SAMA

Safeguarding Protocol

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UNIVERSITY OF LEEDS

Contents

1.0 What is this protocol and who is it for?

This document primarily details safeguarding adolescents from potential risks that may arise from their participation in intervention activities as well as research activities related to interventions in SAMA Stage 2 and our protocol to both *minimise* the potential for harm and to respond when harm or need for intervention is identified. Stage 2 will involve SAMA Snehitharus, adolescents, parents and teachers. It includes a step-by-step guide to safeguarding to be adhered to by the SAMA Team.

The document has been compiled by Ritwika Nag, Dr Sphoorthi Prabhu, Dr Poornima Bhola, Dr Mina Fazel, Dr Pavan Mallikarjun and Dr Siobhan Hugh Jones and has been informed by the Sangath Risk Protocol for Stress and Problem-Solving Programme (Khandeparkar P, personal communication, March 1, 2021) and the NIMHANS child and adolescent psychiatry project safeguarding protocol (Policy & Advocacy-SAMVAD. (n.d.). Retrieved February 26, 2021, from *https://nimhanschildprotect.in/policy-advocacy/*) along with other relevant documents. The protocol was also submitted to external reviewers Dr Chetna Duggal, Tata Institute of Social Sciences and Dr Sachin Shinde, Harvard School of Public Health and further adapted based on their expert comments

2.0 What do we mean by safeguarding?

Safeguarding in mental health research, and in public health settings like schools, is complex. Beyond research ethics frameworks, there is little published on safeguarding adolescents in mental health research in India. We view our safeguarding protocols of SAMA as important learning processes. Our aim is to work collaboratively with a range of stakeholders to iteratively develop effective protocols that may be of additional value to other researcher teams working in India as well as to Indian schools in addressing school safeguarding needs.

The UK Collaborative on Development Research (UKCDR) define safeguarding (potential harm related to being a participant in the research itself or any deterioration in mental health) in the context of international development research as *preventing and addressing any sexual exploitation*,

abuse or harassment of research participants, communities, and research staff, plus any broader forms of violence, exploitation, and abuse, such as bullying, psychological abuse and physical violence.

Thus, SAMA safeguarding commitments apply to all people involved in and connected to our research. We also recognise that some groups we may meet are disproportionately at risk of harm including adolescents excluded from their peer groups, females, young people with specific learning difficulties, or significant mental health needs, or coming from families affected by substance abuse/ involved in the criminal justice system, LGBTQI groups, people in subjugated socio-economic groups or castes or those without primary caregivers due to several reasons.

Adolescents identified to be at risk will need Safeguarding processes and protocols in research, which refers to *proactive* actions to keep them safe during a study and being prepared with *responsive* action if actual or risk of physical, sexual, or emotional harm is identified (based on UNICEF, 2018). In SAMA, we recognise that those in contact with research participants, and especially adolescents, have a responsibility to take all reasonable measures to ensure that the risks of harm to them are minimized, and, where there are concerns about their welfare, to take appropriate actions to address those concerns, considering Indian law, policies, and procedures.

However, safeguarding these adolescents requires a balance between protection and autonomy which, as stated in The Helping Adolescents Thrive toolkit (WHO & UNICEF 2021), must be made “in the best interests of the adolescent” (pg. 8). Our protocol tries to strike this balance by adopting the following principles, informed by the UKCDR guidance:

- Adopting a rights-based approach and conveying this to adolescent participants, i.e., that they have the right to be safe.
- Ensuring it is clear to adolescents how SAMA will monitor and respond to safeguarding concerns or allegations.
- Ensuring it is clear to adolescents what is not within the remit of SAMA safeguarding, e.g., difficult relationships with no identified immediate risk.

- Having multiple ways for adolescents to report their safeguarding concerns to SAMA or designated others.
- Prioritising, as far as is feasible and safe, the adolescent's preference for action/support.
- Involving teachers or parents when there is a high or moderate risk assessed by the researcher, as may be deemed necessary even if the adolescent is reluctant to do so. For example, if there is a high or moderate risk of suicide.

The Indian Council of Medical Research (2020) has classified risks and defined the distinct types of risk as the following:

Type of risk	Definition/description
Minimal risk	The probability of harm or discomfort anticipated in the research is not greater than encountered in routine life activities/ serious harm or adverse event is unlikely.
Minor increase over minimal risk or low risk	Increment in the probability of harm or discomfort is only a little more than the minimal risk threshold. Social risks, psychological harm and discomfort may fall in this category. Low-risk research should have a social value.
More than minor/high risk	The probability of harm or discomfort anticipated in the research is invasive and greater than the minimal risk.

For the current safeguarding protocol, we have used the terms **low risk** (to indicate minimal risk), **moderate risk** (to indicate a minor increase over minimal or low risk) and **high risk** (to indicate more than moderate risk). Indicators for each of these will depend on the context/situation and is described in later sections.

We adopt the **UKCDR guidance** to utilise an *Anticipate – Mitigate – Address* approach.

- *Anticipate* – as far as possible, the potential harms that our research could inadvertently create or exacerbate.
- *Mitigate* – take actions and put processes in place to mitigate the harms have identified.
- *Address* – take actions to ensure adequate processes to report, investigate and provide redress for any safeguarding harms which may arise.

In this protocol, we have not duplicated the ethical practices that are part of safe research which respects the rights of participants, and which are set out in our ethics applications and documentation. In brief, these include:

- Signed participant informed consent, including parental consent and adolescent assent.
- Right to withdraw without giving a reason.
- Permission to share quotes, narratives, audio, or video clips based on the understanding of what, how and where data will be shared.
- Anonymity and safe storage of personal data.
- No sharing of personal data.

The SAMA safeguarding protocol is different and more comprehensive than the available safeguarding protocols and related documents due to the following reasons:

- Most of the available safeguarding protocols are not specific to the social or cultural context of India and do not consider the scenario in Indian schools.
- Most of the research regulating bodies and documents such as Guidance on Safeguarding in International Development Research by the UK Collaborative on Development Research (UKCDR, 2019) and the Indian Council of Medical Research (ICMR, 2017) in India set out ethical guidelines to be followed by researchers from different disciplines including behavioural sciences. However, they usually do not elaborate on

the various risks such as those related to emotional well-being.

- The available documents on safeguarding adolescents in schools (such as Oberoi International School Child Safeguarding Policy and Procedures, Stone Hill International School Child Protection Handbook, and others) are adopted from international institutions and are neither applicable to Indian adolescents nor the context of research. These are developed by the schools/organizations for their functioning- guidelines to be followed by the Institutes in the recruitment of staff, rules while working with children and measures to be taken when there is a violation. These do not usually involve the assessment of risks or responses to such risks.
- The only relevant safeguarding protocol that we obtained was developed in the context of research in Indian schools: "The Risk Protocol for Stress and Problem-Solving Programme" developed by Sangath for their SEHER study. This protocol was shared by Ms Prachi Khandeparkar, Psychologist and Project Lead, Sangath who is currently also a part of SAMA hand as been partially adapted to suit project SAMA. In addition to this, the SAMA safeguarding protocol also details various risks that a team member can encounter (involving both adolescent and adult participants) during the process of research, ways to assess these risks and measures that can be taken to address each of these risks.
- Most importantly, the SAMA protocol takes into consideration the dearth of available mental health resources in the schools and community contexts in India and the need for the operating procedures to be adopted within the purview of the Indian acts and policies.
- The SAMA safeguarding protocol would also continue to evolve and be strengthened by incorporating inputs and suggestions from various mental health professionals working with children and adolescents and from the Youth Advisory Board as well. The SAMA researchers would also be trained about ways of mitigating safeguarding-related issues (Appendix E).

2.1 Key terms and definitions

Risk: The Department of Health's Best Practice in Managing Risk (2007) defines risk as relating to the likelihood, imminence and severity of a negative event occurring (i.e., violence, self-harm, neglect). Risks may be categorised

into **low**, **moderate** or **high** risk of a particular outcome which later has been elaborated in the document depending on their types. The assessment of clinical risk in mental healthcare is challenging but provides an opportunity to engage with individuals, and their carers and families to promote their safety, recovery, and wellbeing. We use the terms **low risk** (to indicate minimal risk), **moderate risk** (to indicate a minor increase over minimal or low risk) and **high risk** (to indicate more than moderate risk). Indicators for each of these will depend on the context/situation and is described in later sections.

Child protection: Child protection is a broad term that encompasses policies, guidelines, standards and procedures to protect children from both intentional and unintentional harm and violence. In the context of schools, it applies particularly to the duty and responsibility of authorities, and other stakeholders associated with the schools towards children in the schools.

3.0 Safeguarding adolescents

We first set out some general guidelines for *addressing* safeguarding concerns that will apply in many situations, regardless of the concern raised. We then proceed to set out the specific risks to adolescents that we *anticipate*, and ways in which the SAMA team members who are clinically trained will specifically *mitigate* or *address* them.

3.1 General guidelines for managing face-to-face disclosures (address)

We set out these guidelines to clarify common expected procedures if an adolescent discloses harm or risk of potential harm when participating in the study.

The SAMA team member is to:

- Build trust and listen openly and actively to the participant's concerns (the risk or potential harm they disclose) and emotions. Express interest in what the participant is saying (verbally and non-verbally). Explain to the adolescent the role of the SAMA team member and responsibilities in

response to any disclosure made.

- Allow them to choose who is present in the room (for example a teacher or friend) whenever possible.
- Allow the participant to describe what happened to them in a way that is manageable for them. Use non-stigmatising and age-appropriate language.
- Do not force them to speak or answer questions. Minimize the need to repeatedly tell their history as it can be re-traumatizing.
- Maximize the participant's control and participation in decision-making. Agree on next steps and check that the adolescent understands. Check the adolescent's preference for communication with the SAMA team and / or others. Ensure contact information is obtained. Give the adolescent information on how to contact the research team or who to contact in crisis (if appropriate).
- High-risk situations will be immediately (same day within 24 hours) reported to the Safeguarding Team Lead, Dr Poornima Bhola. High-risk situations will also be reported to the Principal Investigators. Cases of low or moderate risk will be reported to the project manager who will log the report, act on low-risk decisions or escalate for advice from Dr Bhola as needed.
- Often writing contemporaneous notes is important and then after to ensure completion of the risk reporting form or other assessment forms and documenting the whole process until termination is mandatory (in compliance with SAMA confidentiality principles).

