • Sexualized behaviour (applicable only to sexual abuse).

**Time-lines to be checked with child and in medical records, to establish whether these signs occurred during the child's stay in the institution or before admission to the institution.*

Level 2: Discussions with Children

One of the highest levels of certainty is when children themselves disclose that they have experienced abuse. Frequently expressed concerns in this regard are: 'how can children be believed?' or 'what if they are not telling the truth?' At the outset, it is important to understand that it is unlikely that children lie about abuse-related issues—firstly, they have little to gain from such lies, and secondly, abuse is too complex a matter to concoct stories around, especially given the developmental abilities of children. In case of institutionalized children, generally drawn from exceedingly vulnerable backgrounds of abuse, neglect and

family dysfunction, they are even less likely than their counter-parts from intact homes/ families, to 'make up' stories about abuse; this is because institutionalized children have no other security and support systems to fall back on, and so, on the contrary, tend to be reluctant to disclose abuse, for fear of losing what little support and facilities they have.

Another perspective on the (dis)belief issue may be taken by considering the following situations:

- We believe the children(who report that there has been abuse), and it is found later on, that it is untrue/ there has been no abuse, there are no harmful consequences per se—at least not to the children.
- We believe the children (who report that there has been abuse), and it is found later on, that it is true/ there has been abuse, then the children receive assistance and protection.
- We disbelieve the children (who report that there has been abuse), and it is found later on, that it is untrue/ there has been no abuse, there are no harmful consequences. (We are lucky that it actually did not happen!)
- We disbelieve the children (who report that there has been abuse), and it is found later on, that it is true/ there has been abuse, then children receive no assistance or protection…in fact, they continue to be abused.

So, whilst taking a position on (dis)belief, it is better to err on the side of belief than on the side of disbelief. In other words, if one were to make an error of judgement, it is better to believe and be wrong (since there will be no harmful consequences to the children) than to disbelieve and be wrong (in which case the children will seriously suffer). In short, always believe—at least at first instance, and proceed with further investigations as necessary.

Some general guidance on Interviewing Children on Abuse-Related Issues:

- ✓ Be gentle and reassuring.
- ✓ Never hurry, harangue or force or threaten children to disclose their experiences.
- ✓ Remember that it is difficult for anyone to be disclosive about abuse experiences, and that you are a relatively new, unknown person to the children.
- ✓ Bear in mind that particularly for children who have experienced abuse, they are afraid and confused, no longer sure of who to trust—and that includes you.
- ✓ -You might, therefore, not be able to get the requisite information in a single interview/ discussion, and so may have to come back multiple times to the institution, for further discussions with the children
- ✓ Do not use the law as an argument in your persuasion i.e. talking about police and legal procedures (as true as those aspects are) only serve to intimidate children rather than encouraging them to be disclosive.
- ✓ Focus instead on the children's difficulties (in the wake of abuse), their right not to be hurt, and your commitment to assisting them.
- ✓ Reiterate issues of permission and confidentiality (outlined in the *'Introduction'* section of the discussion guidelines (below).

In interviews with children, it may be preferable to start with a group discussion, so that children do not feel threatened or singled out, as might happen if inquiry started with individual interviews. Also, the general questions are likely to yield generic information, that all children should have a chance to feed into.

