CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

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Exploitation, Labor and Sex Trafficking of Children and Adolescents: Health Care Needs of Patients

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abstract

Exploitation and labor and sex trafficking of children and adolescents is a major public health problem in the United States and throughout the world. Significant numbers of US and non-US–born children and adolescents (including unaccompanied immigrant minors) are affected by this growing concern and may experience a range of serious physical and mental health problems associated with human trafficking and exploitation (T/E). Despite these considerations, there is limited information available for health care providers regarding the nature and scope of T/E and how providers may help recognize and protect children and adolescents. Knowledge of risk factors, recruitment practices, possible indicators of T/E, and common medical, mental, and emotional health problems experienced by affected individuals will assist health care providers in recognizing vulnerable children and adolescents and responding appropriately. A trauma-informed, rights-based, culturally sensitive approach helps providers identify and treat patients who have experienced or are at risk for T/E. As health care providers, educators, and leaders in child advocacy and development, pediatricians play an important role in addressing the public health issues faced by children and adolescents who experience exploitation and trafficking. Working across disciplines with professionals in the community, health care providers can offer evidence-based medical screening, treatment, and holistic services to individuals who have experienced T/E and assist vulnerable patients and families in recognizing signs of T/E.

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This clinical report targets primary care and specialty pediatric providers working in private and public clinics, hospitals, emergency departments, and urgent care centers. Research demonstrates that children and youth who experience sex and labor trafficking and

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exploitation (T/E) may seek health care in a variety of settings,[1–3] making it essential that pediatric providers anywhere are equipped to recognize potential T/E and respond appropriately. The guidance offered here is aimed to assist health care professionals in recognizing previously unidentified T/E, as well as in providing a basic initial response to suspected and confirmed cases of exploitation. Referrals for higher-level care may be indicated and are discussed. Providers and all of their staff need to adopt a trauma-informed, rights-based, culturally responsive approach to care of patients suspected of experiencing T/E, although these skills are relevant to care of any patient who may have experienced significant trauma. That is, the skills are generalizable and highly relevant to daily clinical practice. Creating a trauma-informed workspace and providing care to patients who have experienced T/E and other major traumatic experiences is, admittedly, time-consuming and poorly reimbursed by payers. However, having basic skills in rights-based practices and a protocol summarizing staff roles and responsibilities for managing suspected T/E will significantly reduce the time expenditure and very likely improve outcomes for vulnerable patients. Ample resources for training staff on trauma-informed care and creating a clinic or hospital protocol are available in this document and elsewhere.[4–8]

Human sex and labor trafficking and exploitation (T/E) are significant global health issues involving egregious violations of an individual's fundamental dignity and human rights.[9] However, many who experience T/E do not perceive themselves as being exploited, which makes identification and assistance challenging. Per the International Labor Organization, child sex trafficking is considered a subset of forced labor, with global estimates of approximately 3.3 million children and adolescents experiencing forced labor in 2021, of whom approximately 1.7 million were subjected to commercial sexual exploitation.[10] Reliable national prevalence data for child labor and sex T/E in the United States are not yet available. Violence and psychological manipulation are common in both types of T/E, and affected individuals are at increased risk of inflicted and work-related injury, sexual assault, infectious diseases, substance use disorders, untreated chronic medical conditions, malnutrition, toxic exposures, posttraumatic stress disorder (PTSD), complex PTSD, major depression, anxiety disorders, and other mental health diagnoses.[3,11–20] Given the large number of children and adolescents involved and the numerous adverse effects on physical and mental health, pediatricians and pediatric health care providers are in a unique position to identify and assist those who experience labor and/or sex T/E.[21]

When labor or sex trafficking occurs in a person's home country, it is termed domestic trafficking; when international boundaries are crossed, it is termed transnational trafficking.[22] In fiscal year 2018 (the most recent federal data available), the top 3 countries of origin of persons experiencing trafficking in the United States were the United States, Mexico, and the Philippines.[23] However, few data are available on the prevalence of transnational trafficking of both accompanied and unaccompanied children and adolescents immigrating to the United States or of domestic trafficking once these individuals have settled in the United States.[24] Available data from the Unaccompanied Refugee Minor Program of the Office of Refugee Resettlement demonstrates that the number of children and adolescents experiencing labor and sex trafficking has significantly increased in recent years.[25]

According to US federal laws, child sex trafficking occurs when a minor (<18 years) exchanges a sex act for something of perceived value. Unlike adult sex trafficking (persons over age 18), sex trafficking involving a minor does not require demonstration of force, fraud, or coercion, although these are often present. Child labor trafficking occurs when someone compels a minor to perform forced labor.[26,27] Given that minors may work legally and willingly (as a general rule, the Federal Labor Standards Act sets 14 years as the minimum age for employment[28]), force, fraud, or coercion are necessary to constitute child labor trafficking. Individual state laws vary somewhat but generally resemble the federal definition.

Smuggling differs from trafficking in that it represents a crime against a country (illegally crossing a border), rather than a person (exploitation), and by definition, requires transportation.[29] Trafficking may occur in the absence of victim transport. Although smuggling may be transformed into trafficking through fraud and deceit, the former typically involves a limited and voluntary business agreement between smuggler (often called a coyote) and client that ends after border crossing, whereas human trafficking involves force, fraud, or coercion or exploitation of a minor and an indefinite period of exploitation. Smuggling across the US-Mexico border has increased significantly in recent years and crossing to the US side without detection has become more difficult. As such, smugglers may charge immigrant families upwards of $10 000 with children and adolescents. Furthermore, families may be subsequently forced to work to pay off these inordinate debts.[30]

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It is important to note the spectrum of terminology surrounding human T/E. Specific terms being used in legal and other settings have implications for children and adolescents, themselves, in addition to influencing public perception. Commercial sexual exploitation of children is closely related to sex trafficking and involves online or offline "crimes of a sexual nature committed against juvenile victims for financial or other economic reasons. … "[31] These crimes include sex trafficking, "prostitution" (a term no longer being used when referring to children and adolescents,[32] given the psychosocial implications of this term), the mail-order-bride trade, underage marriage, the production and/or viewing of child sexual abuse materials (formerly termed "child pornography"), stripping, online sexual exploitation, and performing in sexual venues such as "peep shows" or "clubs." Many also include "survival sex" in this definition (exchange of sexual activity for basic necessities, such as shelter, food, or money), a practice common among homeless and runaway youth.[33–36] This report addresses both trafficking and exploitation (T/E).

Child marriage is common in many areas of the world[10,37,38–40]; the International Labor Organization estimated that approximately 40% of the 22 million people involved in a forced marriage in 2021 were married when they were younger than 18 years.[10] One example of forced underage marriage involves immigrant youth, including US-born individuals of immigrant parents who are sent to the parental country of origin to be married to a relative or family acquaintance. The marriage partner may be decades older than the child. It is unknown how many children and adolescents residing in the United States are at risk for forced underage marriage. In some situations, child marriage may involve slavery-like conditions, including coercion, force, and sexual and labor exploitation, consistent with human trafficking.[40] Globally, forced underage marriage may increase significantly with pandemics such as the coronavirus disease 2019 (COVID-19) pandemic[10] and with other natural disasters or public health crises as in some cultures, female children and adolescents are considered a "burden" economically, with significant cultural restrictions in education and opportunities for financial independence. Rates of child marriage may increase in response to extreme economic and/or social conditions, such as during the mass migration related to the Syrian crisis.[41]

RISK FACTORS FOR LABOR AND SEX TRAFFICKING AND EXPLOITATION

Studies generally indicate that the typical age of entrance into sex T/E is 11 to 17 years, although much younger individuals may be involved, especially in intrafamilial cases (eg, situations in which a family member is involved in the exploitation).[12,22,29,42,43] Labor T/E in the United States tends to focus on adults and adolescents rather than young children;[36,44–46] whether this reflects true disparities among age groups or a bias in recognition and reporting (perhaps young children are harder to identify) is unclear. Certainly, forced labor involving young children is a major global problem and is well-documented.[47–51]

By virtue of their young age, children and adolescents are vulnerable to manipulation and exploitation, because they have limited life experiences, a need for attachment and acceptance, an immature prefrontal cortex (with limited ability to control impulses, think critically about alternative actions, and analyze risks and benefits of situations), and limited options for action. Adolescents are learning about their own sexuality and adjusting to physical changes associated with puberty. However, some children and adolescents are at further risk because of individual, relationship, and community factors.[52] Extreme poverty may drive children, adolescents, and caregivers to migrate to large cities or immigrate to other countries and accept high-risk proposals for jobs that involve exploitative conditions. Early childhood adversity, including child abuse and neglect, is common,[53] especially among those in foster care. These traumatic experiences may drive children and adolescents to run away from home or custodial care.[54] Other risk factors are listed in Table 1.