3.2 General Guidelines for Managing Online Disclosures.

Anticipate: In the pandemic, some stages of the research (e.g., workshops, consultations) may be conducted online. The following are potential risks/harms during SAMA online interactions with adolescents:

Potential risk/harm	Degree of risk/harm	Probability of occurrence
Taking screenshots/photos in the middle of sessions.	Low	Moderate
Cyber bullying (bullying that includes wilful and repeated harm inflicted using computers, cell phones, and other electronic devices).	Moderate	Low
Cyber stalking (the use of the Internet or other electronic means to stalk or harass someone which may include threats, defamation, manipulation).	Moderate	Low
Inappropriate comments (discriminating/ sexually oriented).	Moderate	Low
Use of inappropriate language during online interactions (that has the purpose or effect of violating the dignity of an individual and/or creating an intimidating, hostile, degrading, humiliating or offensive online environment).	Moderate	Low
Unnecessary chain messages/ spamming.	Low	Low

Mitigate: Where the research involves online work (e.g., workshops, meetings) with young people the following steps will be taken. These are drawn from Hooke et al. (2018) and discussions among the SAMA Safeguarding team:

- Participants will be asked to agree to a set of ground rules for online working as part of consenting procedures (Appendix B).
- The option of controlling the tools of the online platform (like recording, annotations) will be disabled for the participants. Only the facilitator will be able to control the tools.
- There will always be two facilitators in every online meeting. Chat functions will be constantly monitored, and any irrelevant chats (targeting at any participant) will be monitored and deleted if required by a facilitator and the chat function might also be disabled for the individual.
- A research team member will be present in each of the break-out rooms. This will be possible as we plan small groups for online working.
- If a participant raises a safeguarding concern in the session, the facilitator will contain it at that moment and ask the participant to remain in the session at the end.
- The participant will be affirmed for making the disclosure and communicated that they are in a secure online platform and are being taken seriously. The steps outlined above for managing disclosures will be followed.
- At the beginning and end of sessions, participants will be told how to contact the research team. This would allow those participants wanting to express any concerns to seek help. The details would also be available in the study information. Email details of the research team will be given to the participants.
- If there are a series of sessions with the same group of participants, check-ins will be done with them from time to time to give them a chance to raise anything of concern to them.

Note: In the case of risk to an adolescent, an appropriate adult be that teacher/ parent/ guardian of the adolescent would be informed as chosen by the adolescent in consultation with the facilitator/ SAMA team member and a follow up by email/phone will be sent to ensure the adolescent is receiving

any support that they might require, any issues raised have been addressed and to check nothing else needs to be done.

Checklist for online interactions:

- ✓ Adhering to ground rules.
- ✓ Only facilitator controls the tools of online platform.
- ✓ Two facilitators in the meeting.
- ✓ Irrelevant chats deleted by facilitator.
- ✓ Participants told to get in touch with researchers if needed at the beginning and end of sessions.
- ✓ Email details of the research team provided to participants.

Vignette 1

A female adolescent Megha had reported to the facilitator Apurba that one of the workshop participants Ashutosh has been trying to reach out to her through phone (calls and texts). She was feeling uncomfortable about the situation, felt that she could not ask them to stop and asked the facilitators to intervene.

How would you respond to this scenario?

Suggested response

She was reassured that it was the right thing for her to have raised this issue and for being open about it and her discomfort was validated. She was told that the Ashutosh would be spoken to, and an attempt will be made to address the issue. Apurba reported the incident to the YAB lead Dr Muthuraju and a session was taken with Ashutosh asking him to explain what was happening. It was ensured that his side of the story was heard before drawing any conclusions to understand what had happened and why. The facilitator also chose at the next session to remind all participants of the ground rules of participation and that contact outside of the sessions with participants should be minimised. Further they discussed the safety

measures she could take like blocking his number, informing her parents or a trusted adult, not receiving calls from unknown numbers etc. Her choice of not continuing to attend further sessions was respected. Ashutosh was asked to refrain from any such behaviour henceforth. He was also made aware of how it could be a legal offence punishable according to Indian law. The facilitator also contacted Megha a few weeks later to check that she was OK and offered for her to participate in a new group if she wanted.

What are the further steps that can be taken? What if something like this happens with one of the SAMA researchers? What could we do in such a situation?

3.3 Reporting Disclosures.

All safeguarding concerns will be logged in a standardised reporting form (under development).and stored securely in a password protected file on our approved platform.

4.0 Domains of Risk in SAMA Stage One

4.1 Mental health

SAMA team members will be alert to the mental health of adolescent participants. We differentiate between mental health conditions and mental health as follows.

Mental health condition: According to the American Psychological Association (2018), mental illnesses are health conditions involving changes in emotion, thinking or behaviour (or a combination of these) and are associated with distress and/or problems functioning in social, work or family activities.

Mental health: we conceptualise mental health as a spectrum, on which a person can experience good, moderate or poor mental health, where poor mental health might be indicated by symptoms and could be considered sub-clinical.

4.1.1 Anticipating Risk

We anticipate encountering cases where an adolescent discloses or is identified as having a need for mental health support. We also anticipate that being a research participant may potentially escalate mental health risk. This section considers non-acute mental health risks (acute risks are considered under suicide and self-harm risks), recognising that risks could escalate if an adolescent is left without support.

We anticipate that **many** young people will be experiencing:

- Stress
- Low mood
- Anxiety

We anticipate that **some** young people will be experiencing:

- Bullying
- Substance misuse
- Behavioural problems

We anticipate that a **small minority** of young people will be experiencing

- Severe or complex mental health conditions.
- Sexual abuse and severe emotional or physical abuse and neglect.

We also anticipate that taking part in SAMA may:

- Increase an adolescent's concern about their mental health or that of their peers.

We anticipate that identification of risk could be via:

- Adolescent self-disclosure
- Peer report
- Parent report
- Teacher report

- SAMA team member observation

4.1.2 Mitigating Risk

To mitigate the risks above, we will:

- Normalise the experience of varying levels of mental health and well-being and give guidance on the more common symptoms that indicate help should be sought.
- Give multiple routes for adolescents to report if they or a peer are vulnerable to or being harmed.
- Give multiple options for help and support inside and outside of school.

4.1.3 Addressing Risk

If an adolescent, teacher or parent from the school reports a mental health safeguarding concern:

- The general guidelines will be followed (Section 3.1). In particular, the researcher will clarify information from the adolescent/parent/ teacher/ any other caregiver to establish whether what they are referring to is likely to be an actual risk. It is also important to assess the level of severity depending on: (i) what kind of difficulties the adolescent is experiencing; (ii) how disturbing it has been for them; (iii) how long the difficulties have been persisting; and (iv) the impact of the difficulties on the functioning or on the quality of life of the adolescent.
- If the adolescent would like, and is likely to benefit from support, options will be discussed, depending on what is available in school, or an appropriate local referral will be made in consultation with Dr Poornima Bhola (Appendix C).
- If the adolescent is not using professional support, information about professional support options and ways to motivate the adolescent for professional support can be discussed along with the parent/another caregiver in the family/trusted adult (to be discussed).
- A similar approach will be followed for online working.

4.2 Suicide and non-suicidal self-injury

4.1.1 Anticipating Risk

Self -harm vs suicide: Suicide is defined as death caused by self-directed injurious behaviour with any intent to die as a result of the behaviour whereas non-suicidal self-injury is defined as the deliberate, self-inflicted damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned (The International Society for the Study of Self-Injury, 2018). The principal risk of self-harm behaviour is that it can become chronic and may evolve toward other forms of self-injurious behaviour, such as suicide attempts.

- Self-harm rates among adolescents in India are 17.2 percent (Singh, 2018). The risk is therefore **serious**.
- Suicide rates among adolescents in India are high and increased from 9.9 percent in 2017 to 10.2 percent in 2020 (Mathew, Suja & Priya, 2020) and the risk is **serious**.

4.2.2 Mitigating Risk

We will mitigate these risks by:

- Giving multiple routes for adolescents to report if they or a peer are vulnerable or being harmed.
- Giving multiple forms of help and support inside school (if available) or outside of school.

4.2.3 Addressing Risk

If an adolescent reports suicidal ideation or non-suicidal self-injury, or if the SAMA team member suspects it, or if a case is reported by someone from the school, then the researcher's role is to follow the general guidelines on responding to disclosures, remaining aware that of the stigma and discrimination sometimes associated with self-harm, both in the wider society and the health service, and adopt a non-judgemental approach.

Risk screening will be completed by the SAMA team member for the adolescent asking them if they have been having any difficult or upsetting

thoughts which can sometimes include thoughts about hurting themselves or of suicidal ideas/ death wishes/ if there have been attempts. (Sample questions, Appendix D):

If someone answers affirmatively during the brief screening, a full risk assessment will be completed as urgently as possible with an effort to do it preferably within 24 hours using a Self-harm and Suicide Assessment Form (Appendix D) which covers the following domains:

- Type of thoughts
- Onset and frequency
- Plans and access to means.
- Intent
- Past experiences
- Protective factors

Based on the assessment, the adolescents will be classified as one with low, moderate or severe risk for suicide/self-harm:

- Low Risk: Current thoughts of suicide/self-harm but no plans, intent and behaviour.
- Moderate Risk: Current suicidal/self-harm ideas with a plan AND/OR history of non-life-threatening suicidal/self-harming behaviour.
- Severe Risk: Current suicidal/self-harm ideas with a plan and either strong intent OR a history of life-threatening suicidal/self-harming behaviour.