Level 2: Discussions with Children

Introduction	*My name is……. You may have seen me here sometimes. My job is to work with children and ensure that they feel safe and protected…and to help them if they have any difficulties or are hurt in any way. Part of my job is also to make sure that children's institutions are run well and that children are looked after. I am here today to talk to you about your views and experiences—which are really important for me to understand. Also, whatever you share with me, will not be shared with the caregivers of the institution. If I feel that something needs to be done about the issues you share with me (in case there are difficult issues), I will first consult you, tell you whom I will speak to and only do so with your permission. [I would not do things without your permission as I do not want you to get hurt in any way].*
General Questions	*- Tell me about how you spend the day…what activities do you do from the time you wake up…?* *- Tell me about the different rooms and spaces in your institution…where do you eat? Where do you sleep? Where do you play/ do your homework?* *- What time do you eat dinner? And what happens after that…? What do you all do?* *- What are some of the things you like best about being in this institution?* *- What are some things you find difficult about being in this institution?* *- Tell me something about each of the caregivers who are in this institution…we can name them one by one and you can tell me what they do here/ how they help you/ what activities each of them do with you…* *- In many institutions, children help out and do things around the place…like some chores related to cleaning and cooking. Tell me a little about what chores you do in this place…or if you do chores in any other place too (although you live here).* *- Has anyone forced you to do work/ chores that you don't want to do? Tell me about it…*
Questions about observable physical and emotional-behavioural signs of abuse	*- I see that (some of) you have hurt yourselves…I notice that you have marks on your arms/face…Can you tell me how these injuries happened?* *- Did you meet the doctor about these injuries? What did he/she say?* *- (Some of) you look a little sad and afraid (or dull)…is there anything that make you feel sad/ afraid/ angry?* *- Has anyone said or done anything that has made you feel upset or uncomfortable during the time you have been here?* *- Has anyone forced you to do anything that you don't want to do or that makes you uncomfortable? Tell me about it…*

As shown in the box above, there are three parts to the discussion, whether had with children either in a group or individually:

- An introduction of the child protection staff/team, so that children know and understand who they are speaking with and what the purpose of the discussion is; ideally (and time permitting), this stage should include a simple game and a round of introductions of the children too.
- General questions about the children's daily routine including places they go to and activities they do. In case children do not go to school or go to places/engage in activities that seem inappropriate, there must be a suspicion about abuse. It is also important to observe children's body language and non-verbal cues as they respond to questions—do all children respond? Do all agree or corroborate what some say

about their routine and activities? Do several children appear silent and non-responsive? Do some children have a different response in terms of what they do? It is critical to wait for children to respond, listen for dissenting voices and gather information that is different from even what the majority voice may be, in order to identify abuse.

- Questions in relation to observable physical and emotional-behavioural signs of abuse may be asked in a group, especially if many children have observable signs of abuse; however, these questions may also be met with silence or resistance, by several children, who may be uncomfortable making disclosures in a group situation. Therefore, these questions, which elicit information that is very sensitive in nature, are better used in individual interviews with children in whom child protection staff observe signs of abuse and/or children who volunteer information and seem more ready to be vocal.

Level 3: Medical & Psychiatric-Mental Health Records

Level 3 of the inquiry entails correlation between observed signs and medical records/ reports and correlation between observed signs and psychosocial/ psychiatric records/ reports. Child protection personnel need to ask the child care institution superintendent and staff for the children's files and medical records to check whether and what types of treatment children have received for illness and injury and/or emotional and behavioural problems. If the medical records do not contain (adequate) reports of children's treatment or fail to corroborate children's accounts or do not adequately explain children's injuries and problems, it is indicative neglect and/or of abuse—and the matter may be reported to the relevant authorities for action.

As erstwhile mentioned, medical records are particularly important indicators for children in institutions providing care to children between 0 to 6 years and to children with intellectual and other disabilities. Since most of these children may be partially or completely non-verbal, it would not be possible to implement Level 2 of the inquiry with them.

Level 3: Medical & Psychiatric-Mental Health Records

Medical records explaining the injury marks/fractures/burns	- Date of injury - Name/ details of agency that conducted assessment/ treatment * - Nature of the injury - How and when the injury/ illness occurred - Treatment child is under
Psychiatric assessments and records explaining emotional & behavioural signs and symptoms:	- Date of assessment - Name/ details of agency that conducted assessment/ treatment* - A detailed account of child's emotional and behavioural issues, including explanations on the context of the child's problems - Treatment inputs child has received

*****Credibility of individual and non-governmental organization assessments are likely to be suspect as monitoring and accountability of such entities is limited.

Level 4: Individual Interviews with Institution Staff

Considering that the objective is to identify abuse taking place within child care institutions, some or all child care institution staff are likely therefore to be responsible and/or involved in any child abuse that occurs in these spaces. They are also likely, therefore, like most perpetrators of abuse, to either completely deny abuse or to provide conflicting/ contradictory reports on children's injuries/ health problems. In the light of this, interviews with caregivers are the last level of inquiry, and also lowest on the index of certainty.