In the United States, societal attitudes of gender bias and discrimination, sexualization of females, exoticism of American Indian and Alaskan Native (AI/AN) and Asian females, and glorification of the "pimp" in US popular culture, add to the vulnerability of children and adolescents.[23] In addition to the vulnerability associated with young age, many groups including lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ+) (particularly Black trans "womyn/gurls") and AI/AN youth are at high risk of T/E, not because of individual or group characteristics that render them vulnerable but because of the very history of US systematic enslavement, colonization, forced migration, marginalization, and discrimination against Black, Indigenous, and people of color over centuries. This systematic, often codified marginalization and discrimination has led to a loss of cultural identity, language, family ties (through US forced separation of enslaved children and adolescents and AI/AN minors from their parents), community, and means for advancement and prosperity.[55] In the case of the LGBTQ+ community, this

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TABLE 1 Risk Factors for Labor and Sex T/E[22,36,53,81,90,99,181–189]

Individual	Relationship	Community	Societal
History of maltreatment	Family violence and/or dysfunction	Tolerance of sexual exploitation	Gender-based violence and discrimination
Homeless or runaway	Family poverty	High crime rate, lack of law enforcement	Cultural attitudes or beliefs (eg, homophobia, transphobia, xenophobia)
Substance misuse	Forced migration	Lack of community resources or support	Systemic and historical racism or discrimination
History with juvenile justice	Intolerance of gender identity and/or sexual orientation	Transient male populations	Natural disasters
History with child protective services			Political or social upheaval
Unaccompanied immigrant minor or undocumented immigrant status			
Exposure of children and adolescents to sexual abuse material or violent pornography			
High number of adverse childhood experiences (ACEs)			
Mental illness			

marginalization, including by family members, may lead to increased rates of running away from home, limited job opportunities, substance use, and social isolation. All of these factors play a part in increasing the risk of T/E.[56–60]

There are global concerns that vulnerability to T/E has increased during the COVID-19 pandemic, although it is too early in the pandemic to obtain a strong evidence base to confirm these concerns.[61–69] Evidence suggests that the pandemic has disproportionately impacted minority communities within the United States, consistent with global reports that stress the particularly heavy impact on marginalized groups.[63,65,68,70,71] Some of this disparity may be related to differences in prevalence and severity of pre-existing chronic disease among population groups and to variations in social determinants of health.[71] Although measures undertaken to control viral spread are critical for public health, unintended negative consequences may increase the risk of T/E. For example, closures of businesses and schools, lockdowns (which vary in severity by country), travel restrictions, and border closures have led to (a) increased isolation of persons at risk for exploitation; (b) increased exposure to abusers and traffickers (eg, intrafamilial traffickers and exploiters of domestic workers); (c) loss of income (particularly impacting those working in low-paying jobs and the informal sector); (d) increased vulnerability to unscrupulous money lenders and to debt bondage; (e) limited access of mandatory reporters to children and adolescents at risk for T/E; and (f) limited services to individuals who have experienced, or are at risk for T/E (eg, immigrants, street-based children and adolescents, AI/AN communities).[61,67,68,72–74] School closures, increased poverty, and lack of access to social support during a crisis exacerbate these conditions.[60,75] COVID-19–related anxiety and stress may increase the risk for T/E by exacerbating mental health issues in parents, children and adolescents, and individuals who have experienced exploitation. Substance use, exposure of minors to violence in the home, and unsupervised online screen time also may have increased during the COVID-19 pandemic.[76–79]

The ratio of female-to-male children and adolescents experiencing T/E is unclear, because reliable estimates of the prevalence of human trafficking are difficult to obtain.[80] Much more attention has been paid to affected females, and this may be related to a number of factors, including a true higher proportion of females identified in large-scale studies,[9] evidence to suggest that females are more likely than males to be controlled by third-party traffickers,[81,82] that females present for health care more often because of T/E-related pregnancy and/or pelvic inflammatory disease, public discomfort with the idea of males having sex with men, public and media misperception that males cannot be subjected to sex T/E, objectified, or coerced,[83] and a general lack of screening of males for possible commercial sexual activity.[84] Sex trafficking also tends to dominate the public interest at the expense of attention to labor T/E, where males are frequently identified.[9] It is likely that the number of males experiencing T/E is grossly underestimated, because males may be less likely to be seen as "victims" by themselves[82] or by others.[14,85]

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Individuals identifying as LGTBQ+ are at elevated risk of running away from home, being told to leave home, and of homelessness, and further, of engaging in transactional sex.[81,86–88] In a study of homeless youth in New York City, transgender youth were nearly 7 times more likely to engage in transactional sex than were nontransgender youth, and homosexual and bisexual youth were 6.6 times more likely than their heterosexual counterparts to engage in transactional sex.[89]

Individuals experiencing labor and/or sex T/E may be recruited by peers, relatives, community members, or strangers.[12,90–92] They may be seduced by promises of love, money, attention, assistance, or acceptance.[42] They may be induced (by force, coercion, or lack of options) to exchange sex or engage in exploitative labor to obtain drugs, meet survival needs, or help their family's extreme poverty.[47,50,93] Fraudulent employment agencies may promise lucrative jobs, only to involve the children and adolescents in debt bondage.[94] Smugglers may decide to traffic immigrant youth after crossing a border.[19] Parental authority may be used in cases of intrafamilial T/E.4,12

Recruitment may begin over the Internet, often through use of social media, or it may involve face-to-face encounters. The process may be abrupt or prolonged. Once recruited into labor and/or sex T/E, many children and adolescents may be controlled by traffickers through use of psychological manipulation, false information (eg, labor rights, immigrant rights, deportation policies), fulfillment of an individual's need for attention and love, or threats of harm to the youth or their family. Traffickers may exert control through blackmail, fraud or deception, and/or violence.[42,45,92,95] By alternating acts of violence and cruelty with acts of kindness and "love," a trafficker may build strong bonds with children and adolescents, making it very difficult for youth to leave the situation.[22] Individuals experiencing labor or sex T/E may not recognize their situation as exploitative, instead feeling that they "owe" their traffickers obedience because of previous kind behaviors or because of an exorbitant debt. They may feel that engaging in commercial sex or submitting to exploitative work conditions is "voluntary," or that their actions demonstrate their love for an intimate partner or family member.[42,96,97] Immigrant children and adolescents exploited in a new country may feel they have no rights to better treatment and are often unfamiliar with local labor laws. They may lack familiarity with a new culture or may hold cultural views that condone inequality and discrimination.[98,99] Individuals may remain in exploitative conditions for extended periods and may return to a trafficking relationship 1 or more times before final extrication.[92]

As a result of the intense and prolonged psychological and physical trauma experienced by children and adolescents during their periods of forced labor or sexual T/E, many develop medical and mental health issues (Table 2). Some may have pre-existing physical and mental health diagnoses. A history of prior sexual abuse and other adverse childhood experiences may be associated with subsequent health problems that are exacerbated by exploitation.[100,101–104]

IDENTIFICATION AND EVALUATION

Health care providers may encounter children and adolescents with a history of T/E in emergency departments, family planning clinics (including Title X clinics), tribal clinics, child abuse or foster care clinics, public clinics or private offices, school-based health centers, urgent care centers, inpatient hospital wards, pediatric intensive care units, or institutional settings.[1,3,16,57,105,106] Care may be sought for routine health maintenance, child abuse, sexual assault, or any of the conditions listed in Table 2.[1,3,105,107] Clinicians may provide care to children and adolescents whose parent has experienced T/A for labor or sex. In these cases, it is essential for providers to determine current risk to the patient as well as to the parent or guardian and intervene for both patient and guardian, as relevant.