Management for **low** suicide/self-harm risk: If the adolescent presents with low risk, a risk management plan is not required. Suicidal/self-harm thoughts should be contextualised and reassured that they can talk to the researcher/their teacher/parent/any trusted adult if they need any help to think about and cope with their problems. The researcher can briefly assess for any other psycho-social issues. If the issue requires a few sessions, a referral can be made. The adolescent should be reminded that if these thoughts should get worse at any point, they need to talk to someone regarding them (refer to Appendix C). In case no referral is made, the researcher should check the how the adolescent is doing at regular intervals.

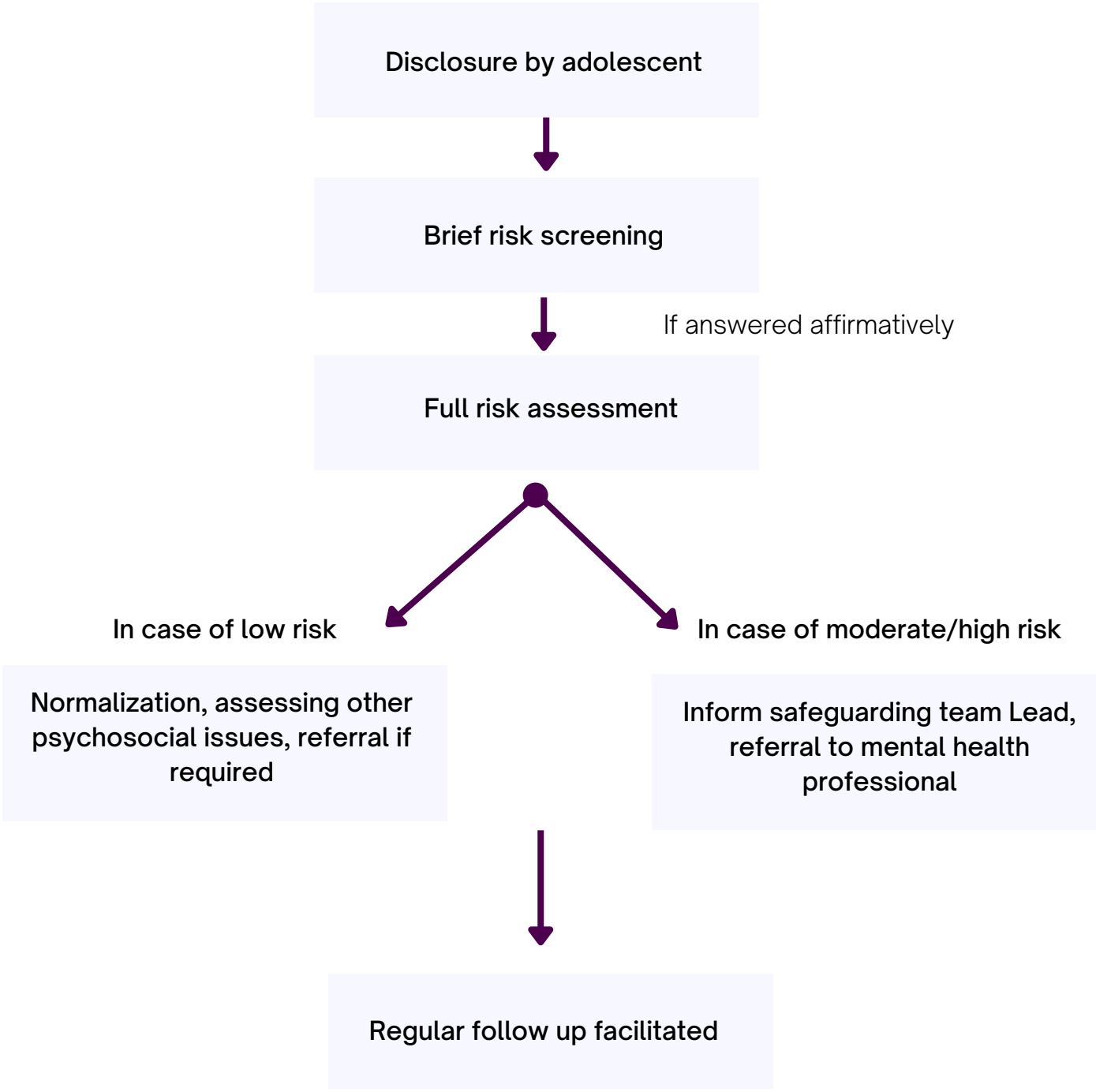
Management for **moderate** and **high** suicide/self-harm risk: Inform the adolescent that in the interests of his/her safety, breaching confidentiality may be necessary. It is necessary to bring such incidents to the notice of the Safeguarding Team Lead, Dr Poornima Bhola. A discussion can be done within the team regarding the next steps that need to be followed. The researcher should complete a Risk Reporting form (Appendix E) with the details they have. Depending on the context, the issue at hand and the adolescent, it is to be decided what should be the further steps that need to be taken. The researcher also needs to talk to the adolescent asking them whom they think should be contacted (any adult member who he/she trusts or is close to) and who will be able to help them. The researcher may need to talk to the parents to ensure their safety. If an adolescent has any reluctance about parental involvement, explore them and address them sensitively, emphasizing the importance of their safety. The researcher could also refer to the Clinical team or provide a list of contact numbers, including our own (official number) that she/he can reach out to if the suicidal risk increases.

- In case of an active high suicidal risk, any adult (as chosen by the adolescent, could be a parent/ some other family member/ someone they trust or feel close to) needs to be guided by the researcher to refer the adolescent and their SO for a formal psychiatric evaluation (Appendix C) to ensure timely provision of immediate crisis intervention and to assess further risk and plan necessary interventions.
- Regular follow-up to the SAMA research team is to be facilitated.

4.2.4 Reporting

The disclosure (by the adolescent or others) and the process will have to be documented using the adolescent's own words and as many details as possible and assess the need for further management and follow-up.

[Sections from here on will be presented in Anticipate – Mitigate – Address format]


Disclosure by adolescent
Brief risk screening
If answered affirmatively
Full risk assessment
In case of low risk
In case of moderate/high risk
Normalization, assessing other psychosocial issues, referral if required
Inform safeguarding team Lead, referral to mental health professional
Regular follow up facilitated

4.3 Sexual Abuse

4.3.1. Definition

The Protection of Children from Sexual Offences Act (POCSO), 2012 defines a child as any person below eighteen years of age. The act defines different forms of sexual abuse, including penetrative and non-penetrative assault, as well as sexual harassment and pornography, and deems a sexual assault to be "aggravated" under certain circumstances, such as when the abused child is mentally ill or when the abuse is committed by an older adult or a person in a position of trust or authority vis-à-vis the child, like a family member, police officer, teacher, or doctor.

4.3.2 Risk Assessment

All incidents of sexual abuse will be considered high risk. The cases included are as follows: Any incident described by the adolescent which may relate to the following:

1. Penetrative Sexual Assault
    - If a person penetrates his penis, or inserts any object into the adolescent, or puts his/her mouth on the vagina, anus, mouth, or urethra of any child, or makes the child do the same with him/her, or any other person.
2. Aggravated Penetrative Sexual Assault
    - If a Parent, Police Officer, Public Servant, armed /security forces/staff of a hospital, jail, school, observation home, protection home, religious institution or any other place of custody and/or protection, or any other person in a position of trust or authority, or more than one person commits penetrative sexual assault on a child.
3. Sexual Assault
    - If a person touches the vagina, anus, penis or breast of a child with sexual intent, or makes the child do the same to him/her or another person. Also, whoever does any other act which involves physical contact with sexual intent.
4. Aggravated Sexual Assault
    - If a Parent, Police Officer, Public Servant, armed /security forces/staff

of a hospital, jail, school, observation home, protection home, religious institution or any other place of custody and/or protection, or any other person in a position of trust or authority, or more than one person commits sexual assault on a child or adolescent.

Warning signs for sexual abuse of an adolescent:

- An adolescent's report or self-disclosure.
- Reported or disclosed by adolescent's guardian.
- Stays away from certain people or fear or distrust of a particular adult.
- Avoids being alone with certain people, such as family members or friends.
- Runs away from home without a specific reason.
- Shows sexual behaviour that is inappropriate for their age.
- Has physical symptoms such as:
  - Frequent genital or anal infections, pain and itching.
  - Evidence of physical trauma or bleeding to private parts.
  - Difficulty with urination.
  - Has discomfort walking or sitting.
  - Sexually transmitted diseases.
  - Pregnancy.
  - Reports nightmares or bed-wetting.

The project team would be sensitive and recognize that one of the reasons for adolescent anxiety could be sexual abuse at the hands of parents/adults/teachers. Such children would be identified, special attention would be given to developing rapport and facilitating ventilation of their emotions and further exploring abuse details (Sample questions: Appendix E).

Vignette 2

After the SAMA sessions, an adolescent Uma seemed very distressed during the entire session. She was spoken to later by the counsellor Priyanka. After a while, during the conversation, Uma made some reference of an incident that had happened a few

months ago. Priyanka was really concerned and so spent some more time with her and eventually, Uma was able to disclose that she had inappropriately been touched by one of her family members. She spoke more about the incident to Priyanka and said that she had kept this a secret and was sharing this for the first time. Uma was worried about her parents' response to this disclosure and about the conflict it could create in the extended family.

What would you do if you were the facilitator?

- Convince Uma to disclose to the parents? Call the parents immediately? Inform school authorities?
- Report to the police?
- Other options?

Suggested response

The POCSO ACT (Protection of Children against Sexual Offenses Act) require mandatory reporting of any sexual offenses which is otherwise legally punishable. Uma refuses to let her parents know about any of this as she could be the one who is later punished and there may be issues brought up in the family due to it. Priyanka is also aware that she has an ethical obligation to ensure that there is confidentiality regarding what Uma reveals or speaks about. Priyanka wants to do what is in the Uma's best interests. There may be conflicting ethical and legal obligations. However, the legal laws supersede professional codes of conduct. Priyanka considered the following options- (i) Reporting the abuse and encouraging her to make a voluntary disclosure about the incident to her parent(s), guardian(s) or caregiver(s), which could hopefully translate to familial support; (ii) involve a third party outside the family to represent the minor adolescent and report it for POCSO.
What other options could be adopted? In such conflicting legal and ethical proceedings how would you choose to act?

