The Behavioral Health Sector Response to Child Sexual Abuse, Exploitation, and Trafficking: A Call to Action

Journal of Indian Association for Child and Adolescent Mental Health
19(3) 258–262, 2023

DOI: 10.1177/09731342231220479
journals.sagepub.com/home/iam
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Abstract

Child sexual violence is a major public health problem in India and is associated with myriad short- and long-term behavioral health effects. Affected children are at an increased risk of post-traumatic stress disorder, major depression, anxiety disorders, behavioral problems, and substance misuse. Behavioral health professionals are highly likely to encounter patients at risk of or with a recent/remote history of child sexual abuse, sexual exploitation, or sex trafficking. Caregivers of patients may report a history of child sexual violence. Clinicians must possess the knowledge and skills to recognize and appropriately respond to suspected child sexual violence using a culturally responsive, trauma-informed, and rights-based approach. Many behavioral health professionals lack the knowledge of child sexual violence and the confidence of working with affected patients. Child sexual violence is not routinely addressed in medical school curricula, nor is it systematically addressed in postgraduate training programs. Practicing clinicians may feel ill-equipped to recognize and manage patients exposed to child sexual violence and may miss opportunities to offer critical support and assistance to vulnerable children and their families. The behavioral health sector needs an organized, systematic, and trauma-informed response to child sexual violence, and this requires specific training of professionals and development of organizational response protocols tailored to fit the needs of the organization and its patient population. Multiple resources are available in India to assist behavioral health professionals, and organization administrators accomplish these goals.

Keywords

Child sexual abuse, child sexual exploitation, child trafficking, child sexual violence, behavioral health, training

Submitted 01 November 2023; accepted 01 November 2023

Background

Child sexual violence (CSV), including sexual abuse, exploitation, and trafficking, is a major global public health problem and a critical issue within India.[1,2] Prevalence estimates of CSA in India vary from 1.6% to 57%, depending on the population sampled, types of sexual abuse considered (e.g., contact, non-contact), and the measurement tool used.[3–8] An estimated 2.8 million Indian women and children are trafficked for commercial sexual exploitation,[9] which may involve prostitution (through human trafficking or tribal/religious practices, associated with travel/business, or as mode of survival), production of child sexual abuse materials (child pornography), and child marriage. Of India's 223 million child brides, 102 million were married before their 15th birthday.[10]

Child sexual violence has significant health and behavioral health impacts on children and adolescents, in the short and long term. Affected children and adolescents are at an increased risk of substance misuse, post-traumatic stress disorder (PTSD), major depression, anxiety disorders and other behavioral health conditions, as well as sexually transmitted infection (STI), HIV/AIDS, inflicted injury, and unwanted

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pregnancy.[11-16] They may seek behavioral health care for these and other problems, near the time of the abuse event(s) or at variable periods thereafter. They may present to primary pediatric medical and behavioral health providers, to general clinics or to hospitals, with or without a known diagnosis of CSV. It is critical that behavioral health professionals possess the skills, resources, and confidence to recognize and appropriately respond to children at risk of or exposed to CSV. The behavioral health sector needs an organized, systematic, and trauma-informed response to CSV to help ensure the safety and wellbeing of their pediatric patients and clients.