It is critically important for health care facilities to have guidelines or protocols in place to assist providers in identifying patients at risk for labor and sex T/E and to offer optimal, patient-centered, trauma-informed, rights-based, and culturally sensitive care to the patient and caregivers.[108] The patient's best interest should guide all decisions, as should respect for basic child rights, such as the need for information, privacy, and the right to consent or provide assent.[109] There are resources to assist in the development of such guidelines (https://training.icmec.org/courses/course-v1:icmec+ICMEC103 + 2021/about).[7,8,110] It is also feasible to incorporate T/E information into guidelines originally created for related conditions, such as child sexual abuse,[6] and into protocols for the medical care of immigrant children and adolescents and patients in foster care.[111]

Although many individuals experiencing T/E have access to medical facilities for primary, reproductive, mental health, or emergency care,[112] others experience significant barriers related to transportation, inability to miss work, lack of knowledge of health care services, insurance issues, lack of identification, language barriers, fear of deportation because of immigration status, fear of stigma or shame, or the need to care for

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TABLE 2 Health Conditions Associated with Labor and Sex T/E[11,14–16,18–20,47–49,52,59,98,120,146,190–194,195–197]

Health Condition
Physical
Traumatic injury (work-related; assault)
Sexually transmitted infections (STIs)
Other communicable diseases (eg, tuberculosis,[2] scabies)
Unwanted pregnancy and associated complications
HIV or AIDS
Malnutrition, weight loss, or stunting
Dehydration
Exposure (heat or cold)
Toxic exposures (eg, lead, chemicals, dust, silica, mercury)
Over-use injuries; scarring; loss of function
Chronic pain
Fatigue
Dizziness
Untreated or late-presenting acute or chronic conditions
Mental or emotional health
Post-traumatic stress disorder (PTSD)
Complex PTSD
Major depression
Suicidality
Anxiety disorders
Substance use disorders
Behavioral problems (eg, opposition, aggression, antisocial behavior)
Somatization
Memory problems
Attention deficit, hyperactivity
Self-harm behaviors

others.[57,107] Minors may seek care without parental consent for certain conditions (ie, reproductive health, substance use, mental health, and sexual assault). However, if care is sought for other conditions, parental consent may be necessary, unless the clinician determines that emergency care is required. In these cases, the need for parental consent may prevent children and adolescents from seeking health services.

Some individuals may access care but experience significant barriers to disclosing their exploitation.[91,113–115] Fear of involvement of police or child protective services, deportation, breaches in patient confidentiality, or repercussions by the trafficker may inhibit children and adolescents from openly discussing their situation with clinicians. Some individuals may be told to provide false information to health care staff and may be closely monitored by their trafficker (who may accompany the child or track the health visit through a cell phone).[107] Others may not perceive their situation as exploitative, as described previously. Mistrust of health professionals and the health system may be associated with deep roots in systemic racism, historical trauma, discrimination (eg, homophobia and transphobia), and expectations of and/or prior direct experience of implicit or explicit bias by medical staff.[57,116]

Barriers to patient disclosure of victimization originate with health care providers and health facilities as well. Lack of labor and sex T/E staff training is a major problem. In 1 study of health care professionals working in outpatient and inpatient settings, 75.9% reported no prior training related to human trafficking.[117] Provider discomfort with asking sensitive questions, provider bias, and lack of knowledge of resources may prevent clinicians from broaching the subject of T/E; limited time, use of family members as interpreters rather than certified medical interpreters, and lack of space for private conversations may present additional challenges.[107,112,118,119]

Given the numerous barriers to patient disclosure of T/E, health care providers must remain alert for the possibility of exploitation. "Red flags" for potential labor or sexual T/E may be associated with the circumstances around the patient's presentation for care (eg, delayed presentation for a significant medical condition; domineering companion), historical factors identified during the medical history (eg, prior work-related trauma; multiple sexually transmitted infections [STIs]), or findings noted on physical examination (eg, evidence to suggest inflicted injury). Some red flag signs and symptoms are listed in Table 3. However, it is important to keep in mind that patients who have experienced T/E may exhibit none of these characteristics, and the presence of such conditions is not specific for trafficking and exploitation. In addition, strong empirical data are lacking for many of the red flags listed in Table 3, especially for specific populations such as AI/AN and immigrant children and adolescents.

Screening Tools

Screening tools to identify people who may be experiencing T/E designed for a busy health care setting are emerging.[120,105,121–123] The goal of a screen is not to obtain a patient's definitive disclosure of T/E but to determine which patients are at particularly high risk and what major factors may be contributing to that risk to inform medical intervention. For example, the Short Screen for Child Sex Trafficking[120,105,124] includes questions about risk factors (eg, substance use, involvement with law enforcement, number of sex partners, and history of STIs) rather than

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TABLE 3 Potential "Red Flags" for Labor or Sex T/E

Initial presentation
Accompanied by domineering adult who does not allow child to answer questions
Accompanied by unrelated adult
Accompanied by peers and only 1 other adult
Inconsistent information provided by patient or companion
Delay in seeking medical care
Patient is poor historian (from sleep deprivation or drug intoxication)
Chief complaint involves:
• Acute assault (sexual or physical)
• Work-related trauma or toxic exposure
• Mental and emotional health issues
• Genitourinary symptoms or signs
• Substance use or ingestion
Historical factors
Multiple sexually transmitted infections
Previous pregnancy or termination
Frequent visits for emergency contraception
Frequent substance use
Prior sexual abuse, assault, or other maltreatment
Recent immigration; does not speak local language; undocumented immigrant status
Physical findings
Withdrawn, fearful, hostile, or suspicious demeanor
Evidence of malnutrition
Untreated chronic disease or injury
Evidence suggestive of inflicted injury
Signs of substance use or abuse (eg, nonmedical use)
Dental trauma or evidence of neglect
In possession of expensive items, such as clothing, inconsistent with rest of presentation
Constantly checking phone, appears anxious or afraid

specific questions about T/E. A positive screen should prompt follow-up questions to assess the level of risk and to determine patient needs. This focus on risk allows for a tailored approach to intervention and emphasizes patient needs over law enforcement response. Furthermore, most health care providers are not in a position to discern the nuances of legal definitions (eg, between child labor exploitation and labor trafficking).

The screen may be performed verbally using pen and paper or via electronic devices. If administered in a language other than English, certified medical interpretation or translation should be used. A review of psychosocial assessment tools found that adolescents demonstrated higher disclosure rates with written or online instruments compared with verbal administration of the tool.[106, 125] A study using the Short Screen for Child Sex Trafficking administered in English and Spanish via electronic tablet showed high rates of disclosure of sensitive information, suggesting that patients are comfortable sharing this type of information with health professionals.[122]

If screen results indicate features of concern for possible T/E, further assessment with open-ended questions about the positive screen items is indicated. Depending on patient comfort level, more direct questions about T/E may be asked as well. Examples include:

1. "You indicated in your questionnaire that you have run away from home in the past. Can you tell me about the last time this happened?"
2. "Sometimes kids are in a position where they really need food, clothing, a place to stay, or they want to buy something for themselves or someone else, but they don't have money, so they have to consider trading sex for what they need. Have you ever been in a position where you've had to consider doing this?" (Note: A positive answer does NOT indicate sex T/E actually occurred [children and adolescents may have decided not to engage in transactional sex] but likely indicates a high-risk situation warranting intervention on the part of the provider. This may involve a discussion of possible community services to address underlying needs, and potentially a report to authorities about suspected trafficking.)
3. "I have heard that sometimes people are asked if they would have sex in exchange for something. Has that ever happened to you?"
4. "Have you ever been forced to do things for someone to pay off a debt, or make money for that person? Do you feel comfortable telling me about that?"

These questions should be asked sensitively, using a conversational approach rather than reading, verbatim, from a checklist. For example, the clinician may engage the patient in a general discussion about sexual practices, sexual identity, and sexual preference, including some of these questions in the conversation.