4.3.3. Management

The researcher's role in risk management for sexual abuse is to:

- Be patient and actively listen to what the adolescent has to say. Make sure he/she feels comfortable and validated. This may involve clarifying information from the adolescent by asking questions to establish whether what they are referring to is an actual risk. However, this is to be done very carefully. In case the adolescent does not feel like opening, be patient and a non-judgemental verbal acknowledgement is to be done. It might be that they need to be seen a few times to enable trust to develop and to understand the steps that might be taken following a disclosure,
- Inform the adolescent that in the interests of his/her safety, breaching confidentiality may be necessary.
- Any disclosure about CSA will be immediately brought to the notice of the Principal Investigator/Safeguarding protocol Team Head and other Co-investigators for planning supportive interventions. The safeguarding team can discuss the further steps that needs to be followed. The researcher needs to inform the adolescent that s/he will discuss the case with any other adult that the adolescent is comfortable with, who in turn may talk to other responsible adults such as parent/ legal guardian and school authorities to ensure their safety. They will then be explained about informing the ChildLine/child welfare committee and that the research team will support them through the process.
- We may encounter a scenario where the alleged offender may be seniors in the school/ teachers/office staff. In this case, an adult who the adolescent trusts or is comfortable with may be involved. If the adolescent is comfortable with his/her parent, they may be involved. (If possible, the school head can be involved to reach the parents). The report is to be submitted to the Special Juvenile Police Unit and Child Welfare Committee with the permission and consent of parent/legal guardian.
- If an adolescent has any reluctance about such disclosure, the researcher should explore his/her concerns and address them sensitively, emphasizing the importance of maintaining safety.
- Complete a Risk Reporting form (Appendix E) with the details they have and consult with the respective teacher. Briefly try to clarify what exactly

is happening and mandatorily report it.

It is important to engage the adolescent and build hope and confidence in them. Make a 'Keeping Safe Plan' with the adolescent to:

- **Avoid conflicts:** Suggest staying away from the perpetrator. Suggest moving to another room and avoiding all confrontation.
- **Self-protection:** If avoidance of conflict seems difficult, suggest going outside the house to a safe place, like a neighbour's house, until the adolescent is safely able to return to his/her own house.
- **Ask for help:** Suggest them to ask a trusted adult, relative, neighbour or friend for help in case their physical safety is compromised. Also, suggest calling and taking help from one of the helpline numbers provided.

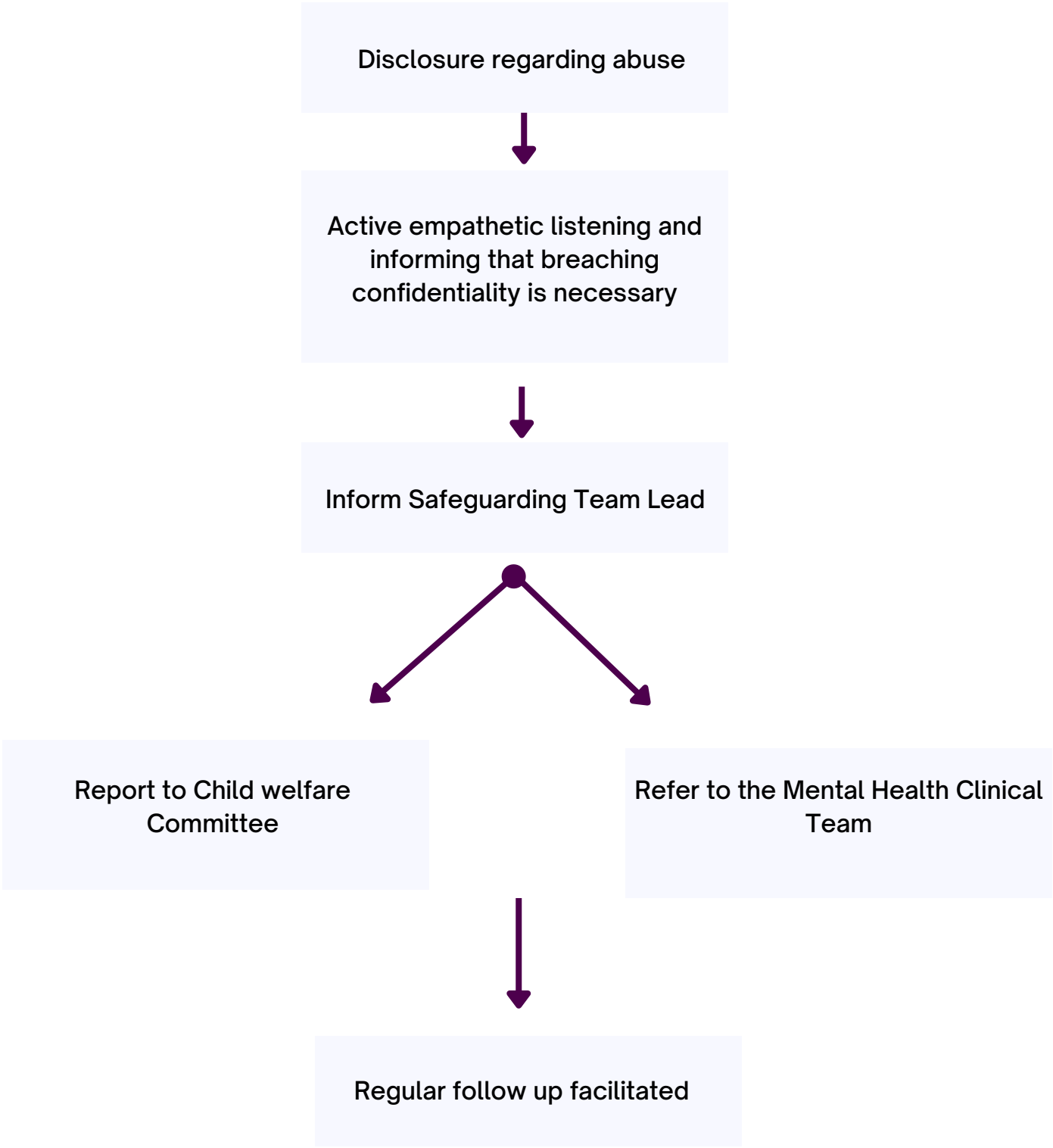
In making the Keeping Safe Plan consider the following:

- **Where to go:** Decide on a safe place where they can go in case things get out of control. This can be a friend or relative's house, a neighbour, hospital, or public place.
- **What to do:** Agree on what adolescents can do during the incident to keep themselves safe (call a relative, neighbour, hide, etc.).
- **Who to contact:** Determine who the adolescent can call for help. The adolescent can also call 1098: a free helpline number operated by Childline. Also, consider informing the police.

The original Keeping Safe Plan should be provided to the adolescent to be used in time of need and a copy should be taken for our records. Verify that the adolescent understands the safety contract/plan and is willing to follow it.

4.3.4 Documentation

The disclosure (by the adolescent or others) and the process will have to be documented.


Disclosure regarding abuse
Active empathetic listening and informing that breaching confidentiality is necessary
Inform Safeguarding Team Lead
Report to Child welfare Committee
Refer to the Mental Health Clinical Team
Regular follow up facilitated

4.4 Physical Abuse

4.4.1 Definition

According to A Study on Child Abuse: INDIA 2007 by the Ministry of Women and Child Development Government of India, physical abuse has been defined as beating manifested as kicking, slapping, beating by family members and others including peers, police, employer, caregivers, etc. It also includes beating which may result in physical impairment or damage to the child. These acts could include the following.

- Kicking, punching, slapping, biting, throwing things at, burning, stabbing or cutting the person in a manner that endangers them.
- Unreasonably restraining or confining a person.
- Physical abuse would include physical violence towards the adolescent at home, in the community or at school. Any of these acts that are committed by an individual in a position more powerful than the adolescent, whereby the intention is to hurt, injure or intimidate the adolescent would be considered as abuse. If the adolescent is expressing physical or emotional distress, due to the actions of another individual, it would be categorized as physical abuse.

Certain warning signs that indicate physical violence in an adolescent:

- An adolescent's report or self-disclosure.
- Reported or disclosed by the adolescent's parent/ caregiver/ friends/teacher.
- Unexplained bruises, burns, sprains, dislocations, cut marks, bald spots or bite marks on the adolescent's body.
- Withdrawal or aggression – behavioural extremes are shown by adolescent.
- Refusal to discuss injuries and injuries that have not received medical attention.
- Withdrawal from physical contact.
- Fear of returning home or of parents being contacted.
- Showing wariness or distrust of adults.
- Self-destructive tendencies.

- Repeated absences or running away from home.

4.4.2 Risk Assessment

Be patient and actively listen to what the adolescent has to say. Make sure he/she feels comfortable and validated. This may involve clarifying information from the adolescent by asking questions to establish the level of risk that they are being exposed to. In case the adolescent does not feel like opening up, be patient and a non-judgemental verbal acknowledgement is to be done.

Identify and assess the severity of Physical Abuse based on what exactly is happening and the:

- Consistency and frequency of abuse.
- Impact on adolescent in terms of thoughts, emotions and functioning.
- Severity of abuse and whether there have been any broken bones or visible marks on the body.

(Sample questions to assess the severity of the physical abuse is available in Appendix A).