Given the uncertainty of the role and positions of different institution staff, it would be inadvisable to conduct a group discussion as it would be critical to get different observations and viewpoints to understand the situation, especially in situations where some but not all of them may be involved in perpetration of abuse. A group discussion may not allow staff who have certain observations or information about abuse incidents to report these matters freely. It is therefore necessary to conduct individual interviews with each of the staff and with all of them—including part-time and full time staff, and those involved in direct care of children as well as those involved in administrative and cleaning tasks.

In case it is reported (by children or other sources) that the institution caregivers are involved in abuse perpetration, and/or in case there is denial or caregiver is unable to account for it or gives conflicting/ contradictory reports on children's injuries/ health problems, no further questions should be asked of them. The matter should be immediately escalated to the relevant authorities.

Level 4: Individual Interviews with Caregivers

Introduction	*My name is……. You may have seen me here sometimes. [or you know that I visit the institution/ work on child welfare issues]. Part of my job is also to make sure that children's institutions are run well and that children are looked after. I am here today to talk to you about your views and experiences of the children and the staff in this institution—I will be talking to each of the staff independently, as different people may have different views on how this institution is run…and so that each person can express his/her views freely. I will not share your viewpoint with any of the other staff members I talk to and interact with.*
Questions	*- Have you noticed any injuries/ health issues in the children? Tell me more about it?* *- Have you observed injuries?* *- Have children reported any injuries/ health problems to you?* *- Any sudden or unusual behavioural changes in the children? Sleep patterns/ feeding patterns/ socialization/ daily activity/ sudden onset of bed-wetting?* *- What measures have you taken to help children access treatment for injuries/ health problems and/or psychological problems?* *- Have children reported any misbehaviour to you about any staff here? Or have you observed any staff behaving in ways that you feel are not child-friendly?*

5. Response to Abuse & Maltreatment in Child Care Institutions

In case physical abuse and maltreatment is identified in a CCI, the CWC or JJB members may report the matter to the concerned personnel, such as the Project Director, ICPS, Director and/or Principal Secretary in the Dept. of Women and Child Welfare (or the concerned state department under which CCIs and care and protection of children fall).

In case of sexual abuse, the CWC/ JJB members would not only be required to bring the matter to the notice of the concerned government department, but also, as per the POCSO Act 2012, report the matter to the police.

Furthermore, after the concerned administrative and legal authorities have been informed and due processes are set in motion, the CWC/JJB members (along with the administrative authorities) need to ensure continued support to the children as follows:

- Removal and re-location of children to safe spaces or alternative child care institutions.
- Medical examination and treatment for injuries/sexually transmitted diseases/ tests for pregnancy (and related decisions for medical termination of pregnancy).
- Mental health assistance, with a focus on providing assessments and interventions for post-traumatic disorder and other anxiety and depression-related issues common in children who have undergone traumatic experiences, to ensure healing and recovery of abuse-related trauma, both in the immediate and longer term.
- Enablement of (institution) caregivers to provide psychosocial support to the children.
- Assistance to children and relevant legal personnel for facilitation of legal/mandatory processes, with particular focus on sensitive methods of child interviewing i.e. forensic interviewing undertaken in collaboration with mental health professionals.
- Medium to long term rehabilitation of the children, ensuring continued access to care and protection, education and mental health assistance as required.

Additionally, the concerned authorities need to ensure that assistance to children is provided in accordance with the following issues, so as to maintain child rights and child's best interests:

- ✓ The children cannot be subjected to multiple questioning by multiple agencies as victims of sexual abuse or sexual offences should not be required to re-live the trauma.
- ✓ The children's physical and mental health is best addressed by agencies that have the expertise in these areas.
- ✓ The police and other legal authorities will need to proceed with the investigations but such investigations should be conducted (keeping in mind the interest of the children) with the assistance of qualified medical and child mental health professionals (ideally from a government hospital or institution, so as to ensure adequate monitoring and accountability).