Pediatric T/E screening tools designed for health settings are limited and are not validated for preadolescents, children, and adolescents with significant cognitive disabilities, immigrant populations, or AI/AN patients. They do not screen for labor T/E. In these situations, the health care provider may choose to "screen" for T/E by asking general, open-ended questions about risk factors, such as early childhood abuse and neglect as well as about living and working conditions. For example, the clinician might begin with: "My next question is about work. The words, 'work' and 'job' can mean lots of things, from formal jobs in areas like construction

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or restaurant work, to informal arrangements to clean someone's home, take care of children, or to help a relative with their job. Sometimes 'work' involves selling drugs, stealing or some other activity that a person does for someone else. Have you ever had a job or done work for someone else?" With an affirmative answer, the clinician might continue with, "Can you tell me something about it? What did your work involve? Did you have specific work hours? Did you wear any safety equipment (if appropriate)?" Then, move on to more specific questions about possible exploitation, "Have you ever had a job, only to find that the work you are doing, or the conditions of your work are not what you were promised? Has anyone associated with your work ever made you feel scared?"

Helpful information may be gained from detailed social histories. As an example, AI/AN children and adolescents are at high risk for homelessness, family violence, sexual abuse or assault, poverty, and severe systemic racism and discrimination, all of which render them at risk for T/E.[57–60] Undocumented immigrant children and adolescents (especially those who are unaccompanied) are very vulnerable to T/E because of their age and dependence on others, their unfamiliarity with new culture and laws, difficulty accessing resources, widespread xenophobia and adjustment challenges with family reunification, or placement with a nonparent sponsor.[126–128] Some of these risk factors may be identified through use of the HEADSSS assessment (home, education or employment, activities, drugs, sexuality, suicide or depression, and safety),[125] especially if questions about family conflict and living and work conditions are incorporated. If during the HEADSSS questions, a patient mentions something that may raise concern for sex and/or labor T/E, this should be explored in more detail to better assess risk. HEADSSS questions focusing on the child's feelings regarding their sexuality, school experiences of bullying and discrimination, and potential familial tension over the child's gender identity or sexual orientation may reveal evidence of significant social rejection and ostracism. Such rejection may increase the risk of running away from home and experiencing sex or labor T/E.[35,129]

Whether formal screening is conducted, it is very helpful to offer patients education about healthy relationships and the impact of violence on health, with an offer of relevant resources.[130] Such "universal education and resources" have been shown to be helpful for women experiencing intimate partner violence.[130,131] Other topics of education may also be relevant, including basic worker rights for youth who have a job,[132] common exploitative work practices, STI prevention, and harm reduction techniques for those experiencing high-risk situations such as homelessness. Examples of the latter include strategies to minimize risk of assault when sleeping at night or having a companion present if the individual will be engaging in high-risk activities (eg, getting into a car with a stranger).

Screening, education, and provision of resources are unlikely to be fruitful if not provided in a trauma-informed, rights-based, and culturally appropriate manner and in the patient's primary language.[5,108,109] These strategies should be employed by all staff interacting with the patient, from those in charge of scheduling, to interpreters, clinicians, and support staff. Multigenerational, historical trauma, and other forms of chronic, repeated, and severe trauma experienced before and during a period of T/E may cause an individual to adopt feelings, beliefs, attitudes, and behaviors that help them to survive a dangerous world but that seem maladaptive in nonthreatening situations.[133] Examples may include hostility toward health professionals or others in positions of perceived authority, marked withdrawal, very low self-esteem, self-medication through substance use, or engagement in high-risk sexual behavior. Considering the impact of trauma on a patient's thoughts, emotions, behaviors, and development and making appropriate accommodations in response are hallmarks of a trauma-informed approach.[4,5] Building a sense of trust and safety is a critical first step in enabling a patient to discuss their needs and concerns.[134] To further establish trust and foster a supportive clinical relationship, the health care provider needs to promptly address the chief complaint and other immediate concerns that are voiced so that children and adolescents feel their needs are being taken seriously.[135] Table 4 outlines practical strategies for a trauma-informed approach to patient interaction.[5]

Individuals who experience T/E may be subjected to bias and discrimination on multiple levels related to stigma against homelessness, poverty, immigration status, systemic racism, and historical domination (Fig 1).[136] Cultural sensitivity must extend beyond the individual practitioner to the health care organization,[137] with policies and practices in place to foster a sense of cultural safety ("an environment which is safe for people; where there is no … challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening").[138,139] Cultural sensitivity includes zero tolerance policies for bias and

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TABLE 4 Practical Strategies for a Trauma-Informed, Rights-Based Approach to Patient Care[5,108,109,137,140–142,156,198–201]

Concept	Strategies
Safety and trust	(1) Have a discussion with the patient without the companion present, to promote sharing of sensitive information. Separating the child or adolescent from the companion may be facilitated by explaining that it is organizational practice to spend some time alone with patients. Once alone with the patient, the provider can ask if the child or adolescent feels comfortable or if they wish the companion to be present. If the child does not feel safe speaking to the provider alone, sensitive questions should NOT be asked in the presence of the companion. (2) Take time to build rapport. (3) Attend to basic physical needs ("Are you warm enough?") (4) Avoid any suggestion of blame or shame. (5) Have a chaperone in the room (preferably of a gender of patient's choosing). (6) Promptly address the patient's chief complaint(s).
Privacy and confidentiality	(1) Ensure the room is quiet and staff interruptions are minimized (eg, put a sign on the door). (2) Discuss limits of confidentiality involving: • Mandatory reporting • Access to electronic health record (EHR) by others
Respect	(1) Use a calm, nonjudgmental, open, and empathic manner. (2) Actively listen, maintain good eye contact, acknowledge patient's views, and accept their perspective. (3) Listen more than speak. Ask questions to demonstrate caring and involvement. (4) Recognize the strengths and resilience of your patient and remind them of these strengths.
Transparency	(1) Explain your role, and review all steps of visit, including the reasons for each step (eg, reason for asking sensitive questions, performing physical and anogenital examination, obtaining forensic evidence kit and diagnostic tests, and offering specific treatments).
Empowerment and collaboration	(1) After explaining each portion of the medical visit, ask "What questions do you have?" Invite patient to share their concerns. (2) Ask permission to perform each of the steps of the medical visit; respect patient wishes to decline steps whenever safe and feasible. Make sure the patient understands that they can refuse components of the health visit. (3) Offer choices whenever possible (eg, "Would you like to sit in the chair or on the exam table while we chat?") (4) Ask for the individual's opinion, acknowledging their role as an expert on themselves. (5) Before offering services and resources yourself, ask the patient what they feel would be helpful to them after they leave the health facility. Then ask them if they would like to hear some ideas you have for possible resources. (6) Encourage shared decision-making throughout all steps of the visit, and when discussing potential referrals and resources. (7) Recognize circumstances that require patient consent, parent consent and/or patient assent when proceeding with medical intervention (must be familiar with adolescent rights in the state you practice).
Sensitivity to culture, gender, and historical issues as well as systemic racism and discrimination	(1) Be aware of potential cultural differences involving gender roles; views of sex, sexuality, and virginity; mental health disorders and treatment; social hierarchies; communication styles; causes of health problems; and philosophies of life. (2) Avoid assumptions about gender identity, sexual orientation; use gender-neutral language; clarify preferred pronouns. (3) Consider your own biases that may influence your interaction with the patient; take steps to monitor yourself to avoid engaging in discriminatory or stigmatizing behavior. (4) Be aware of bias and discrimination in the workplace and actively address issues that arise. (5) Use professional medical interpreters in all cases and not patient companions. Ensure that the patient and family do not know the interpreter or come from the same community. (6) Take time to learn about beliefs and practices within the cultures often encountered in your health care setting; learn from interpreters, staff at refugee organizations, and other experts in the community.
Minimize retraumatization	(1) Be aware of conditions in the health setting that may mimic adverse experiences related to trafficking, including situations in which the patient feels out of control, uncertain about what will happen next, threatened, shamed, coerced, or vulnerable. Many of these situations may be prevented by demonstrating respect, providing explanations, obtaining permission, and maintaining transparency. (2) Monitor the patient for signs of distress while obtaining the history and conducting the examination. Take steps to diffuse the anxiety (eg, pause, acknowledge distress, allow the patient control over whether to continue or stop the activity [if feasible]; provide support and reassurance). (3) Do not label or judge the patient; use language the patient is using so as to avoid making assumptions or being perceived as judgmental or biased, though that may not be the intention of the provider. Give the patient the power to ask the provider to stop or indicate (verbally or nonverbally) when something makes them uncomfortable.