Based on the assessment the adolescents will be classified:

- **Low risk:** The adolescent is not at ongoing and frequent risk of physical abuse that would bruise or leave a mark and the adolescent's mood is euthymic, no changes in behaviour and functioning are reported. There is no change in academic performance. No physical injuries reported.
- **Moderate risk:** The adolescent is at ongoing and frequent risk of physical abuse that would bruise or leave a mark AND/OR the adolescent's mood and behaviour are significantly impacted by the abuse.
- **Severe risk:** The adolescent is at ongoing and frequent risk of physical abuse that would cause serious injury or death.

4.4.3 Management

In case of low risk, no safe plan is required. The adolescent is to be

reassured that the physical abuse they are suffering is not their fault; no one deserves to be hit, beaten or bullied.

In case of moderate and high risk, inform the adolescent that in the interests of his/her safety, breaching confidentiality may be necessary. The researcher needs to inform the adolescent that s/he will discuss the case with any adult member who he/she trusts or is comfortable with who in turn may talk to the adolescent's parents (if required/considered necessary) to ensure their safety. If an adolescent has any reluctance about parental involvement, explore them and address them sensitively, emphasizing the importance of their safety.

In the case of moderate and high risk, keeping a safety plan may be required. Inform that breaching confidentiality may be necessary. Rapid follow up with the adolescent is to be ensured along with a follow up with the parent or a significant other where necessary. When the abuser is a family member and other members can't do anything about it, they may have to be referred to social welfare service organizations (Appendix C).

4.4.4 Documentation

Document the disclosure by the adolescent or any other adolescent/teacher. The details must be recorded in the Risk Reporting form using the adolescent's own words and as many details as possible and assess the need for further management and follow-up.

4.5 Corporal Punishment

4.5.1 Definition

As per the provisions of the Right of Children to Free and Compulsory Education Act 2009, corporal punishment may be identified as physical punishment, mental harassment or discrimination by a member of school staff to the students. Corporal punishment will also include all forms of sexual offences as per the Protection of Children from Sexual Offences Act, 2012.

"Physical punishment" is any action that may cause pain, injury and discomfort to a child including causing physical harm to a child with a hand or

cane/ stick, making children assume an uncomfortable position e.g., standing on a bench or holding ears through legs, detention in the classroom, library or

"Mental harassment" is any non-physical professional support that is detrimental to the psychological wellbeing of a child e.g., sarcasm that hurts or lower the child's dignity, calling names and scolding using humiliating adjectives, intimidation, using derogatory remarks on the child, ridiculing the child on background or status or parental occupation, belittling a child in the classroom due to his/her inability to meet the teacher's expectations of academic achievement etc.

"Discrimination" is understood as prejudiced views and behaviour towards any child because of her/his caste/gender, occupation or religion and non-payment of fees or for being a student admitted under the 25% reservation to disadvantaged groups or weaker sections of society under the RTE, 2009. It can be latent; manifest; open or subtle. It includes but is not restricted to the following:

- Bringing social attitudes and prejudices of the community into the school by using belittling remarks against a specific social group or gender or ability/disability.
- Assigning different duties and seating in schools based on caste, community or gender prejudices (for example, cleaning of toilets assigned by caste; the task of making tea assigned by gender); non-payment of any prescribed fees.
- Commenting negatively on academic ability based on caste or community prejudices.
- Denying mid-day meal or library books or uniforms or sports facilities to a child or group of children based on caste, community, religion or gender.
- Deliberate/wanton neglect.
- Announcing, verbally or otherwise in the class, the names of the community or castes or tribes of the students.

Corporal punishment amounts to abuse and militates against the freedom and dignity of an adolescent. It also interferes with an adolescent's right to education because fear of corporal punishment makes them more likely to

avoid school or to drop out altogether. Hence, corporal punishment is violative of the right to life with dignity.

4.5.2 Risk Assessment

Clarify information from the adolescent to establish whether what they are referring to is an actual risk. It is also important to assess the level of risk or harm being caused to the adolescent as a result of the punishment depending on:

- What is happening?
- How frequently does it occur?
- What is the impact of corporal punishment on the thoughts, emotions and functioning of the adolescent?

4.5.3 Management

If the school has a clear protocol to guide teachers with respect to corporal punishment about which situation needs assessment and intervention it is to be followed accordingly.

In case the school does not have any such guidelines, the researchers can bring it to the notice of the school head/principal and if required, can decide on ways to address the issue. If a decision is made to have sessions with the teacher/staff, then the below-mentioned measures can be followed:

- The teacher or school staff engaging in corporal punishment is to be made aware that it amounts to abuse and militates against the freedom and dignity of an adolescent. It may also lead to adverse physical, psychological and educational outcomes – including increased aggressive and destructive behaviour in adolescents.
- The researcher can suggest to the teacher/staff to reflect on why the adolescents misbehave and how to discipline them in a positive manner. Positive discipline techniques can be used to make an adolescent understand and learn desirable/acceptable behaviour without the fear of punishment.

4.5.4 Documentation

Document these disclosures by the adolescent or any other adolescent/teacher/ parent. The details must be recorded in the Risk Reporting form (Appendix E) using the adolescent's own words and as many details as possible and assess the need for further management and follow-up.

4.6 Emotional Abuse and Neglect

4.6.1 Definition

Emotional abuse is the persistent emotional ill-treatment of a child/adolescent to cause severe and adverse effects on a child's emotional development. Emotional abuse features the following behaviours: (1) Psychological harm that causes children to feel hated, useless or frightened. (2) Silencing children to prevent them from expressing their opinions and criticizing the way they interact. (3) Imposing expectations on young people that are improper to their age or developmental ability. (4) Witnessing others being bullied leads them to feel a sense of fear (Al-Qaysi, 2018). Some level of emotional abuse is involved in all types of ill treatment of a child, though it may also occur alone.

Neglect is the persistent failure to meet a child's basic physical or physiological needs, likely to result in serious impairment of the child's health or development. Possible indicators of neglect:

- Medical needs unattended
- Lack of supervision
- Inadequate nutrition, fatigue
- Self-destructive behaviours
- Extreme loneliness
- Extreme need for affection
- Poor personal hygiene
- Being frequently late or non-attendance at school
- Low self-esteem
- Poor social relationships
- Compulsive stealing, drug or alcohol abuse

4.6.2 Risk Assessment

During any disclosure of emotional abuse or neglect by the adolescent, teacher or friends, first clarify information from the adolescent to establish the nature of the risk that they are raising. It is also important to assess the level of risk or harm being caused to the adolescent as a result of the emotional abuse depending on:

1. What is happening?
2. How frequently does it occur?
3. What is the impact of the abuse/neglect on the thoughts, emotions and functioning of the adolescent? (Sample questions to assess the severity of the risk is available in Appendix E)

4.6.3 Management

Once the level of risk is established, if of sufficient concern then any concerned adult who the adolescent trusts/is comfortable with must be informed the case should be discussed with them along with the further management plan that needs to be taken care of.

Developing a safety plan for adolescents and non-offending caregivers includes:

- Assessing the adolescent's emotional safety needs (sample questions- Appendix E).
- Involving the adolescent and caregivers in safety planning, what is safe to do so, proactive steps they can jointly take to prevent the emotional abuse and neglect, prioritizing the emotional wellbeing of the adolescent.
- Referral to other relevant agencies (Appendix C), in consultation with the adolescent, if the child's safety is at risk. Information including contact details of relevant agencies should be made available.

If the parent/caregiver might be the perpetrator or, in the case of a non-offending caregiver may have allowed the professional support to continue or felt powerless to stop it and being aware of potential safety concerns for the child: It is to be ensured that the (non-offending) parent/caregivers understand the potential negative consequences of the emotional abuse or

or neglect. If they do understand, appropriate interventions are planned accordingly (as mentioned in the previous point). If the non-offending parent is also non-cooperative, then involvement of other relevant agencies will have to be decided jointly with the adolescent.

4.6.4 Documentation

Document the disclosure by the adolescent or any other adolescent/teacher. The details must be recorded in the Risk Reporting form using the adolescent's own words and as many details as possible and also assess the need for further management and follow-up.

4.7 Bullying (Inside and Outside Schools)

Bullying includes both physical and emotional abuse to the adolescent.

4.7.1 Definition

Bullying may be defined as deliberately hurtful behaviour, usually repeated over a period, where it is difficult for those bullied to defend themselves. It can take many forms, but the three main types are physical, verbal and emotional, both face to face and via social media and other online forums. It can take place inside the school as well as outside the school. The damage inflicted by bullying is often underestimated. It can cause considerable distress to children and adolescents to the extent that it affects their health and development or, at the extreme, cause them significant harm (including self-harm); of note these risks can persist throughout that individual's life-course.

Cyberbullying is when a person uses technology i.e., mobile phones or the internet (social networking sites, chat rooms, instant messenger, tweets), to deliberately upset someone. Bullies often feel anonymous from the incident when it takes place online and bystanders can easily become bullies themselves by forwarding the information on. Possible Signs of Bullying:

- Verbal abuse, such as name-calling and gossiping
- Non-verbal abuse, such as hand signs or text messages

- Emotional abuse, such as threatening, intimidating or humiliating someone
- Exclusion, such as ignoring or isolating someone
- Undermining, by constant criticism or spreading rumours
- Controlling or manipulating someone
- Racial, sexual or homophobic derogatory comments
- Physical assaults, such as hitting and pushing
- Online cyberbullying

Cyber Bullying includes:

- Sending threatening or abusive text messages
- Homophobia, racism or sexism
- Making silent, hoax or abusive calls
- Creating and sharing embarrassing images or videos
- 'Trolling' - the sending of menacing or upsetting messages on social networks, chat rooms or online games
- Excluding children from online games, activities or friendship groups
- Setting up hate sites or groups about a particular child
- Encouraging young people to self-harm
- Voting for or against someone in an abusive poll
- Creating fake accounts, hijacking or stealing online identities to embarrass an adolescent or cause trouble using their name
- Sending explicit messages, also known as sexting
- Pressuring children into sending sexual images or engaging in sexual conversations.