To protect children under 18 years from sexual assault, sexual harassment, and child "pornography" (current preferred term: child sexual abuse materials), the Indian government passed the Protection of Children from Sexual Offenses Act (POCSO) in 2012.[17] This law criminalizes the above sexual acts, defines mandatory reporting requirements, and establishes special courts to manage cases of CSV. It requires registered medical practitioners to report to authorities whenever CSV is suspected. The procedure for reporting a case has been spelt out in Section 19; Sub-section (1) of the POCSO Act. It says any person (including the child) who has the knowledge that the offence under the Act is likely to be committed or has the knowledge that such an offence has been committed shall provide the information to the special juvenile police or the local police. As per Section 27 of the POCSO Act, doctors are required to provide prompt comprehensive medical and psychological treatment to affected children without waiting for police requisition or a magistrate order. As per Rule 5 of the POCSO Act, when the special juvenile police and other local police are satisfied that the victim against whom the offense has been committed is in need of care and protection, they shall make immediate arrangements in the nearest hospital, shelter home, or local hospital within 24 hours. The police are required to report the matter to the Child Welfare Committee (CWC) and the designated special court within 24 hours. Under the POCSO Act, no person shall incur any liability, whether civil or criminal, for giving the information in good faith and for the purpose of Section 1 of reporting guidelines. While One-Stop Centers designed to provide immediate medical and psychosocial care to children (girls only) who have experienced CSV are located in many Indian cities,[18] behavioral health professionals at hospitals and clinics may still need to work with affected children, either because the suspicion of abuse initially comes to light during a behavioral health visit or because the child/family seeks care for emotional and behavioral problems associated with a history of CSV.

Preventing, recognizing, and appropriately responding to CSV requires specific training of all behavioral health professionals. Basic knowledge of the dynamics of CSV and appropriate clinical management are not regularly taught in medical schools. A global review of barriers faced by individuals who sought health care related to human trafficking demonstrated that a lack of health professional training, staff bias and discrimination, and a lack of provider knowledge of trauma informed approach (TIA) hinder the disclosure of exploitation and thwart efforts to provide appropriate services to patients.[19] In a multi-site study of general and pediatric emergency department staff in the United States, only 12.4% of respondents indicated feeling "very confident" in recognizing child trafficking.[20] Providers who identify social or historical factors concerning CSV may have little knowledge of how best to approach this sensitive issue with parents and may be tempted to ignore their own concerns. A failure to recognize children at risk of, or experiencing CSV, represents a lost opportunity to intervene, offer critical services and referrals, and facilitate the healing process for the child. It allows victimized children to remain in dangerous situations and increases the risk of long-term adversity such as substance misuse, high-risk behavior (e.g., running away from home, engaging in unprotected sex), PTSD, depression and suicidality, and behavioral challenges that interfere with social development.[3,21]

Lack of knowledge of CSV and of trauma-informed approach to patient interactions is but one barrier to adequate recognition and response to CSV for behavioral health professionals. Cultural norms regarding sexuality including taboos around premarital sex, virginity, and any open discussion of sexual concerns make it difficult for providers to broach the topic when suspicions arise. For similar reasons, children and families are reluctant to disclose abuse to health practitioners, which places the onus on providers to detect potential risk factors and indicators, and to initiate the appropriate legal and treatment responses. A lack of awareness regarding the available community resources and worry over possible future court involvement contribute to a reluctance to screen for or pursue concerns of CSV.

While behavioral health professionals may engage in secondary and tertiary prevention of CSV by recognizing victimization and initiating treatment interventions, they may also play a vital role in primary prevention. Using a public health approach[22] and the socioecological model of victimization,[23] practitioners may provide anticipatory guidance to child patients and caregivers regarding body safety and healthy relationships, internet safety, and key information regarding common recruitment strategies used by human traffickers and online sex offenders.[24,25] However, behavioral health professionals need to be aware of these prevention strategies and empowered to incorporate them into routine practice.

Training on CSV and the trauma-informed, patient-centered, culturally responsive approach should occur at all levels of behavioral health professional training and should be offered as a continuing education to the active practitioner. Periodic routine training on CSV should be included in policies and procedures of health and behavioral health facilities, with a system in place for monitoring and evaluating the training impact. Presentations on CSV could be delivered during grand rounds and staff meetings, as part of a larger organizational training or during local or regional conferences. They may be offered as an interactive, self-paced online module or as a live webinar. In one study, participants recommended training in the form of a 1-hour module/webinar/lecture (43.1%), grand round presentation (40.5%), written guidelines (9.8%), and individualized,

case-based learning (6.6%).[20] It is helpful to provide periodic supplementary learning opportunities to encourage sustained practice changes. This may involve quarterly e-mail or social media messages highlighting key facts about CSV and tips for interacting with patients and families, fact sheets posted at workstations, or sample case scenarios discussed at staff meetings.