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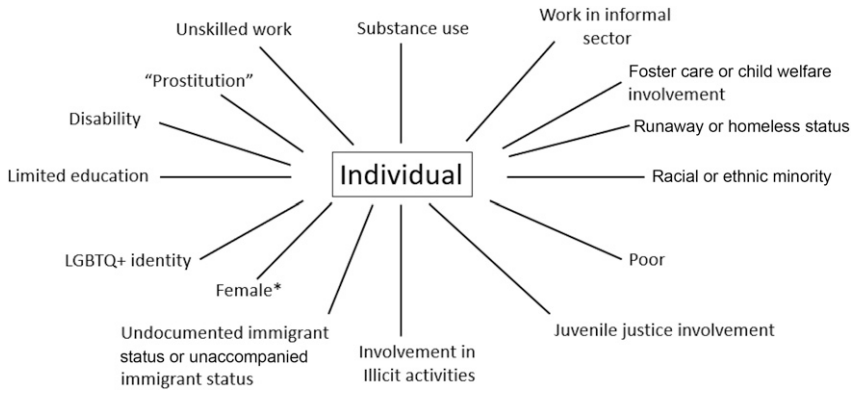

FIGURE 1
Intersectionality of bias and stigma with trafficking and exploitation. *Male status may also lead to stigma in situations involving sexual exploitation.

discrimination by staff, strategies for patients, families, and staff to report experiences of discrimination, and encouragement of staff to appropriately respond to discriminatory behavior observed in the practice (active bystander approach). Resources to assist health care providers and facilities in developing culturally sensitive strategies for patient interaction are available.[108,138,140,141,142,143–145]

MEDICAL HISTORY AND EVALUATION

In addition to obtaining details of the chief complaint and addressing the typical elements of a medical history, information may be sought regarding whether children and adolescents have a regular source of medical care or a medical home, their immunization status, reproductive history (eg, STIs, pregnancy or abortions, use of emergency contraception, anogenital trauma, number and gender of sexual partners, types of sexual activity, age at first intercourse, condom use), history of work-related injuries, physical abuse and assault or dating violence, substance use, and history of mental health signs or symptoms. Such information should be obtained using an open and nonjudgmental approach, with the goal of informing recommendations for testing and referrals and opening the door to anticipatory guidance. Questions regarding current housing and the youth's feelings of safety in that housing also may be enlightening. A brief mental health assessment may be especially important because many patients who experience labor or sex T/E develop mental and emotional health conditions listed in Table 1, some of which may present as acute psychiatric emergencies.[11,13,16–19,20,60,146,147,148] The provider may ask about past thoughts or actions related to self-harm, current suicidal ideation, and current symptoms, such as intrusive thoughts, nightmares, dissociation, and panic attacks.

For migrant children, it is important to obtain travel and detailed social histories. These histories may include questions regarding how and with whom the child came to the United States (or other destination country), their current living situation, immigration status, possible child or family debt, school enrollment and attendance, and employment or work status. Also important is information about prior abuse, assault, T/E, or persecution in the child's home country and during their journey. It is essential to explain that legal status (or lack thereof) will not be documented in the patient's chart and will not affect patient care and that the reason these questions are asked is to determine the potential need for confidential referrals to immigration legal support services.

Each step of the medical examination and diagnostic evaluation should be explained to children and adolescents and permission sought to proceed, as developmentally appropriate. A patient's refusal of aspects of the examination or diagnostic evaluation should be respected, if at all possible. In some cases, an individual may refuse 1 step of the evaluation (eg, STI testing), but agree to have it completed at the follow-up visit. The evaluation focuses on:

- Assessing and treating acute and chronic medical conditions, including documentation of late-presenting conditions, and evidence of toxic exposures.
- Assessing overall health, nutritional status (including iron and other micronutrient deficiencies), hydration, growth, and development.
- Assessing dental health and care.
- Referring to an appropriate sexual assault response team, if indicated, with potential forensic evidence collection. Health care providers should work collaboratively with law enforcement investigators to refer the patient to the medical provider in the community who provides such services, and keep in mind that people who have experienced labor T/E may also have experienced sexual exploitation. When these resources are not available locally, care may be obtained via telemedicine, either as a real-time consultation or a delayed review of examination photographs or video by a professional with expertise in T/E and sexual abuse or assault.[9]
- Documenting acute or remote injuries, genital and extragenital

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(ie, cutaneous, oral, closed head, neck, thoracoabdominal injuries, and skeletal fractures); sequelae of old injuries, including functional impairment, permanent injury, and scarring.

- Documenting tattoos, especially those signifying gang affiliation, those with sexual connotations, or symbols of money or wealth and those suggesting that a patient is someone's property.[149]
- Assessing for mental health issues, especially acute emergencies.[150]
- Testing for pregnancy, STIs (ie, gonorrhea and/or *Chlamydia* infection, trichomoniasis, syphilis, hepatitis B and C, and HIV), and repeat testing for syphilis, HIV, hepatitis B and C at 6 weeks and 3 months after last known exposure; if an immigrant child, testing also for possibly vertically transmitted infections (eg, HIV, hepatitis B and C, and syphilis).[151] Sites of STI testing will depend on history of contact and may include the pharynx, vagina, cervix, urethra, and anus. Urine and serum specimens may be obtained.
- Urine and/or serum screening for alcohol and substance use, as clinically indicated (eg, if the patient gives a history of unexplained lapses of time and drug-facilitated sexual assault is suspected). Testing should only occur with the patient's permission and only after explaining how the results will be used.[150]
- Laboratory testing for micronutrient deficiencies (eg, iron, vitamins A, E, and B_{12}, folate), toxin exposure (eg, lead, mercury, nicotine, depending on occupational sector involved), communicable diseases related to crowded living conditions (eg, tuberculosis), COVID-19, or for infectious diseases endemic in the country where the child lived or traveled, as indicated (eg, strongyloidiasis, schistosomiasis, hepatitis B and C, soil-transmitted helminth infections) (https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic-guidelines.html).[151]
- Offering contraceptive options, with particular focus on long-acting reversible contraception. Given that this population can be medically transient, efforts should be made to address this concern at the time of evaluation, when able, given that this is 1 of the most frequent reasons for seeking health care in this population. Referral for a later visit may not be possible, given the patient's circumstance.
- Offering prophylaxis for STIs and emergency contraception and postexposure prophylaxis, and preexposure prophylaxis for HIV, as appropriate.
- Offering immunizations as needed.

Health care providers who do not routinely provide gynecologic services for children and adolescents, forensic examinations in cases of sexual assault or abuse, health care for transgender patients, or medical evaluations for immigrant populations are encouraged to familiarize themselves with the resources available in their communities, including child abuse pediatricians or hospital child protection teams, child advocacy centers, sexual assault nurse examiner programs, adolescent medicine specialists or gynecologists, immigrant or refugee clinics, legal clinics for undocumented immigrants, and federally qualified health centers. The National Children's Alliance (https://www.nationalchildrensalliance.org/cac-coverage-maps/) provides links to local child advocacy centers throughout the United States. In addition, American Academy of Pediatrics (AAP) resources are available, such as the Immigrant Health Toolkit (https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Immigrant-Child-Health-Toolkit/Pages/Immigrant-Child-Health-Toolkit.aspx), as are resources from the Centers for Disease Control and Prevention (CDC [https://www.cdc.gov/]), particularly the CDC Domestic Refugee Screening Guidelines (https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic-guidelines.html), CareRef (https://careref.web.health.state.mn.us/), and the World Health Organization (http://www.who.int/en/). The clinician should be aware of state laws on conducting medical evaluations (including sexual assault evidence kits) without guardian consent.[152,153] In many cases, the guardian does not accompany the trafficked patient, and laws regarding consent to examination, photography, testing, treatment, and obtaining forensic evidence are complex. Clarification and recommendations are available.[154,155]

The trauma-informed, victim-centered, culturally sensitive approach extends to the examination. A staff chaperone (of the gender preferred by the patient, if available) should be present during the examination, and the patient may want the person accompanying them to be present as well. If that person is a suspected exploiter, their presence should be avoided if at all possible and if exclusion is not likely to prompt retaliation toward the patient.[156] It is helpful to carefully explain each step to the patient and monitor for signs of distress.[157] Routine aspects of the examination may trigger traumatic memories; this often involves the anogenital examination or photography of injuries.