4.7.2 Risk Assessment

In case the adolescent or their friend or teacher discloses being a victim of bullying (either inside or outside the school), the researcher's role in risk management for bullying is to; Make them feel comfortable and safe as they may be reluctant to report any instances due to fear of retaliation, not wanting to worry parents, being ashamed that they can't defend themselves, feeling that nothing can change the situation and fearing the teacher or parent would make the situation worse.

If possible, clarify information from the adolescent to establish as any of the

facts as possible and assess the level of risk. It is also important to assess the level of risk or harm being caused to the adolescent as a result of the bullying depending on:

- What is happening?
- How frequently does it occur?
- What is the impact of bullying on the thoughts, emotions and functioning of the adolescent? (Sample questions to assess the severity of the risk is available in Appendix E)

4.7.3 Management

We can start with general principles that schools need to have in place to ensure that bullying is properly acknowledged as a problem and addressed. We can find out if there is a school policy for bullying, is it clear what would happen to the perpetrators etc.... that the schools need to have multiple different strands to their bullying strategy- including the whole school, teachers, classes and individuals.

- In case of low risk: The adolescent is to be reassured that being bullied is not their fault and no one deserves it. The researcher can work out strategies with the adolescents to protect themselves. The teacher should be informed, and the case can be discussed with them in order to address the problem and the further management strategies that can be adopted such as whole-school programs/ activities. For example: being assertive and asking them to stop, stop engaging or paying attention to them, reducing contact with the bully, being in the company of those who would protect/defend the adolescent from the bully. Inform the adolescent that they can come back to speak to you if the bullying should worsen and they don't feel able to handle it.
- In case of moderate and high risk: After explaining in a similar manner to the adolescent, the teacher must be informed within 24 hours and the case should be discussed with them along with the further management plan that needs to be taken care of. Depending on the severity and frequency of bullying, the researcher and the teacher, in consultation with the other school authorities, should determine the strategies in dealing with it which may range from disciplining practices for the bullies to report

them to their parents or childcare services in case of violation of the Indian laws. Any disciplinary action must take account of special educational needs or disabilities that the adolescents involved may have.

Inform the incident to the adolescent's parents or significant caregiver especially if the bullying is severe or if it occurs outside the school. It is to be ensured that the parent/caregivers understand the potential negative consequences of bullying. Appropriate interventions are planned accordingly by referring them to relevant agencies (Appendix C) which will have to be decided jointly with the adolescent. The facilitator will also follow -up with the school and try to ensure that steps have been taken to better protect the students.

4.7.4 Documentation

Document the disclosure regarding bullying made by the adolescent or any other friend/teacher/ parent. The details must be recorded using the adolescent's own words and as many details as possible. In case of cyberbullying, it would be better to keep a record of the messages, emails, images etc if possible as evidence and further appropriate interventions are to be planned accordingly.

4.7.5 If the Adolescent is Playing the Role of a 'Bully'

In case the adolescent discloses being a bully (either inside or outside the school), the researcher's role in risk management for it is to:

- Be patient and attentive to what the adolescent has to say and listen to him/her in a non-judgemental manner. This may also involve clarifying information from the adolescent by asking certain questions. Clarify from the adolescent to establish whether or not what they are referring to is an actual risk. It is also important to assess the level of harm being caused by the adolescent as a part of the bullying act on 1. What is happening? 2. How frequently does it occur? 3. What is the impact of bullying on the thoughts, emotions and functioning of the adolescent?
- He/she is to explain what the reasons for could be involving themselves in the bullying act and the potential long term negative impact that bullying

bullying has on others as well as on them. Inform the adolescent that in the interests of his/her safety as well as that of others, breaching confidentiality may be necessary.

- The teacher and the school authorities are to be informed regarding the disclosure and he/she is also asked to consult an expert, for an appropriate professional support plan in terms of therapeutic intervention.
- Document the disclosure by the adolescent. The details must be recorded in the Risk Reporting form using the adolescent's own words and as many details as possible and assess the need for further management and follow-up.

Vignette 3

An adolescent girl Sakshi was hindering the course of the workshop. She kept interrupting the facilitator during presentations with questions that were not relevant. She kept spamming the chat box with various comments that were unrelated to the workshop because the facilitator had forgotten to disable the chat option. On being asked to speak, she would remain quiet and not participate in any of the activities that were conducted as a part of the workshop.

What else could you have done? Would it be okay for Sakshi to drop out from the workshops? Is bullying a concern of the school and should be just handled by the school authorities?

Suggested response.

The facilitator asked the adolescent that she would be given time after the workshop to ask if there were any further questions and to help the facilitator continue progressing with the workshop. The facilitator was polite but adopted an assertive stance and limit setting was done. The chat facility was then disabled till the end of the session. She also kept it mind doing so at the beginning of the subsequent sessions. The YAB Lead Dr Muthuraju was informed regarding the behaviour of the adolescent, and they decided to have a separate session with her. She was asked how she was

doing in general. During this, it was realised that:
a. She was not really interested in participating in the workshop.
b. She was being bullied by some of her classmates

She was told that her participation in the workshop had to be completely voluntary, and that she can choose to no longer be a part of it even without stating any reason. She just needs to inform the Youth Advisory Board Lead Dr Muthuraju.
She was assured that it was a safe space where she could talk about the bullying. The teacher and school authorities were informed in order to determine if any disciplinary action needed to be taken regarding her experience of bullying. Depending on the intensity and severity of the instances of bullying, it was decided whether professional support was required for Sakshi. The facilitators also followed up to ensure that the bullying had also been addressed by the school directly.

5.0 Potential Risk and Harm that may be Reported by a Parent

The general guidelines for management of disclosure will be similar to the ones mentioned in section 3.1.

5.1. Mental Illness or Mental Health Issues and substance abuse

In case an adolescent/his or her friend/teacher/other parent reports any mental health, difficulty or use or dependence of substance in a parent, the researcher's role in risk management is to:

- Be patient and supportive and actively listen to what they have to say in a non-judgemental manner. Make sure he/she feels comfortable, and their emotions are validated.

- If they have any questions, they can be answered and information can be provided to them regarding the same. Explain to them how the adolescents of parents with mental illness or substance dependence may experience greater levels of emotional, psychological and behavioural problems than others. Also, parents may struggle to manage their parenting role effectively and hence management of these issues may be essential.
- If the parent is not receiving professional support, information about professional support options and ways to motivate the parent(s) for professional support can be discussed.

Documentation: The details must be recorded using their own words and as many details as possible and assess the need for further management and follow-up.

Vignette 4
During a co-production workshop with the adolescents, the facilitator Ankita notices that an adolescent Rakesh was affected by something that was said or discussed. He had stopped talking and remained quiet for the rest of the session.

If you were the facilitator, what are the diverse ways you could have responded to this?

Suggested response
After the workshop, Ankita contacts Rakesh individually and asks him how he felt about the session, and what caused him to remain silent. It is ensured that he is in a safe space and is free to talk about whatever is bothering him. He revealed during the session that while discussing about parents, he was reminded of how his father drinks every day and on one occasion had hit his mother. Though he was unable to do anything at that time, he had suddenly been reminded of it. His mood, functioning and severity of thoughts were assessed to determine if there was any ongoing risk to him or his family and whether his thoughts were interfering with his everyday functioning. Based on the assessment, it was decided that further professional support was required, and a referral was made accordingly.

5.2 Abuse

When a parent discloses being a victim of abuse in any form, the researcher is to:

- Provide recognition and validation of his/her situation. Listen attentively and give the individual time to say what they need and express their feelings and emotions especially if it is an incident that had occurred in the past.
- If they report an incident of ongoing abuse, they are to be made aware of

the Indian laws regarding it and in case of any cognizable offence it may be reported to the police unit. Help them arrive at a decision through your discussion and inform them of other community resources.
- Discuss other management strategies.
- Referrals will also be made if required (Appendix C).

For **domestic abuse** reported,

Definition: According to The Protection of Women from Domestic Violence Act, 2005, any act, omission or commission or conduct of the respondent shall constitute domestic violence in case it—
(a) harms or injures or endangers the health, safety, life, limb or well-being, whether mental or physical, of the person or tends to do so and includes causing physical abuse, sexual abuse, verbal and emotional abuse and economic abuse; or
(b) harasses, harms, injures or endangers the person with a view to coerce her or any other person related to her to meet any unlawful demand for any dowry or other property or valuable security; or
(c) has the effect of threatening the person or any person related to her by any conduct mentioned in clause (a) or clause (b); or
(d) otherwise injures or causes harm, whether physical or mental, to the aggrieved person.

Management
When a parent discloses being a victim of domestic abuse, the researcher is to:

- Provide recognition and validation of her situation. Listen attentively and give the individual time to say what they need and express their feelings and emotions.
- She is notified of her right to file a complaint at the local police station under section 498A of the Indian Penal Code. Alternatively, they can be given the contact number of Mahila Sahayvani and other helplines (Appendix C) to lodge a complaint.
- On occasions where males are the victim to domestic abuse, a similar approach is to be followed.

- Though they are informed about their rights, avoid giving advice and rather help them to work through the issues and make their own decisions with your help.
- Referrals for family intervention can also be made when deemed necessary after having a discussion with the family members regarding the importance of the same.

Documentation: The disclosure made is to be well documented to assess the need for further management and follow-up.

When a parent discloses being a perpetrator of domestic abuse, the researcher is to:

- Be patient and attentive to what the parent has to say and listen to him/her in a non-judgemental manner. This may also involve clarifying information from the parent.
- He/she is to be assured that disclosing it to the researcher is a step towards preventing it from happening in the future. He/she is to be made aware of the Indian laws regarding it and how it is a cognizable offense and the impact it may have not only on his/her partner but also on the adolescent.
- He/she is also asked to consult an expert, for an appropriate professional support plan in terms of therapeutic intervention (refer Appendix C for referral).
- The disclosure report is to be well documented to assess the need for further management and follow-up.

If an adolescent report any such incident, happening at his/her home (however the violence is not towards him/her), he/she is to be comforted and his/her feelings are to be validated. Then a session is to be taken with the parent after informing the teacher and school authorities and the same procedure is to be followed.