Behavioral health professionals cannot implement significant practice changes without organizational support. In addition to providing training opportunities to staff, health administrators need to work with clinicians to develop, implement, and evaluate a protocol/guideline specifically addressing the recognition and clinical management of suspected CSV. Such a protocol should clearly define the roles and responsibilities of each staff member, provide information on common risk factors and possible indicators of CSV, and describe in detail the process for recognizing and managing cases of suspected CSV, from the initial presentation to the time of discharge, including community referrals and mandatory reporting procedures. A proactive approach will save time and resources and increase the confidence and competence of staff members. A detailed, comprehensive protocol may improve patient and family satisfaction with care and facilitate referrals for critical aftercare services. It may also provide important guidance to staff if an alleged sexual offender arrives at the facility and attempts to contact the patient. Having an established procedure for handling potentially disruptive situations increases the likelihood of a good outcome and helps instill a sense of safety among staff, patients, and families.

Children at risk of, and experiencing CSV, have many needs, extending well beyond the purview of the behavioral health professional. Providing holistic care to child victims of sexual violence is critical since it may be difficult for a child and caregiver to engage in mental health services when they face major difficulties in other domains (e.g., housing, immigration relief, financial resources). Comprehensive services require a multidisciplinary community response that involves interaction of the behavioral health provider with professionals from outside agencies and organizations. For those with limited experience in cross-agency collaboration, this may be overwhelming and intimidating, especially if the provider has little knowledge of available community resources. A protocol on CSV should include guidance on how to make "warm referrals" (e.g., facilitate patient contact with referral organization prior to leaving the behavioral health facility) and a directory of community service organizations. As part of their training on CSV, all staff should receive training on the CSV protocol.

Resources for Behavioral Health Professionals

Behavioral health professionals and organization administrators have resources available to them to address their training and protocol needs. In partnership with the International Centre for Missing and Exploited Children (ICMEC), the Indian Child Abuse Neglect & Child Labour (ICANCL) group (www.icancl.org) established an Indian Child Protection Medical Professionals Network (ICPMPN) in 2017 to train medical doctors all over India to respond to CSV in accordance with the Indian laws, such as the POCSO Act and the Juvenile Justice (JJ) Act, and guidelines from the Ministry of Health and Family Welfare (MOHFW), Government of India.

The ICANCL Group (www.icancl.org) is a nationally registered professional society, which was started within the framework of the Indian Academy of Pediatrics (IAP) (www.iapindia.org) in the year 1996. Recognizing the impact of socioeconomic, cultural, and environmental factors on child health, development, and overall welfare, the ICANCL Group specifically focuses on comprehensive child welfare, child rights, abuse, neglect, exploitation, and rehabilitation. The ICANCL Group addresses the problems of child abuse and neglect (CAN) with a multidisciplinary approach with other agencies and community organizations interested in child welfare. The group has committed its efforts to reach out to neglected, abused, and exploited children for their comprehensive needs, which include health aspects, education, rehabilitation, protection, and prevention. Membership of the ICANCL Group is open to people of all disciplines interested in the protection of children. Advocacy, information, and sensitization are the crucial issues.

The ICANCL Group organized the 9th Asia Pacific Conference of the International Society for the Prevention of Child Abuse and Neglect (ISPCAN) (APCCAN) at New Delhi in October 2011. Denial of health care and education was highlighted as a serious form of neglect. An outcome document, "Delhi Declaration," was presented to the Government of India. National conferences (CANCLCON) of ICANCL Group are organized regularly across India to update and train pediatricians, physicians, and allied medical professionals. The group's silver jubilee conference was held at the Advanced Center of Pediatrics, PGIMER, Chandigarh, in November 2022. The group publishes an annual newsletter, *CANCL News*, highlighting its work and professional updates in the field.