Documentation of acute and healed anogenital, oral, and cutaneous injuries is best accomplished with photography and detailed written description of the size, shape, color, location, and other notable characteristics of each mark.[158] Photographs should be stored on a

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secure electronic platform; if this is not available, other security measures should be taken to protect privacy and confidentiality. Inflicted trauma may be suspected when injuries are noted in protected areas of the body (ie, torso, genitals, neck, medial thighs),[159] when they have a patterned appearance, or when the explanation provided by the patient is incongruous with the injury.[158] Laboratory testing and diagnostic imaging for possible internal injury may be indicated.

The anogenital examination is best performed with the aid of a colposcope, digital camera, or camcorder so that if a provider with specific training in child sexual abuse or assault (eg, child abuse pediatrician or sexual assault nurse examiner) or a pediatric gynecologist is not available to perform the examination, photographs or videos can later be submitted to an expert for evaluation (see above). The assistance of a child life specialist may help reduce patient anxiety. Complete visualization of the external genitalia and perianal area is necessary. Typically, a speculum exam is not necessary unless there is bleeding and internal injury is suspected;[160] a bimanual examination is helpful to assess for pelvic inflammatory disease in adolescent females. If speculum examination is required, pubertal status as well as patient discomfort must be considered and an examination under anesthesia (EUA) may be necessary. The provider should consider the potential for patient distress associated with an EUA, related to the child's loss of control and/or pain or disorientation experienced during recovery of full consciousness. Although visible injury may be present, it is not unusual to have a normal or nonspecific anogenital examination in cases of sexual abuse even with repeat anogenital penetration.[161,162] Injuries that do occur typically heal quickly, within days to a few weeks, and scarring is very unusual.[163]

With the patient's informed consent, a sexual assault evidence kit may be obtained up to 120 hours after an assault (according to patient age and law enforcement jurisdictions).[164] Time must be taken to explain the purpose of the sexual assault evidence kit to clarify that it may be used in a law enforcement investigation. This explanation requires an open discussion about whether the patient may choose to proceed with speaking to law enforcement to file a formal complaint.

Pregnancy testing and baseline testing for STIs may be offered and performed, as described previously. Other testing may be considered (eg, hepatitis D in addition to HBV; herpes simplex virus). The F has issued guidelines for testing and treatment of STIs in cases of acute sexual assault.[165] Because follow-up of patients is not guaranteed, the health care provider should consider offering the patient prophylaxis for gonorrhea, *Chlamydia*, and trichomoniasis as well as hepatitis B vaccination or hepatitis B immune globulin if the child has not been vaccinated previously. For females, emergency contraception may be offered as appropriate. In addition, human papillomavirus vaccination may be offered to a patient 9 years or older who has not yet been immunized. Postexposure prophylaxis for HIV should be considered and discussed with the patient and nonoffending caregiver, because multiple HIV risk factors are frequently present (eg, multiple sexual partners of unknown HIV status; potential anal intercourse; inconsistent condom use; potential mucosal injury at time of intercourse). The health care provider may want to consult with an infectious disease specialist or refer to CDC guidelines.[165] Tetanus boosters may be considered if patients have open wounds without confirmation of up-to-date tetanus immunizations. Many patients, especially those from resource-limited countries, may have had limited access to health care and need other immunizations.

DOCUMENTATION

Documentation of sensitive information regarding risk factors for T/E and details of exploitation should be approached with careful consideration for patient privacy and confidentiality. Patients may fear that information in their medical record will become accessible to those who may cause them harm (eg, angry caregiver, trafficker, Immigration and Customs Enforcement), that medical staff will stigmatize and judge them, or that sensitive information may be used against them in court proceedings (eg, criminal, immigration, or civil cases). Guardian access to an electronic patient portal increases the ease with which parents may access health information on a minor.

The health care professional should explain to the patient (as developmentally appropriate) and nonoffending caregiver that although health facilities go to great lengths to protect patient privacy and confidentiality, others outside the care team may gain access to the record (eg, law enforcement and child protective services in cases involving mandatory reporting, legal officials, health care administrative staff, payer of claims staff, guardian, etc). Before broaching sensitive topics of the medical history, it is important for the clinician to discuss with the patient and nonoffending caregiver these limitations and those associated with mandatory reporting. It is helpful to discuss changes to information available in the electronic patient portal associated with the 21st Century Cures Act.[166] This should include a description of strategies used by the health facility to protect access to

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sensitive information (eg, "confidential notes"). If the guardian is present, it is preferable to obtain verbal consent to speak with the patient alone and include disclosed information in a confidential note, as appropriate.

Providing clear information on the limits of confidentiality allows the patient to determine what information they choose to disclose, consistent with their basic human rights. The level of detail of this conversation will vary according to the circumstances of the visit and the developmental capabilities of the patient. For undocumented immigrant individuals, expert opinion suggests that legal status not be documented in a patient record per standard practice.

At the end of the visit, the clinician should discuss what information a patient wants included in the health record. The goal is to include information that is critical to the continuity of patient care yet respects the individual's desires for confidentiality, excluding nonessential information, and taking steps to phrase relevant information in a way that does not result in patient shame, distress, or retraumatization. Decisions about information to be included in the record must be subject to legal and administrative policies. Additional discussion of documentation of sensitive health information is available.[167,168]

REFERRALS, RESOURCES, AND MULTIDISCIPLINARY INTERVENTION

As with all aspects of the patient interaction, the discussion about reports and referrals should be trauma informed. It is important to engage the patient (and caregiver as appropriate) in this process, seeking their active input and opinions about suggested resources. The health care provider may empower their patient by beginning the discussion of potential referrals by asking what children and adolescents think would be most beneficial after discharge and if they have ideas for resources. Any referrals should be consistent with patient and family cultural practices and beliefs.[57,141] The latter may influence the way the patient views their condition, their health, and their desired treatment. Cultural practices and traditions may be empowering to children and adolescents and assist in building resilience. When making referrals for services, the health care provider should strive for a "warm handoff" to the referring agency. That is, the provider should offer to contact the referral agency while the patient and family are present or allow the patient or family to make the call while still in the health care setting. This helps to ensure that appointments for follow-up are made.

Individuals who have experienced sex or labor T/E have a variety of immediate needs (eg, shelter, food, clothing, materials and resources to address menstrual needs, interpretation services, emotional support, health and mental health care, and treatment of substance use disorders) and long-term needs (eg, housing, education, life skills and job training, victim advocacy, family services, immigrant legal services, a medical home, and mental health resources).[169] Undocumented immigrant children and adolescents who may have been trafficked, abused, neglected, and/or abandoned need prompt referral to a pro bono immigration attorney or other qualified professional who can assist in addressing immigration issues and in applying for federal assistance through the Trafficking Victims Protection Act. They may also qualify for asylum or other legal status protections. A Department of Health and Human Services (DHHS) Interim Assistance and Eligibility Letter will allow children and adolescents access to federal programs typically available to asylees and refugees, including food stamps, public housing, Medicaid, medical and mental health services, Temporary Assistance for Needy Families (TANF), and employment opportunities through Job Corps.[170]

Providing for the many needs of patients with a history of T/E requires health care providers to work with law enforcement, social services, mental health professionals, immigration lawyers, and service organizations. It is important for the medical provider to identify available community resources and if possible, to establish relationships with agency representatives to ensure that referrals are appropriate for patient needs. Cultivating these relationships before encountering a patient is paramount. To identify local, state, and federal resources, health care providers may:

- Conduct a community mapping exercise: Engage with community partners and other health professionals with expertise in child abuse or human T/E for assistance in creating a directory of available services to address the needs of patients who have experienced T/E or who are at risk.
- Request assistance from the National Human Trafficking Resource Center Hotline (1-888-3737-888), which offers information in more than 200 languages and operates 24 hours per day.
- Contact the US Department of Health and Human Services, which has comprehensive information about services available to trafficked persons who may or may not have legal status in the United States.[145,169]
- Obtain information and resources for homeless and runaway youth from the National Network for Youth (http://www.nn4youth.org; 1-202-783-7949).

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It is helpful for health care providers to be aware of policies that may or may not allow organizations to provide shelter and support for a period of time before disclosing a patient's whereabouts to family or authorities.