6.0 Potential Risk and Harm that may be Reported by a Teacher

6.1 Mental Illness or Mental Health Issues

In case a teacher/ staff from the school reports any mental health issue, the researcher's role in risk management is to:

- Be patient and actively listen to what the teacher/staff has to say in a non-judgemental manner. Make sure he/she feels comfortable, and their emotions are validated. Assess the degree and severity of the mental health issues that are reported.
- If the issue requires brief intervention the same can be addressed by the SAMA team member and signposting to resources provided. If the issue requires proper psychiatric evaluation and intervention, referral to a mental health professional can be made for the same (Appendix C).
- The details will be documented.

6.2 Abuse

Abuse can be of any type including the experiences of bullying and sexual harassment. When a teacher discloses being a victim of abuse in any form, the researcher is to:

- Provide recognition and validation of his/her situation. Listen attentively and give the individual time to say what they need and express their feelings and emotions especially if it is an incident that had occurred in the past.
- If they report an incident of ongoing abuse, they are to be made aware of the Indian laws regarding it and in case of any cognizable offence it may be reported to the police unit. For example: If a female teacher reports of sexual harassment, she will be explained about the Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act 2013 and informed about seeking help. Any steps taken by the research team should ensure that the there is no re-victimisation.
- Help them arrive at a decision through your discussion.

- Discuss other management strategies.
- Referrals will also be made if required (Appendix C).

7.0 Other Potential Disclosures

If a **teacher/parent/adolescent** discloses about issues that do not require safeguarding or that does not have any risk of harm to the adolescents, for example, involvement in a romantic relationship, different sexual orientation, etc., there would be no management required. The researcher however is to have a conversation with them normalising the situation and explaining how adolescence is a crucial phase of life that is accompanied by changes for the young problem. They are to understand that the present concern is not a threat to the safety and well-being of the adolescent within the wider social context. However, if they may seem to require longer sessions, then referral will be made.

Vignette 5

An adolescent Lakshmi reveals that she has been experimenting with smoking and doing this in the school bathroom at times. Sometimes she has taken money from her mother's purse to buy cigarettes.

As someone who had interacted with her in the past, you did not expect this as Lakshmi seemed to be very considerate and respectful in sessions. What do you do? Should you let the school authorities know? What about her mother?

Suggested response

- Speak to Lakshmi using an open and non-judgmental approach
- Reflect on your role – are you supposed to be a moral custodian?
- Review the help-seeking options available with Lakshmi

Vignette 6

One of students in school, Shravan reported that he was unable to do some SAMA activity that had been assigned to him as he was extremely distracted and preoccupied with his thoughts most of the time. On being told that it is okay, and he can share what is bothering him if he wishes to, he reports that he is attracted to another boy in his class. He feels it is wrong as he is a boy and when he had shared it with another friend, she had laughed about it and a few of his classmate's made fun of him and started teasing him as well.

How would you respond to such a situation? What would you do or tell him?

Suggested Response

Make sure you adopt a non-judgemental approach and allow them to speak at their own pace and comfort. You can say "This must be distressing to you. I am glad that you are talking to me about it". Let them know that it is okay to be attracted to boys/girls/ both. General awareness programs in the schools regarding the LGBTQ community, gender identity and gender fluidity can be conducted to make the adolescents more aware. Assure him that there is nothing to worry about. You can also let him know that there are professionals that he can speak to if he remains distressed and a referral for the same can be made. If he wishes to speak to his parents regarding this, assistance can be provided. Ensure regular follow up with the SAMA team.

Vignette 7
An adolescent, Shilpi, later spoke to one of the SAMA team members, Mr Akhilesh that she likes a senior boy in her school, and they have been missing school for a couple of days and have been going out with each other. She also reports how she has been doing academically well in her class and is worried about her teacher knowing about it and reporting to her parents.

What would you do? Would you report it to her teacher/her parents? Would you consider this as a safeguarding issue for Shilpi?

Suggested Response
Adopt a non-judgemental approach and engage in active listening. Validate the emotions of the adolescent and her concerns. Let her know that whatever she shares with you will be kept confidential and unless it is a threat to her or others or is illegal it will not be shared with anyone else unless she wishes to do so. She will be assured that in case she wishes to speak to someone about this and requires assistance in doing so, help would be provided by the researcher. She was told that though it is okay to like someone and spend time with them, the missing school could impact her studies and could lead to trouble as well. She was asked to get back to the researcher if there was any help she wanted.

7.1 Procedure for referrals

If there is a referral made by any participant regarding their family members/ someone they know, the following procedure is to be followed:

- Build trust and listen openly and actively to the concern of the individual and their emotions. Express interest in what the individual is saying (verbally and non-verbally). Validate the emotions of the individual if there is any distress caused due to the concern. Explain to the individual that

the role of the SAMA team member and responsibilities as a researcher may have certain boundaries but we would try to help them in the best manner possible.

- Assure them that confidentiality will be maintained unless it is a threat to the safety of themselves/others.
- If the concern is normal behaviour and not a mental health concern, the same is explained to the participant. Information can be provided to them, if required, regarding the concern.
- If the concern requires proper evaluation or intervention, a referral is to be made either to NIMHANS or to other available resources.
- The process would be reported to the Safeguarding Team and documentation regarding the same would be done which would also include the steps that had been taken to mitigate the concern.
- Follow-up with the individual would be done at regular intervals. Assure the individual that they can come back and speak to the team member if the issue persists.

7.2 Roles and responsibilities of the Safeguarding Team

Team member	Role	Responsibilities
Dr Poornima Bhola	Professor, Dept of Clinical Psychology Co-PI SAMA Project	Safeguarding Team Lead, Responding to High-Risk situations and taking decisions about mitigation strategies in response to the safeguarding concern
Dr Janardhan N	Professor, Dept of Psychiatric Social Work Principal Investigator, SAMA Project	Safeguarding Team Lead, Responding to High-Risk situations and taking decisions about mitigation strategies in response to the safeguarding concern
Dr Sphoorthi Prabhu	Project Manager, SAMA Project	Safeguarding Team, Responding to Moderate and High-Risk situations and discussing further management plans in response to a safeguarding concern
Dr Muthuraju A	Project Manager, SAMA Project	Safeguarding Team, Responding to Moderate and High-Risk situations and discussing further management plans in response to a safeguarding concern

Team member	Role	Responsibilities
Ms. Ritwika Nag	Research assistant, SAMA Project	Safeguarding Team, Assist in responding to any low, or moderate and high-risk safeguarding situations reported by the research participants or SAMA Snehitharus
Mrs. Jayalaxmi KP	Research assistant, SAMA Project	Safeguarding Team, Assist in responding to any low, or moderate and high-risk safeguarding situations reported by the research participants or SAMA Snehitharus
Mrs. Krupa AL	Research assistant, SAMA Project	Safeguarding Team, Assist in responding to any low, or moderate and high-risk safeguarding situations reported by the research participants or SAMA Snehitharus

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9.0 Storing safeguarding related data

All the safeguarding related data would be anonymised. We will store all the data related to safeguarding in a secure NIMHANS drive, which has been approved for storage of data and a safeguarding folder of documents. This will be encrypted and accessible only by the safeguarding team and the SAMA research team.

10.0 Appendices

10.1 Appendix A - List of resources used for the protocol

Laws/ Acts/ Policies in India reviewed:

- CBSE Guidelines for Prevention of Bullying & Ragging in Schools
- The Child Labour (Prohibition and regulation) Amendment Act, 2016
- The Prohibition of Child Marriage Act, 2006
- Guidelines on safety and security of children in India by the Ministry of human resource development
- The Juvenile Justice (Care and Protection of Children) Act, 2015
- Karnataka State Child Protection Policy, 2016
- Karnataka State Girl Child Policy, 2018
- The National Policy for Children, 2013
- NCPR Guidelines for eliminating Corporal Punishment in schools
- The Protection of Children from Sexual Offences Act, 2012
- Protection of Children from Sexual Offences Rules, 2020.
- The Right of children to Free and compulsory Education Act, 2009
- Children with Specific Learning Disabilities (Identification and Support in Education) Bill, 2018.
- The Rights of Persons with Disabilities Act, 2016
- Mental Healthcare Act,2017
- The Narcotic Drugs and Psychotropic Substances Act, 1985
- The Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988

Existing Protocols reviewed:

- SANGATH Risk Protocol for Stress and Problem-Solving Programme
- NIMHANS child and adolescent psychiatry project safeguarding protocol
- OSCAR India Safeguarding Policy 2018
- PAP Safeguarding policy and procedures, University of Kent, 2019
- Canada International School Child Protection Policy

- Oberoi International School Child safeguarding Policy and procedures 2019-2020
- StoneHill International School Child Protection Handbook 2015-2016
- Child Safeguarding Policy by Breakthrough
- Child Safeguarding Policy by Child in Need Institute (CINI)
- Child Safeguarding Policy by ATMA
- Child Protection Policy by Hope Foundation

Other documents reviewed:

- Safety and well-being first child protection policy for schools in Karnataka by Department of Women and Child Development Government of Karnataka, 2014
- Guidelines on safety and security of children in India by the Ministry of human resource development
- Protecting children in research: Safer ways to research with children who may be experiencing violence or abuse (Randall, Anderson & Taylor, 2015)
- How to prevent and address safeguarding concerns in global health research programmes: practice, process and positionality in marginalised spaces (Aktar et al., 2020)
- Manual on safety and security of children in schools developed by National Commission for Protection of Child rights
- Guidance on Safeguarding in International Development Research, UKCDR
- National Ethical Guidelines for Biomedical Research Involving Children
- SOP for enforcement of child and adolescent labour Act, 1986
- Guidance on handling a disclosure from a child
- Child safeguarding annual report 2018/2019
- Guide to assist providers in writing a safeguarding policy

10.2 Appendix B - These rules will be added to the assent/consent form

I agree to **NOT** indulge in the following:

1. Record any session without taking prior permission from the facilitator or higher authority. The tools of the online platform (like recording, annotations) will be used only by the facilitator for the respective session.
2. Take screenshots during a session as it may be distracting and is an invasion of privacy of other participants in the session.
3. Use disrespectful language during online interactions of any form as it may create an intimidating, hostile, degrading, humiliating or offensive online environment.
4. Post or share any kind of inappropriate material online during the interactions.
5. Any kind of bullying activities towards your peers and other participants and be careful to not indulge in any inappropriate interactions.
6. Not share any personal information (such as address, contact number, passwords etc.) with others during online interactions.
7. If I have any issues with any participant, I will raise them individually with the facilitator rather than in the group.
8. Inform the facilitator if anyone in the group contacts you outside of this agreed framework.