In collaboration with UNICEF, the ICANCL Group organized a series of expert group consultations to develop national guidelines and a handbook, "Child Abuse Recognition and Response," for medical doctors and allied health professionals.[26] The handbook provides key understanding of basic knowledge, current guidelines, and standard operating protocols (SOP) for prompt recognition and management of various forms of child abuse in Indian settings. Additionally, the ICPMPN group published "Child Protection in the Context of the COVID-19 Pandemic: Practice Guidelines for Pediatricians," in collaboration with ICMEC and the National Institute of Mental Health and Neurosciences (NIMHANS).[27]

Indian Child Protection Medical Professional Network

To improve the health sector response to CSV in India, the ICMEC and the ICANCL Group of the Indian Academy of

Pediatrics established the Indian Child Protection Medical Professional Network ("India Network") in 2017 (https://www.icmec.org/healthportal-resources/topic/indian-child-protection-medical-professional-network/). As of January 2023, the network consists of 9 expert mentors and 106 trained physicians located in 44 cities and 20 states of India, with one mentor located in the United States. These network members practice pediatrics, obstetrics/gynecology, forensic medicine, community medicine, and psychiatry. They act as local child sexual abuse health care resources for community health and behavioral health care professionals and authorities working on cases of CSV. They answer questions from local health and behavioral health professionals and help identify appropriate resources for patients. They are an excellent source of support and guidance to community health/behavioral health professionals.

In addition to initial intensive training, network members receive ongoing support and technical assistance through online discussions and regularly scheduled webinars. Many of these webinars are open to non-network health and behavioral health professionals. In addition, network members have access to a comprehensive resource library that includes e-learning modules on child sexual abuse evaluation, trauma-informed care, and child trafficking; national and international guidelines and country reports; and webinar recordings.

Non-network health and behavioral professionals are welcome to attend many of the regularly scheduled webinars. In addition, they are invited to attend one-day child sexual abuse awareness workshops sponsored by local network members, often in partnership with the Indian Academy of Pediatrics. Participants of these one-day workshops who express interest in learning more about CSV may apply for ICPMPN membership.

Additional Resources

1. Support, Advocacy Mental health interventions for children in Vulnerable circumstances And Distress (SAMVAD) is a national initiative and integrated resource for child protection, mental health, and psychosocial care. This initiative, supported by the Ministry of Women and Child Development, Government of India, is located in the Department of Child and Adolescent Psychiatry, NIMHANS. It comprises a multidisciplinary team of child care professionals, with expertise in training and capacity building, program and policy research pertaining to child mental health, protection, education, and law (https://nimhanschildprotect.in/SAMVAD-InformationDashboard.html).
2. A "how-to" guide to develop a health care protocol for responding to CSV (a 1-hour online module that guides health care staff through the process of creating a protocol tailored to meet organizational needs, with over 40 supplementary materials) (https://www.icmec.org/healthportal-resources/topic/e-learning/).
3. *Child Abuse: Recognition and Response—Guidelines* from the ICANCL Group, Indian Academy of Pediatrics (www.amazon.in/Child-Abuse-Recognition-Response-Rajeev/dp/9389776384).
4. A toolkit on the health care response to human trafficking, Improving Health Care Services for Trafficked Persons, addresses behavioral and physical health care practices (https://www.icmec.org/healthportal-resources/topic/human-trafficking-toolkit/).
5. HEAL Trafficking and Hope for Justice's Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings (https://healtrafficking.org/2017/06/protocol-toolkit/).

Conclusion

Child sexual violence is a major public health problem in India and is associated with myriad short- and long-term physical and behavioral health effects. Behavioral health professionals are highly likely to encounter patients at risk of or with a recent/remote history of CSV. As such, they must have the knowledge and skills to recognize and respond to the various forms of CSV. They must be competent in providing culturally responsive, trauma-informed, and rights-based care to affected children and their caregivers. For many providers this implies a sustained change in practice, which will require specific training and development of a CSV response protocol tailored to fit the needs of the behavioral health organization and its patient population. Multiple resources are available in India to assist behavioral health professionals and organization administrators.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

Statement of Informed Consent and Ethical Approval

This is a viewpoint article and represents views of the authors. No research participants were involved, and hence, no ethics clearance was sought.

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