Health care providers need to consider and discuss with the patient potential referrals for easily accessible healthcare, including primary care, reproductive health care (with HIV pre and postexposure prophylaxis monitoring), family planning, prenatal care (as indicated), and substance use disorder treatment with access to addiction pharmacotherapy when indicated. Patients may need nutritional guidance and treatment of malnutrition. Children and adolescents in foster care may benefit from referrals to clinics specializing in the needs of these patients. Chronic medical conditions may require subspecialty care. Members of special populations, such as those within the LGBTQ+ community, may require additional subspecialty care, such as referral to a health care provider who is well versed in working with transgender youth. Dental care may be required for acute problems related to trauma or infection or for treatment of long-standing issues related to lack of care. Referral to a plastic surgeon may also be warranted, given that a patient may wish to remove marks or brands related to the trafficking experience.

Referrals to trauma-trained mental health professionals familiar with T/E issues may be extremely beneficial to patients. There may be untreated, undertreated, or misdiagnosed mental health issues related to complex trauma occurring before and during the period of T/E. Local child advocacy centers (eg, organizations serving children, adolescents and families experiencing child maltreatment; child advocacy centers) may provide many helpful services, including mental health assessment and treatment, forensic interviews, and in some cases, second-opinion anogenital examinations. Such centers are available throughout the United States (National Child Advocacy Center: https://www.nationalcac.org/find-a-cac/; National Children's Alliance: https://www.nationalchildrensalliance.org/), and similar programs exist in Europe (Barnahus: https://www.barnahus.eu/en/). However, for patients who have not yet made a disclosure of involvement in labor or sex T/E, child advocacy centers may not be an available resource because of restrictions on patient population, by age, and because of the need for involvement of child protective services and/or law enforcement. This reinforces the need for the health care provider to be aware of other local resources for vulnerable youth.

Health care providers also need to be acutely aware of risk factors and potential indicators of exploitation that migrant children and youth may have experienced in their home country, during migration, while in US custody, or after release to guardians. Clinically validated screening tools designed for the health care setting are not yet available for this population, but open-ended questions about living, working, and traveling experiences; sensitive discussions about potential trauma experiences; and universal education about T/E and basic human and worker rights may set the stage for vulnerable patients and caregivers to seek help. Offering referrals to pro bono immigration attorneys and legal clinics and culturally sensitive mental health organizations is recommended.

The myriad of needs for patients with a history of T/E require a medical home with clinicians well-versed in trauma-informed care. Ideally, multidisciplinary services are integrated into a single-site program, allowing patients increased accessibility to varied services that may improve health outcomes. Across the United States, special clinics are being developed for adults and/or youth with a history of or ongoing involvement in labor and/or sex T/E.[171,172] Such clinics strive to provide services that meet the unique needs of traumatized individuals who may have difficulty accessing health services that use standard operating procedures for clinic hours, no-show rules, and cancellation policies. A youth-serving approach emphasizes recognizing and addressing patient needs promptly, building trusting relationships with patients who respect agency and choice, improving accessibility with 24-hour clinical coverage, and free or sliding scale care.[135] Other clinics that serve vulnerable populations, such as immigrant health clinics, tribal clinics, and teen clinics, may also be appropriate sources of ongoing integrated medical and mental health care. Finally, telehealth services may provide access to a range of care options when on-site care is unavailable; however, clinicians must be aware that exploiters may be monitoring telehealth interactions, out of view of the camera; in these cases, safety issues become ever more important to consider. Although there may be limitations, there may be benefits as well; the provision of telehealth is an area of continued expansion and research.

Health care providers must comply with existing child abuse mandatory reporting laws.[173] In May 2015, the federal Child Abuse Prevention and Treatment Act was amended by adding human trafficking and child sexual abuse materials as forms of child abuse, regardless of parent or caregiver involvement.[26] However, this definition has not been adopted by each state at this time, making it imperative for clinicians to be familiar with the state mandates in their area. Patients currently involved in the child welfare system, even those with

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an active child abuse investigation underway, require a new report to be made when trafficking is suspected. It should be noted that mandatory reporting for suspected child labor trafficking is not present in most states. Clinicians should refer to their state social services law for further direction or reach out to state child protective services. The AAP supports chapter advocacy efforts to classify child trafficking as a form of child maltreatment.

It is critical for health care providers to remember that most mandated reporter laws require only that a "reasonable suspicion" of maltreatment (eg, trafficking) is necessary to make a report in good faith; definitive evidence of exploitation (such as a disclosure from the patient) is not required. However, clinical suspicion and reasonable suspicion (for reporting) may not be synonymous. Regardless, the most important action to be taken is to offer resources to the patient according to needs identified during the visit. In many cases, individuals who are deemed at risk for T/E will have needs very similar to those whose trafficking status is confirmed. Health care providers need to consult relevant law and health administrators to determine whether to contact law enforcement, child protective services (CPS), or other agencies in any given case. For assistance in determining how to proceed with a suspected labor and/or sex trafficking case before initiating a report and to obtain information on relevant laws and reporting recommendations, health care providers may contact national trafficking organizations, such as:

- National Human Trafficking Resource Center Hotline (1-888-3737-888)
- Polaris Project (www.polarisproject.org) (sponsors the hotline above)
- Shared Hope International (sharedhope.org)
- National Center for Missing and Exploited Youth (www.missingkids.com)

Other helpful sources of guidance include:

- Staff from state law enforcement task forces on child trafficking
- State or local law enforcement
- CPS agencies
- Local child advocacy centers (see above)
- Immigration relief clinics that provide medical and mental health forensic evaluations (see the Society of Asylum Medicine, https://asylummedicine.com/ and Physicians for Human Rights https://phr.org/ for details).

In cases involving undocumented immigrants, when a formal or informal screen identifies labor conditions that are potentially exploitative or there are concerns for sex trafficking, the health care provider should contact local authorities. In turn, local, state, and federal officials are required to report suspected labor and/or sex trafficking to the Office of Trafficking in Persons (OTIP) within 24 hours of receiving the information. Prompt reporting is very important, because OTIP may be able to facilitate federal assistance to individuals with a history of trafficking, including those with undocumented status. It is also possible for the health care provider to contact OTIP on their own to make the request for assistance. In addition, it is important to link the patient to free legal services (through government legal aid and nongovernmental organizations) or a pro bono immigration attorney who is part of a local nonprofit legal aid program. This will allow the individual's T/E status to be more fully assessed and options for legal aid initiated (see Resources). The availability of immigration legal assistance varies with geographic region, and clinicians may well lack knowledge of available attorneys within their area. In such cases, referrals may be obtained by contacting a local refugee to immigrant service organization or the National Human Trafficking Hotline (888-373-7888 or text 233733), or visiting the Web site of Kids In Need of Defense. The health care provider should be sure to explain to the individual and caregiver the importance of contacting a legal professional and the need to act promptly. Ideally, the clinician provides a "warm handoff" by calling the referral agency from their office before the patient leaves (or assists the patient or caregiver in making the call). Follow-up at the next patient visit may be very helpful to ensure that contact has been made with the legal professional or to provide further assistance in making the connection.

As has been stressed, mandatory reporting laws and policies must be followed. However, providers should be aware of the potential issues related to reporting to authorities so that they can help minimize potential harm to the patient. Depending on the degree of understanding by child protective services workers regarding the unique issues facing children and adolescents who experience T/E (which generally extend beyond those related to the home environment and caregiver behavior), making a report may not lead to positive intervention for the patient, and the response to the report may be "uncertain and potentially ineffective or even harmful."[31] In addition, although federal antitrafficking laws clearly indicate that a minor cannot consent to engage in commercial sex acts and must be considered a victim,[27] in some cases children and adolescents may be treated as offenders (eg, charged with "prostitution").[12,14,83,85] Involvement in the juvenile justice system as an offender decreases the likelihood that an individual with a history of T/E will receive critical services and protection

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and may lead to further trauma, including reentry into T/E and involvement in other high-risk behaviors. A cogent discussion of the ethical issues related to reporting of child trafficking may be found in a report from the Institute of Medicine,[31] and information regarding individual state laws regarding child trafficking and commercial sexual exploitation may prove helpful to health care providers.[174]

To help minimize potential harm associated with mandatory reporting of suspected child T/E, it is important for health care providers to emphasize to authorities that the patient is a victim of exploitation who needs services rather than a juvenile offender. Describing a child or adolescent's limited ability to understand sophisticated psychological manipulation practiced by traffickers and the lack of brain maturation, which limits their ability to weigh risks and benefits of various behaviors, may help investigators understand the patient's status. Similarly, the health care provider may stress the particular vulnerabilities identified in the individual which have made him or her susceptible to T/E.