10.3 Appendix C - List of external referrals

- Child helpline: 1098
- Domestic violence helpline numbers
  - Women Helpline: 1091
  - Women Commission: 9480051066 / 080-22100435
  - Save India Family Foundation (helpline for men): 9278938978
  - Samaja Seva Samithi: 080-26600022 / 9448945367
  - Vimochana: 080- 25492781 / 82 / 83
  - Abhayashrama: 080-22220834 / 080-22121131
  - Nava Karnataka Mahila Rakshana Vedike: 9490135167
  - Tara Women's Centre: 080-25251929
  - Vanitha Sahayavani: 100, 080-22943225 / 080-22943224
  - Bengaluru Women Police: 080-22943225
  - Karnataka Women Police: 0821-2418400
- Suicide Help lines
  - Arogya Sahayavani: Ph: 104 (24x7 Karnataka)
  - Parivarthan Counseling Helpline Services: Ph: 7676 602 602 (04:00 PM to 10:00 PM | Monday to Friday, Bengaluru)
  - SAHAI: Ph: 080 25497777, 9886444075 (Monday to Saturday: 10 AM to 8 PM, Bengaluru)
  - Sa-Mudra Yuva Helpline: Ph: 9880396331 (24x7, Bengaluru)
  - ICALL: Ph: 022-25521111 and 9152987821
  - Mitram Foundation: Ph: 080-25722573 (Wednesday, Bengaluru)
- Mental Health Centres
  - Dr. Pavana, Psychiatrist Ph: 9986636216 (Bharani Clinic, Doomlight Circle, Kolar) Kolar District SNR hospital, Dr. Shilpa, Ph: 7022151787
  - Dr. Mohan Reddy Clinic, Bangarpet Road, Kolar, Ph: 9845198229 Bengaluru
  - NIMHANS Hosur road, Hombegowdanagar, Bengaluru-570029. Ph: 080-26995000
  - Abhayashram Abhaya Ashram, 4th Cross, Wilson Garden, Bangalore 560027, 080- 22220834 / 080 - 2212 1131
  - Freedom Foundation, #80, Hennur Cross, 080-25440134, 65966444

- Medico Pastoral Association, 47 Pottery Road Fraser Town Bangalore - 560 005 Karnataka, 91-80- 25477375
- TREDA (Professional support Rehabilitation & Education of Drug Abuse), DoddaKennelli, Carmelram Post, Sarjapura Road, Bangalore 560035, 080-28439505
- Prasanna Counselling Centre, C/O Ajita Shree, 8/28, Bull Temple Road Bangalore - 560 004, 91-80-26608926
- MS Ramaiah Hospitals/ M. S. Ramaiah Medical College, MSR Nagar, MSRIT Post Bangalore – 560054, 080-23605190 / 23601742 / 23601743 / 080-23608888/23605408
- Kempegowda Institute of Medical Sciences (KIMS), Banashankari 2nd Stage, Bangalore-560070, 91-80-26715790, 26712791/ 92
- Basic Needs India, No. 114, 4th Cross, OMBR Layout, Bangalore – 560043, 91-080-25459235, 080-25450562
- St.Johns National Academy of Health Sciences, Sarjapur Road Bangalore-560 034, 080 - 22065508 / 22065700/22065504 / 22065505
- St Marthas Hospital, No 5, Nrupatunga Road, Bangalore, 080-22275081
- Spandana Hospital Rehabilitation Center, 558, 26th Main Rd, Sreenivas Nagar, Nandini Layout, 090355 60000
- Abhaya Hospital, Wilson Garden, Bengaluru, 9035016740/41/42/43

10.4 Appendix D - Suicide and self-harm assessment form

Risk Assessment Form for Suicide and Self-harm

Student ID_____ Researcher name _____

Date _____

Introduction

Thank you for coming to meet with me. My name is X, and I am a researcher. I understand that you have been having some difficult thoughts about harming yourself. I'd like to ask you a bit more about it so that I can make sure we get you the right help and support, is that ok?

Recording

I usually record these sessions to make sure that I don't miss anything - This tape won't be shared with anyone outside of me and my supervisor. Would it be ok with you if I record our conversation? It is fine to say no, it is completely up to you.

Thoughts

Type: 'Can you tell me a bit more about the sort of thoughts you have been having about harming or killing yourself?'
Onset & frequency: 'How long have you been having thoughts like this? How often are you having these thoughts?'
Triggers: 'Are there particular situations when you have these thoughts?'

Fleeting or infrequent thoughts	Frequent thoughts	Persistent, long-standing thoughts
(e.g., momentary thoughts in moments of high emotion OR more long-lasting thoughts once or twice in the last month)	(e.g., 3 or more occasions in the past month)	(e.g., thoughts that have been around for over a month and occur regularly)
L	L	M

Current plans

At the moment do you have a plan for how you might kill or hurt yourself?
If yes:
Details: Can you tell me what is it? How often do you think about this? Do you have an idea of when you would do this?
Access to means: How easy would it be for you to do this?

No concrete ideas of how to harm/kill self	**Concrete ideas of means but without further plan** (e.g. i could cut my wrists)	**Active plan without access** (e.g. i would cut my wrists in the bath using a razor but there are none in the house)	**Active plan and access to means** (e.g. i would cut my wrists with my dad's razor in the bath)
L	**L**	**M**	**M**

Intent
‘Do you ever feel like you **want** to act on these thoughts?’ **If yes:** Can you talk more about it? How much do you feel you want to act on these thoughts? How long does this urge/feeling to act usually last? Are there particular situations/times when these urges are most difficult for you?

No intent	Some intent	Strong intent
(e.g., no real urge or desire to act on thoughts)	(e.g., some urge or desire to act on thoughts but also other thoughts/reasons why not to act)	(e.g., strong overwhelming urge or desire to act on thoughts which the student does not feel able to resist OR active intention to act on thoughts)
L	M	S

Past experiences

‘Have you ever tried to hurt yourself before?

If yes: Can you talk more about it? What happened? When? How many occasions? **Intention:** At the time, what did you mean to happen? Did you want to kill yourself? **Outcome:** What happened afterward? Was medical attention required? **Support:** Does anyone else know about this?

No behaviour	Behaviour with intention to self-harm			Behaviour with intention of suicide		
No self-harm or suicide attempt	Preparatory behaviour but no actual harm (e.g., took knife but didn’t cut)	Non-life-threatening self-harm (e.g., superficial cutting)	Potentially life-threatening self-harm (e.g., deeply cutting wrist with razor, needing medical attention)	Preparatory behaviour but no actual harm (e.g., took cloth/rope to hang self)	Non-life-threatening suicide attempt (e.g., took 4 paracetamol)	Potentially life-threatening suicide attempt (e.g., tried to hang self)
L	M	M	S	M	M	S

	Low risk	Moderate risk	Severe risk
Current assessment	Only L ratings	Any M ratings	Two or more M ratings and one or more S ratings

Agreement
‘Can you promise me that you will follow this plan if you have more thoughts of hurting yourself? **If not or some doubts** record below

Student feels able to follow plan	Student feels able to follow plan with some small doubts	Student does not feel able to follow plan
L	M	S

	Moderate risk	Severe risk
Re-rate current assessment	Any M ratings	Two or more M ratings and one or more S ratings

10.5 Appendix E - Risk report form (for any researcher who first detects a risk of any kind)

This form is to be completed by any researcher who first encounters evidence of any risk to the adolescent (this includes suicide/self-harm, sexual abuse, physical abuse, risky behaviour, bullying, corporal punishment, exploitation). This form serves as a record of the initial disclosure as well as any action taken from the time of disclosure to the point that a full risk assessment is completed, or it is established that this is not required. This form should be completed and a call to the supervisor made within 24 hours of the risk being detected.

Note for researchers: This form does not need to be completed if suicide/self-harm risk is detected by the fixed-response answers to the risk screening questions. Only if the student ALSO tells the researcher further information about risk, then this form must be completed.

Student ID: Date:
Researcher Name:

Type of risk:

- Self-harm/Suicide
- Physical abuse
- Sexual abuse
- Risky behaviour
- Clinical deterioration

Details of risk: (record the exact words used by the adolescent)

Supervisor informed --> Name of supervisor
Date Time

Plan agreed with supervisor:

10.6 Appendix F - Training methodologies and processes

Date	Training on	Trained by	Attendees
09/08/2021	POCSO Act and its ground realities	Kushi Kushalappa	Dr Sphoorthi Prabhu, Dr Muthuraju A, Krupa AL, Jayalaxmi KP, Ritwika Nag
10/08/2021	SAMA Safeguarding session 1	Dr Poornima Bhola	Dr Sphoorthi Prabhu, Dr Muthuraju A, Krupa AL, Jayalaxmi KP, Ritwika Nag
23/08/2021	Child sexual abuse reporting and ethical and safeguarding dilemmas	Dr Preeti Jacob	Dr Poornima Bhola, Dr Sphoorthi Prabhu, Ritwika Nag
23/09/2021	SAMA Safeguarding session 2	Dr Poornima Bhola	Dr Sphoorthi Prabhu, Dr Muthuraju A, Krupa AL, Jayalaxmi KP, Ritwika Nag

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