In responding to cases of suspected labor or sex T/E, a health care provider should be transparent about the need for mandatory reports and explain to their patient the reason for the actions. Child and adolescent concerns should be explored, even if their requests cannot be fulfilled. If a report to authorities is not mandated, the clinician should seek caregiver and patient consent before reaching out to law enforcement or child protective services.

Recognizing and responding to suspected child labor and/or sex T/E is complex. Health care organizations should develop a set of guidelines for staff to follow when working with a patient who may have experienced T/E, or who is at risk. Resources for guideline development include:

- The AAP patient care webpage on child trafficking (https://www.aap.org/en/patient-care/child-trafficking-and-exploitation)
- International Centre for Missing and Exploited Children's "A 'How-To' Guide to Develop a Healthcare Protocol for Responding to Child Trafficking and Exploitation"
- Dignity Health's "Human Trafficking Response Program Shared Learning Manual"[175]
- HEAL Trafficking and Hope for Justice's "Protocol Toolkit for Developing a Response to Victims of Human Trafficking in Health Care Settings"[7]
- International Centre for Missing and Exploited Children's "Improving Physical and Mental Health Care for Those at Risk of, or Experiencing Human Trafficking and Exploitation: The Complete Toolkit, 2nd Edition,"[8] (https://www.icmec.org/healthportal-resources/topic/human-trafficking-toolkit/).

A patient who has experienced labor and/or sex T/E faces numerous challenges to exiting their exploitative situation, including emotional bonds with the exploiter, fear of retribution, reluctance to return to a dysfunctional home, ostracism by family or community, debt bondage, fear of deportation, and other difficulties. It is not unusual for patients to return to the T/E environment, sometimes several times, before final extrication.[176]

SELF-CARE FOR THE CLINICIAN

Those caring for patients who have experienced T/E are at risk themselves for secondary traumatic stress (STS), a syndrome with symptoms similar to those of PTSD experienced by those learning about others' trauma.[177] A health care provider may experience emotional, physical, and mental exhaustion attributable to excessive and prolonged stress as a result of too many demands and too few resources. As such, for those working with patients experiencing T/E, self-care is a high priority. The first step in mitigating secondary STS is to identify its signs and symptoms (eg, irritability, hopelessness, intrusive thoughts). Support from others and a work environment that acknowledges and seeks to minimize secondary trauma help combat STS. Resources addressing STS are available.[178]

CONCLUSIONS AND GUIDANCE FOR HEALTH CARE PROVIDERS

1. Individuals who identify as male, female, or any gender identity and who have experienced labor and/or sex T/E may present for health care related to trauma, infection, reproductive issues, mental health concerns (including severe intoxication and overdose from substance use) and other concerns.
2. Patients with a history of T/E rarely spontaneously disclose their situation. Although some individuals have no obvious risk factors or red flags, many have 1 or more vulnerabilities at the individual, relationship, community, and/or societal levels.
3. Screening and/or universal education with resources are helpful strategies for identifying and assisting high-risk patients. Health care providers should use clinically validated screening tools whenever possible. The goal of screening is not to obtain a disclosure of T/E, but instead, to assess the level of risk and identify patient vulnerabilities that may be addressed with community services.
4. To increase patient and family awareness of child T/E, health care providers may display posters translated into multiple languages, including the National Human Trafficking Hotline (1-888-

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3737-888), in waiting rooms, examination rooms, or restrooms, and make brochures and other resources regarding healthy relationships readily available.

5. Evaluation of patients who have, or who are at risk for experiencing T/E is best completed using a trauma-informed,[5] culturally sensitive, rights-based[109] approach that emphasizes support, acceptance, transparency, safety, and patient empowerment.
6. Medical evaluation of a patient who has experienced labor or sex T/E involves addressing acute medical or surgical issues (eg, injuries, toxic exposures, sexual assault), assessing nutrition and hydration status, evaluating possible chronic untreated health conditions, documenting acute or remote injuries, testing for and treating STIs, and obtaining a sexual assault evidence kit, as appropriate. Immigrant patients should be screened as outlined in the CDC "Domestic Refugee Screening Guidelines."[151] Steps of the evaluation should be explained to the patient and permission obtained before proceeding (except in cases of medical emergency).
7. Documentation of sensitive patient information related to T/E, to existing vulnerabilities to exploitation (eg, substance use), and to certain health conditions (eg, STIs, HIV or AIDS) should be undertaken with careful consideration regarding who may access the information in the health record, and under what circumstances. As appropriate, providers should discuss documentation options with patients, working to ensure safety and to respect the individual's wishes for privacy while at the same time preserving continuity of care and complying with relevant laws and policies.
8. Patients who have experienced T/E have many and varied needs, and meeting these needs requires a multidisciplinary, holistic approach (eg, one that addresses all of the needs of the individual, including physical and mental health, as well as social, legal, and immigration needs). The health care provider has an opportunity to work collaboratively as part of a team of community professionals from a number of disciplines. Increasingly, T/E clinics are being developed to provide integrated and comprehensive, multidisciplinary health and mental health care for vulnerable patients.
9. Providers may advocate for patients at risk for and experiencing T/E by educating child-serving professionals and families regarding labor and sexual exploitation and offering anticipatory guidance to parents and children and adolescents regarding internet safety, common trafficking recruitment scenarios, healthy versus unhealthy relationships, and basic labor rights. They may help to prevent T/E by offering high-risk patients and families community and national resources to address vulnerabilities.[179] Finally, health care providers may advocate for victim services at the community, state, and national levels. The AAP has published a policy statement on child trafficking, with recommendations for advocacy measures.[180]
10. Health care providers are mandated reporters of suspected child abuse and neglect. In states where sex trafficking is considered a form of abuse, the provider must make a formal report of suspected T/E to law enforcement and to CPS.
11. Clinic and hospital guidelines for the recognition and response to suspected human labor and sex T/E are necessary so that all staff members are aware of their roles and responsibilities and vulnerable patients may be identified and offered resources. Guidelines should be supplemented with staff training on T/E as well as trauma-informed care, cultural sensitivity and awareness, and management of implicit and explicit biases.
12. Self-care for the clinician is critical in preventing and addressing secondary traumatic stress. A work environment that fosters peer support, encourages open discussion of work-related stress, and implements reasonable work-life balance policies can help protect providers from secondary stress and its consequences.
13. The financial impact and management implications for a clinical practice may be significant, and there is a need for advocacy to ensure fair and equitable resourcing. Staff training, screening of patients, assessment, and provision of services require time and resources for which practices need support.

RESOURCES

- National Human Trafficking Resource Center and Hotline (1-888- 3737-888); https://humantraffickinghotline.org/
- Administration of Children and Families, Office of Trafficking in Persons (https://www.acf.hhs.gov/otip/victim-assistance/services-available-victims-trafficking)
- HEAL Trafficking: An organization of professionals addressing human trafficking through a public health lens; numerous resources for health professionals available on Web site (www.healtrafficking.org)
- Polaris Project: A national resource for human trafficking: https://polarisproject.org/
- Office of Refugee Resettlement release of information: https://

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www.acf.hhs.gov/orr/policy-guidance/requests-uac-case-file-information
- CDC Domestic Refugee Screening Guidelines: Information on approach to medical and mental health screening of immigrants and refugees. https://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic-guidelines.html
- CareRef: In-office tool for medical screening of immigrants and refugees https://careref.web.health.state.mn.us/
- The Society for Asylum Medicine https://asylummedicine.com/
- National Immigration Legal Services Directory: https://www.immigrationadvocates.org/nonprofit/legaldirectory/
- Federally funded mental health counseling for immigrant youth and parents separated by ICE in the US: https://www.senecafoa.org/todopormifamilia/

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ABBREVIATIONS

AAP: American Academy of Pediatrics
CPS: child protective services
PTSD: posttraumatic stress disorder
STS: secondary traumatic stress
T/E: trafficking and exploitation

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